

Child Abuse Prevention: New Partnerships for Protecting Children and Supporting Families

The Policy Institute for Family Impact Seminars



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Child Abuse Prevention: New Partnerships for Protecting Children and Supporting Families

Background Briefing Report
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Revised and updated by Joy Byers

and highlights of the Seminar held on February 21, 1997,
at 1100 Longworth House Office Building, Washington, DC

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Preface

There is a growing awareness of the personal, social, and public costs of child abuse and neglect. Numerous studies show the connection between early maltreatment of a child and the later development of violent and delinquent behavior. Children who are abused and neglected are at greater risk of failing in school, suffering physical and learning disabilities, and requiring mental health services. By one estimate, the minimal annual direct costs of child maltreatment are \$9 billion per year. Ironically, programs to prevent child abuse have received only a tiny fraction of the total amount of federal child welfare dollars that are spent on out-of-home placement and treatment services.

We are nevertheless making substantial progress in learning how to prevent child abuse and neglect. This report, prepared as background material for a seminar held on Capitol Hill in 1997, highlights a number of models of child abuse prevention, including home visiting programs, which have been shown to have dramatic positive long term results. The report also describes a number of community partnerships that are attempting to develop effective community-wide prevention strategies.

Fortunately, two factors have stimulated a renewed interest in prevention. First, welfare devolution has shown that states and local governments can develop innovative and effective solutions to the problem of welfare dependency. Second, the publicity given to the “new” brain research has fueled the determination to intervene early in children’s lives. A vigorous debate is now underway at the national level about how best to redirect federal fiscal incentives and give states and communities greater flexibility to invest in strategies that will protect vulnerable children and support their families. Meanwhile, several states have recently decided to spend substantial state dollars on child abuse prevention.

This welcome policy discussion needs to be based on a sound understanding of the issue, research and practice. For this reason, we decided to reissue this report for distribution to a wider audience.

Theodora Ooms

Executive Director

Family Impact Seminar

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Child Abuse Prevention: New Partnerships for Protecting Children and Supporting Families

*A Background Briefing Report by Diane Dodson
with the assistance of Joy Byers*

Introduction

Rates of child abuse and neglect in the United States continue to climb and, as a result, so have the number of children placed in foster care. In 1997, a national study found that 1,054,000 children were confirmed victims of abuse and neglect. Between 1988 and 1997, child abuse reporting levels have increased 41 percent. In 1996, more than 1,100 children died as a result of abuse and neglect. As a comparison, rates of child abuse fatalities have increased 34 percent between 1985 and 1996.

Public alarm over child injuries and deaths fuels the determination of public officials to enact policies that will ensure the safety of children at risk. While improvements in the child protective service system are clearly needed, they must not deflect attention away from the importance of investing in prevention strategies. The personal, social, and economic costs of child abuse and neglect make a compelling argument for focusing on prevention **before** child abuse occurs. If the system waits to respond until a child is in danger, much damage will already have been done to the child's emotional, social, physical, and cognitive development. Moreover, it is difficult and costly to help parents who are already abusing their children to learn how to safely care for them. And when keeping the family together is not possible, it is even more costly to remove the child and find another permanent home.

The critical questions are: Do we know how to prevent child abuse and neglect? Which children are at risk of being harmed and which adults are at risk of hurting them? What kinds of information, services, and supports do parents and other caregivers need to promote the healthy development of children and keep them safe? Can we afford to provide them?

The causes of child maltreatment are complex, and there are no easy cures. However, several promising approaches are being tested in communities around the country that emphasize (i) preventive and specialized services for families at risk need to be supplemented by an array of undergirding basic family supports, and (ii) communities need to be engaged in a process of sharing the responsibility for abuse prevention and child protection with the child protection agencies.

This background briefing report is designed to provide an overview of child abuse prevention research and program and policy strategies. In Parts I and II, we discuss how child abuse and neglect are defined and measured, what the incidence rates and trends are, and what has been learned about the causes of child maltreatment. In Part III we define the scope of preventive

services and some promising models, including several home visiting programs that have demonstrated some successful results. Parts IV and V describe the federal role in prevention and state and local efforts that are pointing towards a new vision of prevention and child protection. This vision is sustained by partnerships among many different sectors of the community and between an array of private and public funders, all of which are described in Part VI. Finally, we briefly discuss some of the questions and challenges that federal, state, and community leaders should address as they strive to help families and protect children.

I. Scope of the Problem

(Source: National Research Council, 1993)

Defining and Measuring Child Abuse and Neglect

The terms “child abuse” and “neglect” are difficult to define clearly. While it is easy to agree on what constitutes extreme forms of abuse — for example, those that lead to a child’s death or physical injury — it is much harder to achieve definitional consensus on less severe forms of abuse or neglect. For example, legal definitions focus on identifying specific incidents of abuse that can be proven, and practitioners and researchers look more at family and caregiver behaviors that place children at risk of harm. Moreover, culture and education affect beliefs about what constitutes dangerous or unacceptable standards of parental behavior.

Although states’ legal definitions of child abuse differ, most child abuse statutes describe four types of harm to a child that may serve as the basis for coercive state intervention: physical injury, emotional damage, physical neglect, and sexual abuse. Professionals and researchers define child maltreatment more broadly to include caregiver behaviors that endanger children. Many professionals share a concern that a pattern of child abuse and neglect puts children at risk of developmental problems that can last a lifetime. The National Committee to Prevent Child Abuse offers the following definitions of child maltreatment.

- **Physical Abuse:** Non-accidental injury, which may include severe beatings, burns, strangulation, or human bites.
- **Neglect:** Failure to provide a child with the basic necessities of life: food, clothing, shelter, medical care, supervision.
- **Sexual Abuse:** Exploitation of a child for the sexual gratification of an adult, as in rape, incest, fondling of the genitals, exhibitionism, or voyeurism.
- **Emotional Abuse:** Unreasonable demands on a child to perform above his or her capabilities, especially in an excessive or aggressive manner. Examples include constant teasing, belittling verbal attacks, and a lack of love, support, or guidance.

Developing standardized tools to measure these types of child maltreatment is difficult. By default, attempts to measure the incidence and prevalence of these behaviors have relied upon the judgments of child protective service (CPS) workers and other professionals, such as hospital personnel, police, and teachers. (Child protective service workers are representatives of state and local agencies authorized to receive and investigate reports of abuse and neglect.)

The National Center on Child Abuse and Neglect (NCCAN), a federal body established in 1974 under the Child Abuse Prevention and Treatment Act, is required to investigate the national incidence of child abuse and neglect. The first national studies of the incidence of child abuse and neglect commissioned by NCCAN were conducted by the American Humane Association (AHA), which collected state aggregate reports of *suspected* abuse or neglect made by community professionals and citizens (neighbors, family members) to child protective agencies.

While these studies offered an important snapshot of what reports were coming to the attention of the child protective services system, they were never intended to assess the actual occurrence of child maltreatment in the U.S. for several reasons. Because participation in this project was voluntary, the states and territories that sent data varied from year to year. The data included duplicated reports as well as reports that were found, upon investigation, to be unsubstantiated. And, of course, reliance on official CPS reports missed many cases that went unnoticed, unreported, or did not meet legal requirements for substantiated cases.

When child protective service agencies investigate a report of suspected child abuse or neglect, the allegations of abuse or neglect may be categorized as either substantiated or unsubstantiated. Child protective service agencies in most states are required to investigate all allegations of maltreatment, providing they fall under the state's legal definitions of abuse and neglect. In practice, CPS workers must often focus their limited resources on the most serious allegations.

A more deliberate attempt to estimate the prevalence of child maltreatment, known as the National Incidence Study (NIS), has been conducted periodically since 1979 by the research firm Westat, under contract with NCCAN. Using a consistent set of descriptive measures of maltreatment, reports are gathered in a representative sample of counties from child protective, law enforcement, and other community professionals. The NIS data are more detailed than information from reports to CPS agencies. These data may not represent an accurate occurrence of maltreatment because reports made by family members or other citizens are not included.

The NIS data are more detailed than information from reports to CPS agencies. Because reports made by family members, neighbors, or other citizens are not included — nor is undetected maltreatment — the NIS data do not represent the true occurrence of maltreatment, but merely report maltreatment known to community professionals.

The NIS reports on maltreatment data use two different standards. The Harm Standard establishes stringent requirements: the child must have been found to be moderately harmed by abuse or seriously harmed by neglect. The Endangerment Standard includes children who have not yet been harmed but who are exposed to behavior that puts them in danger of being harmed, according to the views of community professionals or CPS agencies.

By 1990, NCCAN had redesigned the data collection and analysis system supervised by the American Humane Association, which became the National Child Abuse and Neglect Data Systems (NCANDS). NCANDS began to collect annual aggregated CPS reports and case data from all 50 states, one territory, and the armed services.

In addition to these government-sponsored surveys, various studies are conducted by the private sector, including the National Committee to Prevent Child Abuse (NCPCA). But these sources suffer from many of the same problems as the government surveys, such as inconsistent definitions, reliance on official reports, missing data sources, and so forth.

Extent and Nature of the Problem of Child Maltreatment

(Sources: National Research Council, 1993; National Center on Child Abuse and Neglect, 1996b, 1996c, undated; National Committee to Prevent Child Abuse, 1996b; U.S. Advisory Board on Child Abuse and Neglect, 1995. References in this section are to National Center on Child Abuse and Neglect, 1996c, unless otherwise specified).

How pervasive is the problem of child abuse and neglect? Is it getting worse? What are the characteristics of the victims and of the perpetrators of child maltreatment? How well is the child protective system responding to the problem? The Third National Incidence Study of Child Abuse and Neglect (NIS-3) offers the most comprehensive and current national assessment of the incidence of child abuse and neglect. Throughout this section of this report, references are to the NIS-3, unless otherwise specified, and to the National Committee to Prevent Child Abuse, 1996b.

Child Abuse Statistics

- **Abused, neglected, and endangered children.** According to community professionals, nearly 1.6 million children were harmed by abuse or neglect in 1993 — 23.1 children per 1,000. Under the more expansive Endangerment Standard, 2.8 million children were harmed or endangered by abuse or neglect.
- **Child abuse and neglect reports.** In 1994, an estimated 2.9 million children were reported to child protective services agencies as alleged victims of abuse or neglect. However, only one million of these reports were substantiated - that is, a child was found to have been abused or neglected following an investigation by child protective services (U.S. Dept. of Health and Human Services, 1996b).
- **Fatalities.** An estimated 1,215 children died from abuse or neglect in 1995. This represented a 39 percent increase in the rate of deaths from child abuse and neglect between 1985 and 1995 — from 1.3 to 1.81 children per 100,000 (National Committee to Prevent Child Abuse, 1996b; McClain, et al., 1993; U.S. Advisory Board on Child Abuse and Neglect, 1995).
- **Young children are at greatest risk of dying of abuse and neglect.** Several studies have found that between 85 and 90 percent of children who have died of maltreatment were under age five. Forty-one to 45 percent were under age one. However, these numbers likely underestimate the number of child maltreatment fatalities. Research has consistently found that some percentage of accidental deaths, child homicides, and Sudden Infant Death Syndrome (SIDS) cases might be more appropriately labeled child maltreatment if comprehensive investigations were routinely conducted. Currently, 36 states have death review committees that have responsibility for scrutinizing the causes of child fatalities (National Committee to Prevent Child Abuse, 1996b; McClain, et al., 1993, U.S. Advisory Board on Child Abuse and Neglect, 1995).
- **The number of children harmed by abuse and neglect is increasing.** The number of children estimated to have been harmed by abuse and neglect in the NIS-3 in 1993 was 1.5 times higher than in the NIS-1 study in 1980. Increases in child abuse cases have been substantial for all types of abuse and neglect, except educational neglect. Much of the

tremendous increase in maltreatment rates, especially the number of endangered children, is likely the result of increased recognition and reporting by professionals rather than significant changes in actual rates of occurrence (NRC, 1993). However, the NIS-3 report points out that the rise in the number of seriously injured children probably reflects a real increase in child abuse and neglect because it cannot plausibly be explained on the basis of heightened awareness.

- **Neglect more common than abuse.** Reports of child neglect continue to account for the large majority of reported cases. In the 1993 NIS-3 study of child maltreatment, 57 percent of the total cases were either physical or emotional neglect, and the rest consisted of physical abuse (35 percent), sexual abuse (14 percent), and emotional abuse (13 percent). (The percentages add up to more than 100 percent because some cases fell into more than one category of abuse.)

Characteristics of the Child Victims

Gender. Girls and boys are equally likely to experience most types of maltreatment, although girls are sexually abused three times more often than boys, and boys are at somewhat higher risk of emotional neglect and serious injury than girls.

- **Age.** Although infants are at greatest risk of fatality, the age group most often identified as abused and neglected are children age 6 to 11 — perhaps because school-age children are more visible than infants to community professionals.
- **Race and income.** The NIS studies have found no race differences in maltreatment incidence. However, many other studies have found that children from poor families are more likely to be reported as abused and neglected, reflecting the impact of the stress of living in poverty. Since minority families are more likely to be poor, children of color are overrepresented in the maltreated population. Some studies report that when income is controlled, there are no racial differences in maltreatment rates. Overrepresentation among the poor and minorities may also reflect that maltreatment is more likely to be noticed in poor families who are more often in contact with public sector services and thus “under surveillance” (NRC, 1993).
- **Disability.** Children with disabilities are 1.7 times more likely than other children to be maltreated by their caregivers. The disabilities most frequently associated with maltreatment are serious emotional disturbance, learning disability, and speech or language delay or impairment. Disability may be the cause or effect of maltreatment. In 47 percent of the cases, the prior existence of disability apparently led or contributed to the maltreatment. In an estimated 37 percent of children who were injured as a result of abuse, the maltreatment contributed to or increased the level of disability (DHHS/NCCAN, undated).
- **Temperament and developmental stage.** Children’s normal oppositional behavior — especially among toddlers and adolescents — may sometimes “trigger” abusive behavior in high-risk parents (National Research Council, 1993 p. 125). A study of fatal parental assaults on infants and young children found that they were often connected to a baby’s inconsolable crying or feeding difficulties, a toddler’s failed toilet training, or highly exaggerated parental

perceptions of acts of “disobedience” (U.S. Department of Health and Human Services, Advisory Board on Child Abuse and Neglect, 1995 p. 12).

Identity of the Perpetrators

- **Parents and Parent Substitutes.** NIS-3 found that of those children who were maltreated, 77.8 percent of the perpetrators were birth parents (a noncustodial birth parent in 3.8 percent of the cases). Other parents and parent substitutes (e.g., stepparents, foster parents, parents’ boyfriends or girlfriends) were the perpetrators in 13.6 percent of the cases of maltreated children.
- **Mothers and Fathers.** Mothers were the perpetrators in 75 percent of the cases of maltreatment by parents, fathers in 46 percent. (Numbers add up to more than 100 percent because some children were maltreated by both parents.) Eighty-seven percent of children identified as neglected — in any of the categories of neglect — were neglected by women. However, children are much more often abused by males than females. (Sixty-seven percent of all abused children were abused by males.) This is particularly true for sexual abuse cases in which 89 percent of the perpetrators are male.
- **Sexual Abusers.** Birth parents were much less likely to be the perpetrators in cases of sexual abuse. Nearly 46 percent of sexually abused children were abused by someone other than a parent or parent figure. Only 29 percent were abused by a birth parent, and about 25 percent by other parents or parent substitutes.

Family Characteristics

- **Structure.** Children of single parents were at higher risk of physical abuse and all types of neglect than children in two-parent families. Those living with single fathers were more likely to be abused than those living with single mothers.
- **Size.** Children in larger families are generally more likely to experience abuse and neglect, but an only child is more likely to experience educational and moderate physical harm than a child in families with two or three children.
- **Income.** Poverty dramatically increases the likelihood of a child’s being abused and neglected. In 1993, children in families earning under \$15,000 per year were more than 22 times more likely to experience some form of abuse or neglect than children whose families earned over \$30,000 (NIS-3).

Response of the Child Protective Services System

These incidence studies also provide stark evidence of the many problems and failures of the overburdened child protective services systems. Despite the dramatic rise in reports of maltreatment, the number of children investigated by CPS has remained fairly stable since the 1986 NIS study. In 1993, CPS investigated only 28 percent of the children identified by community professionals as meeting the Harm Standard of maltreatment (down from 44 percent in 1986), and only 26 percent of the moderately or seriously injured children. It is not clear from the data, however, how much of this gap between identification by community professionals and

investigation by CPS is due to non-reporting by community professionals and how much is due to non-investigation by CPS.

As noted, the child abuse system is plagued by the twin problems of under and overreporting. Among reports investigated by CPS, more than half were found to be unsubstantiated. That is, the incidents did not meet the legal standards of harm. While some of these cases may represent families wrongly accused, others involved troubled families at high risk of abuse and neglect, even though CPS workers could not find enough evidence to prove an incident of abuse or neglect. Even substantiation may not lead to services for families. One study found that CPS workers did not provide any service in almost 60 percent of the cases that were substantiated. On the other hand, CPS agencies only investigated three out of ten children identified by community professionals as being endangered. Children who died as a result of child maltreatment were known to CPS in about 50 percent of the cases.

II. Causes and Costs of Child Maltreatment

(Sources: This section relies heavily on the National Research Council, 1993. Additional sources are: Washington State Department of Health, 1996; Cicchetti & Carlson, 1993; Kelleher, 1994; National Committee to Prevent Child Abuse, 1996b; National Center on Child Abuse and Neglect, 1993; U.S. Advisory Board on Child Abuse and Neglect, 1995.)

For more than 30 years, investigators in different disciplines have struggled to explain why parents and other caregivers harm children. An early wave of studies assumed that they suffered from a distinct psychiatric syndrome or personality disorder. This proved to be untrue. Most maltreaters are described as troubled or anxious, but they rarely exhibit extreme psychopathology. Many do, however, suffer from a variety of mental health problems that require appropriate mental health services.

Current explanations of the causes of child abuse and neglect concur that child maltreatment is the result of the interaction of multiple factors emanating from different levels: the individual child and parent, the family, the community or neighborhood, and broader society and culture. This ecological model identifies many interacting factors that create numerous causal “pathways” by which an adult can come to abuse or neglect a child in her or his care. A complementary public health model identifies factors that protect against abuse, even when several “risk” factors are present. Today’s multicausal, interactive models of child abuse assume that child maltreatment occurs when risk factors outweigh protective, compensatory, and buffering factors.

What are the risk and protective factors researchers have identified to date? While this report cannot provide a comprehensive summary of the large body of research on this question, we highlight some of those most relevant for prevention programs and policies.

Parent Factors

No dominant personality profile emerges from the research on child maltreaters. Characteristics of parents who abuse or neglect their children vary widely and may include low self-esteem, poor impulse control, and depression, but these traits only become significant when they interact with other factors such as unemployment, marital conflict, social isolation, or having a difficult, disabled child. Demographic factors such as young maternal age at the time of the birth of the abused child, single parenthood, and larger family size have all been associated with higher rates of child maltreatment.

Parents who abuse or neglect their children frequently have unrealistic expectations of children, often based on an ignorance of normal child development. They are more likely to see their children’s behavior as stressful and themselves as incompetent than other parents. Social isolation and lack of a network of support from relatives, neighbors, or friends seem especially predictive of abuse for young, single parents.

Much attention has been focused on an intergenerational cycle of child abuse, namely that many abusing parents were themselves abused as children. This finding emerged from studies of abusive parents and not of the population as a whole. Although the majority of abused

children do not grow up to abuse their own children, it has been shown that adults who were abused during childhood are six times more likely to abuse their own children. Those who do not become abusers (a) have better social support systems, including a supportive spouse, (b) had a positive relationship with a significant adult in childhood other than the abusive parent(s) or participated in therapy as an adolescent or an adult, and (c) can recount how they were maltreated as children, with anger and responsibility for the maltreatment directed toward the perpetrator rather than themselves (NRC, 1993: 117-118).

Family Characteristics

Many abusive families are characterized by anger and conflict; social isolation is more characteristic of neglectful families. Husbands and wives or cohabiting couples who are apt to be less happy with their own relationships, less warm and supporting, are more prone to aggression and violence with one another than typical couples. Sibling relationships are also more conflicted. Parents of maltreated children are somewhat more likely to have violent or antisocial behavior outside the family, as well as criminal records.

Two parenting styles have been associated with abuse and neglect of children: (1) a disengaged style in which parents are less involved and show low levels of nurturance, warmth, and control and monitoring of their children, and (2) an authoritarian style in which a parent is punitive, coercive, restrictive, and shows low levels of warmth and support for their children. Although it has been argued that there is no link between physical discipline and child abuse, Dr. Murray Straus conducted a study that demonstrated that moderate corporal punishment can lead to physical abuse.

Chronically neglectful families often have families that are chaotic and unpredictable, with constantly changing household membership. This is particularly true of families at risk of homelessness who may double-up with others to keep the family together in times of economic crisis. Families facing stressful events are at greater risk of child abuse and neglect. Unemployment is one factor that is linked to child maltreatment, although a Michigan study showed that short-term unemployment did not lead to increased child abuse and neglect. Studies in two metropolitan areas demonstrated that increases in child abuse were preceded by periods of high job loss and unemployment.

Poverty and High-Risk Neighborhoods

Although there is a perception that poverty is the single most important predictive variable for abuse and neglect, the majority of poor parents do not abuse and neglect their children. In neighborhoods beset by poverty, unemployment, drug and alcohol use, and community violence, children are at greater risk of abuse and neglect. However, recent studies have found that even when socioeconomic conditions are controlled for, some low-income neighborhoods have higher rates of child abuse while others have lower rates of child abuse.

According to these studies, social resources were less available in neighborhoods with higher rates of abuse, and parents in these neighborhoods tended to use resources only in response to crisis, not in a preventive way. Parents were more likely to seek intervention from formal

public agencies rather than rely on informal community resources. Often information about existing community services is obtained by word of mouth. Parents who participate in home visiting programs, for example, are likely to share their experiences with acquaintances in the neighborhood. In low-risk, poor neighborhoods, on the other hand, parents made constructive use of resources and perceived their neighborhoods as offering a better quality of life than did those in high-risk neighborhoods.

While studies on rural poverty are not readily available, isolation, particularly when coupled with poverty, increases the likelihood of child abuse and neglect. Social services may not be readily available or accessible due to lack of transportation and other factors.

The National Research Council concludes its review of the research on etiological factors in this way:

The influence of family ties and organizational affiliations (including employment and education) are poorly understood but increasingly recognized as powerful forces in shaping parental styles and family functioning. Financial stability, employment, alcohol and drugs, and neighborhoods can create a context that either supports a family during periods of stress or enhances the potential for abuse. Families reported for abuse often have multiple problems, and the abuse may simply be a part — or a consequence — of a broader continuum of social dysfunctions (NRC, 1993: 136).

Some have suggested that a variety of cultural and social values in American society may contribute to child maltreatment, including a preoccupation with violence, an overvaluing of family privacy, and racism. Social policies, like a lack of coherent family leave and family support policy and the absence of preventive health care for children, are also cited as causal factors. However, scholars have not sufficiently explored the possibility that these or other factors may cause child abuse and neglect for any conclusions to be drawn.

Costs of Child Abuse and Neglect

(Sources: Baladerian, 1991; Thornberry, 1994; Wright, 1994; Widom, 1992; National Institute of Justice, 1996; National Committee to Prevent Child Abuse, undated; National Research Council, 1993; U.S. General Accounting Office, 1992).

The personal, familial, social, and economic costs of child abuse and neglect are enormous. In addition to the direct cost of the public response to child abuse and neglect through medical care, child protective services, law enforcement intervention, court processing, foster care, family preservation services and adoption assistance, there are many additional public and private costs.

New scientific evidence shows the negative impact of early stress on brain function. The Carnegie Corporation 1992 report, *Starting Points*, concluded that “this research provides a scientific basis for the long-recognized fact that children who have experienced extreme stress in their earliest years are at greater risk for developing a variety of cognitive, behavioral, and emotional difficulties” (9). Numerous studies cite the connection between abuse or neglect of a child and later development of violent and delinquent behavior (Thornberry, 1994; Wright, 1994; Widom, 1992).

Persons who were abused or neglected as children are more likely to require mental health services, to be developmentally delayed or learning disabled, and to suffer physical disabilities. One researcher estimates that at least 18,000 children per year are permanently disabled by abuse or neglect or suffer mental retardation or sensory and motor impairments, often requiring lifelong services at great cost (Baladerian, 1991). Abused and neglected children are more likely than other children to require special education services and to experience poorer educational outcomes. They are likely to realize lower earnings throughout their lives (National Institute of Justice, 1996).

Although it is very difficult to translate these individual and social costs into strictly economic terms, the National Committee to Prevent Child Abuse has estimated the minimal annual direct costs of maltreatment at \$9 billion per year (using 1990 figures). That figure includes \$1.6 billion in health care costs for children injured during the year, \$6.7 billion for out-of-home placements of children and youths (including \$1.9 billion for foster care, \$1.9 billion for juvenile facilities, and \$2.8 billion for in-patient mental health facilities), and \$0.7 billion in child protective services costs (National Committee to Prevent Child Abuse, undated). This estimate does not include such additional costs as remediation of long-term physical or mental impairments, special education services, adjudicating child abuse cases, or lost productivity and earnings.

III. Prevention Strategies

Defining the Scope of Prevention

A wide range of programs that help parents support and nurture their children could be included under the banner of a child abuse prevention strategy. Indeed, a recent government report quoted a U.S. Department of Health and Human Services official as claiming that billions of dollars a year, were spent by federal agencies on programs including Head Start, AFDC, Medicaid and other block grant programs that seek to reduce or eliminate the underlying stresses that contribute to child abuse (GAO, 1992; 47). For the purposes of this report, however, we define prevention strategies as those programs and policies explicitly aimed at child abuse prevention or services specifically targeted to families at risk of abusing their children.

First, a note should be made about terminology. *Prevention* refers to those activities or services that take place before child maltreatment occurs, and *treatment* or *intervention* is what happens after maltreatment has occurred. In public health jargon, *primary prevention* generally refers to universally available services designed to strengthen **all** families and, thereby, prevent abuse. *Secondary prevention* means services targeted specifically to broad at-risk population groups or specific individuals. *Tertiary prevention* focuses on providing services to maltreating families in order to prevent further maltreatment.

This paper focuses most heavily on secondary prevention - services targeted to high-risk populations to prevent child abuse and neglect. This distinction, however, is somewhat artificial. Many program models which are nominally universal have a targeted impact. For example, home visitor services for new parents, one of the more promising prevention strategies, are sometimes made available as a universal service. However, the intensity of the service may vary according to the needs of the family; with overburdened families receiving the most intense services. Moreover, the effective secondary prevention programs require linking at-risk families to universally available services. Similarly, family resource and support centers are universal programs, with services typically available to anyone in the neighborhood where they are located. The program may be deliberately located in a neighborhood with a population that includes many families who are at high risk for child abuse. Thus these programs may provide both primary and secondary prevention.

There is often no clear distinction in level of family dysfunction between families who have abused or neglected their children and been reported to a child protection agency and those who have not (yet) come to the attention of child protective services. As mentioned above, child protective services investigates only about one-third of the cases of child abuse and neglect identified by community professionals, and there are many cases that do not come to the attention of child protection agencies at all. In addition, there are many other cases which are reported which are not severe enough to cause the agency to open formal cases, but which may involve overburdened families who are very much at risk of child abuse and neglect. These families can be served on a voluntary basis only.

In the next section, we briefly describe some promising program models designed specifically to prevent child abuse and neglect, including a broad array of programs that fall under the general rubric of family support and resource programs, which are an essential component of effective prevention. Lastly, we identify a distinct set of efforts designed to prevent sexual abuse.

Promising Program Models for Child Abuse Prevention

(Sources: Daro, 1993; Cicchetti, 1989; Barnes, 1995; U.S. General Accounting Office, 1992; Olds, 1986, 1990. This section draws heavily on Daro, 1993.)

Current thinking about the causes of child abuse has led to multi-level program strategies that focus on changing the personal characteristics of both parent (or caretaker) and child, as well as improving parenting and family interactions, the family's relationship to the community and society at large, and encouraging communities to accept some responsibility for child abuse prevention. The public health approach suggests looking at "potentiating" factors, which increase the likelihood of maltreatment, and compensatory factors, which decrease the risk of maltreatment. Under this theory, abuse occurs only when the potentiating factors exceed the compensatory or buffering factors (Cicchetti, 1989).

Prevention programs may focus on reducing risk factors and maximizing protective factors on several levels. For example, services may deal with individual characteristics (e.g., mental health or substance abuse treatment for a troubled parent or education on alternative discipline strategies); with family interactions (e.g., teaching parenting or communications skills, providing domestic violence services); with connecting families to social support networks of employment, training, with other neighborhood resources; or with cultural components (e.g., campaigns seeking to reduce the acceptance of violence and the use of physical discipline).

Programs that serve families outside the child protective services system, however, must win their voluntary participation. Parents are generally reluctant to participate in programs identified as serving families at high risk of child abuse and neglect. Therefore, many programs aimed in part at ameliorating risk factors and building compensatory protective factors may not announce to the potential clients or the community that child abuse prevention is a program goal. Instead, they may focus on improving infant health, promoting healthy child development, improving children's school readiness or school performance, or coping with children's disabilities. Do such programs prevent child abuse? While there are only a few rigorous evaluations using control groups, some success in reducing rates of abuse has been documented (NRC, 1993). Several additional evaluations are underway and should be available soon, including an evaluation of comprehensive child abuse prevention programs in nine communities, an evaluation of respite care programs funded by the National Center on Child Abuse and Neglect, and an evaluation of the multi-site Healthy Families America home visiting initiative of the National Committee to Prevent Child Abuse. Evaluation of family support programs, funded by the U.S. Children's Bureau, and an evaluation of Hawaii's Healthy Start program (see discussion below) are ongoing.

The few studies that have examined the cost-effectiveness of services to prevent child abuse have generally shown savings not only from direct child abuse prevention and the avoidance of associated costs, but also in positive outcomes, such as increased maternal earnings. From a prevention perspective, targeting young children and families is critical. The transition to parenthood is a time of stress and adjustment for new parents. The earliest years are the most critical period for promoting a child's physical and emotional development. Most primary and secondary prevention programs focus on the earliest years, beginning either prenatally or just after the child's birth and continuing through part or all of the child's first three years. (Daro, 1988, *Confronting Child Abuse*; The Free Press).

Home Visitation Programs

(Goldstein, Keller, & Erne, 1985; U.S. General Accounting Office, 1992; Olds, 1986, 1990; National Committee to Prevent Child Abuse, 1996a).

Since the late 1970s, home visiting programs, especially those initiated at or soon after the birth of a child, have been considered the most promising approach to child abuse prevention services. The 1991 report of the U.S. Advisory Board on Child Abuse and Neglect stated that “no other intervention has the promise for preventing child abuse and neglect that home visitation has” (U.S. Advisory Board, 1991).

Home visitation programs offer several advantages. Services can be individualized. Home visitors are able to reach isolated young parents who are unlikely to come to a center — whether because of their reluctance to participate in group activities or because of logistical problems with transportation and child care. Further, home visitors can model appropriate parenting skills directly in the home and are alert to problems such as domestic violence or inadequate housing. The major disadvantage of home visiting programs is its relatively high cost.

While home visiting is rapidly becoming a component of health, child-welfare, and mental health programs for families with children, the best known programs are those that provide health-oriented services, including parent education, to families with newborns and toddlers. Child abuse prevention is just one of a number of goals of these programs.

Home visiting programs designed to provide services for new mothers were available in the U.S. early in the 1900s. These services were provided primarily in high-risk communities to immigrant mothers in low-income families. The resurgence of interest in home visitation has occurred in the last decade, first for children at biological risk (premature birth or low birth weight) and then expanded to include children who are at risk of maltreatment.

A variety of home visiting models exists, emphasizing parent education, public health, child development, social support, and school readiness, among other services. The training and experience of home visitors vary widely — including public health nurses, social workers, early childhood educators, child development specialists, graduate students, and, in some cases, paraprofessionals. Many home visitors go to the homes weekly, others less than once or twice a month. Almost all home visiting programs focus on mothers and children and not on other caregivers (i.e., fathers, grandmothers). We report below on three of the best known models.

1. The Elmira Prenatal/Early Infancy Project

The Elmira Prenatal/Early Infancy Project was launched in 1978 by Professor David Olds and his colleagues to study the effects of a comprehensive, intensive program of prenatal and postnatal home visitation by nurses in a rural, New York community, which had the highest rates of reported and verified cases of child abuse and neglect from the early 1970s through the mid-1980s (Olds, 1992). This project has received a great deal of attention because it has undergone the most scientifically rigorous program evaluation of any comprehensive prevention program to date.

The program sought to achieve a number of objectives, including a reduction of child abuse. Four hundred first-time mothers, 90 percent of them white, participated in the study. Each was impoverished, young, or unmarried, and each was randomly assigned to one of four groups in which the level of service intensity varied. The most intensive level of services involved both prenatal home visits and visits for two years after the baby was born.

There were three components of the home visitation program that all program participants were offered:

- (1) Educating parents on fetal and infant development and care, along with educational, vocational, and family planning issues;
- (2) Involving family members and friends in the pregnancy, birth, early care of the child, and support of the mother; and
- (3) Linking family members with other health and human services.

The nurses considered the mothers' personal resources, supports, and stresses in the home, family, or community that might affect pregnancy and child care. They focused on maternal and family strengths. A nurse visited each family home for 75 minutes every other week during the mother's pregnancy. Visits continued from the baby's birth to age two. They were held weekly during the baby's first six weeks, biweekly until four months of age and then every six weeks from twenty months to age two years.

Results. The major finding of this project was that, for the highest risk group (poor, unmarried teen mothers), home visitation services significantly reduced the number- of subsequent child maltreatment reports compared with the control population. In the group of families visited by a nurse, 75 percent fewer cases of child abuse and neglect occurred, 56 percent fewer emergency room visits for injuries occurred, and there were 42 percent fewer subsequent pregnancies. The reduction was especially significant among families judged to be at highest risk.

Other positive outcomes were reported as well. Poor, unmarried mothers who received nurse visits showed an 82 percent higher rate of employment more than those in the control group. In addition, the home visits reduced instances of premature births and low birth weight, excessive use of the health care system, developmental delays, and the number of subsequent pregnancies during the four years following the birth of the first child. Mothers who received home visits were also found to punish their children less frequently, to enjoy better social support, and to increase their use of community services (such as the Women and Infant Children food assistance program) in comparison with mothers in the control group.

Cost effectiveness. A 1990 report concluded that the program's cost of \$3,017 per low-income family (in 1980 dollars) annually, could be offset in about four years. Health care and social services costs for home-visited families were \$468 less per family than in the control group. Because of increased employment, each low-income, home-visited family received \$1,637 less in public assistance and \$770 less in food stamps, on average. Increased tax revenues from their earnings were \$137 per family over the course of the study. (The cost of the program in 1997 dollars is about \$8,000 per family for two and a half years of service.)

Follow up. Preliminary results of a 15-year follow-up on the original Elmira Project are encouraging (Olds, 1997). As compared with the control group, the home-visited group has 90 percent fewer verified reports of child abuse and neglect and over 50 percent fewer juvenile arrests. These reports suggest that the original program will prove to be enormously cost-effective over the long-term.

This program has been replicated in Memphis, Tennessee, with an African American population. Olds is now replicating most elements of this program in Colorado, testing the use of paraprofessional service providers rather than nurses. Plans also are underway to replicate the program in six high-crime neighborhoods under the auspices of the Office of Juvenile Justice and Delinquency Prevention, using funds from a variety of federal and state programs.

2. Hawaii's Healthy Start Program

Hawaii's Healthy Start was the first statewide home visiting program for high-risk families following the birth of a child. Begun in 1985 as a demonstration project, Healthy Start now covers more than half of the new births in the state. Healthy Start sites have been targeted to areas with populations at high risk for child abuse. Administered by the Maternal and Child Health Branch of the Hawaii State Department of Health, services are provided by nonprofit organizations under contract with the state.

The program identifies participants by screening over 52 percent of all new births and interviewing new mothers to identify those at risk for child abuse. Services are voluntary and continue until children are five years old. Home visits, administered by lay people, take place on a weekly to quarterly basis, depending upon the client's assessed level of need. All families in the program begin with weekly visits and gradually progress to less frequent visits as goals are accomplished.

Home visitors provide support to families and help to reduce family stress. Services include counseling and assistance in obtaining needed resources, such as housing, financial assistance, medical care, nutrition, respite care, employment, and transportation. Home visitors also focus on parent/child bonding to promote social and emotional growth in infancy and early childhood.

Results. Only one percent of the high-risk population served by the program were verified as abusive or neglectful. A full-scale evaluation of this project is underway.

3. Healthy Families America

The largest home visitation program, with more than 300 sites in 1998, is Healthy Families America, instituted by the National Committee to Prevent Child Abuse (NCPCA) in partnership

with the Ronald McDonald House Charities. The NCPCA estimates that five percent of American newborns are covered by Healthy Families America services, which includes an initial assessment and extensive home visiting services for families determined to be at high risk.

Sounding more like a “movement” than a program model, Healthy Families America literature describes a vision of offering all new parents support and those parents facing the greatest challenges intensive home visitation services. These latter families are identified in the perinatal period through the use of standardized tools, such as the Family Stress Checklist and the Child Abuse Potential Inventory, that assesses a parent’s likelihood for abusing or neglecting his or her child. Use of these tools allows the program to focus services on families most at need and to periodically measure the family’s progress.

To be credentialed as a Healthy Families America program, a program must include a series of critical program elements based on Healthy Families America’s assessment of best practice in home visitation (NCPCA, 1996). These program features fall into three categories: initiation of services, service content, and selection and training of service providers.

Programs offer services intensively (i.e., at least once a week) with well-defined criteria for increasing or decreasing intensity of service over the long-term (i.e., three to five years). Each visitor has a small caseload (usually no more than 15 families needing intense services, sometimes less than ten) to assure that they spend adequate time meeting each family’s needs. Services are culturally appropriate. Home visitors focus on supporting the parent as well as supporting parent-child interaction and child development. At a minimum, all families are linked to a medical provider. Depending on their needs, families may also be referred to additional services, such as financial, food, and housing assistance programs, school readiness programs, child care, job training programs, family support centers, substance abuse treatment programs, and domestic violence shelters.

Programs are not required to use any particular type of home visitor — they may employ nurses, paraprofessionals, or lay visitors. Service providers are selected primarily because of their personal characteristics (for instance, nonjudgmental approach, compassion, ability to establish a trusting relationship), their experience working with culturally diverse communities, and their skills. Service providers receive intensive training on family assessment and home visitation. Service providers must receive ongoing, effective supervision.

Funding and program location. The Freddie Mac Foundation has been an especially strong supporter of Healthy Families America and other child abuse prevention programs. In addition to private foundation and corporate support, Healthy Families America programs receive funding from a variety of federal and state programs, including the Child Abuse Prevention and Treatment Act, Family Preservation and Family Support Services Program, Medicaid, Title XX Social Services and the Infants and Toddlers with Disabilities Program, and community development block grants, among others. Some programs are housed in public agencies; others are in private agencies.

Evaluation. Local programs are required to have an evaluation component, which includes measurable outcomes (e.g., immunization rates, age-appropriate development, and reports of child abuse and neglect). A comprehensive evaluation of these programs and preliminary findings will be published by the Packard Foundation early in 1999.

Family Resource, Support, and Parent Education Programs

(Sources: Kagan et al., 1996; Staton, et al., 1991; Weiss and Halpern, 1991; Weiss and Jacobs, 1988).

In the not-too-distant past, families, neighbors, and friends assisted new parents by passing along childrearing information, occasional babysitting to give the young parents a break, assistance in helping them find jobs, and perhaps a loan of money for a deposit on an apartment. Today, these kinds of informal support are not available for many young parents. Some live in isolation from family and friends and do not know their neighbors. They may be immigrants far from home, or their own families and friends may be too stressed to be able to help.

Family support programs often help fill this gap. They work to keep families healthy and functioning with a broad array of flexible, culturally sensitive services that offer opportunities for supportive personal connections.

Family support is a term used to describe a wide range of programs that loosely subscribe to a set of common values and principles, and that may share certain program characteristics. Family support *principles* are found in the domains of early childhood education, child mental health, special needs, child welfare, health, social work, and community development, to name a few areas.

Family support programs represent a convergence of best thinking both about preventing child abuse and about fostering other important social goals, such as strong families, healthy parent/child interactions, healthy children, and improved school performance. Under various guises, family resource, support, and parent education programs are proliferating across the nation. Initially established as small, community-based demonstration programs (often with a grassroots origin), they are growing in number, size, amount of funding, and complexity. Parents typically determine many of the program activities. Found in many different settings and locations serving different populations, these programs are being replicated in several states with substantial state financial support. Collectively, they are assuming the shape of a social and programmatic movement in its early, formative stage of development.

Some family support programs are comprehensive, offering a wide array of direct services and linking families to many specialized services. Others address a particular set of program needs or individual situations, such as parent education, family literacy, school readiness, homeless families, or families with incarcerated members. Most programs are center-based, but a few have home visiting components.

Several parent education program models have been very successful and widely replicated in states and other countries — including the Missouri Parents as Teachers (PAT) program and the Minnesota Early Childhood Family Education Program (ECFE). Although designed to be open to all, these programs increasingly target more intensive services to families with special needs or at higher risk of abuse and neglect.

Community-based family support programs are built on the following service goals: (1) to build on family strengths and enhance parents' competence, (2) to demonstrate a holistic approach to families' needs, (3) to be prevention-oriented, individualized, and respectful of different cultural backgrounds, (4) and to offer participation on a voluntary basis. Programs with these characteristics are well suited to address the multiple risk factors associated with high risk for child abuse. In fact, some early family support programs were consciously designed with child abuse prevention in mind. A recent review of the family support program literature, which creates a typology of family support programs based on their stated mission, describes nine programs with the primary mission of preventing child abuse and neglect (Kagan et al., 1996).

Family support programs may act as gatekeepers for parents who need access to a variety of specialized services for problems that create risk of abuse and neglect — including substance abuse, mental health issues, a child's disabilities, lack of income, lack of knowledge about parenting and child development, domestic violence, or marital discord. The programs reduce social isolation and strengthen protective factors that may reduce the likelihood of abuse occurring, even in high-risk families.

Even the best family support programs cannot solve all families' problems. Typically, programs are more successful with young families than with families with adolescents. Because they focus primarily on mothers, they are only beginning to find ways to involve fathers, grandparents, and other family members. They are more capable of dealing with parenting issues than partner/marital issues.

It is important to bear in mind that the success of “comprehensive” family support programs, particularly in preventing child abuse and neglect, depends on the availability in the community of the multiple services needed by high-risk families. Even an excellent family support program cannot make up for a lack of drug treatment slots, services for disabled children, mental health services, child care for working parents, or affordable housing for homeless families.

Specialized Prevention Services

Four types of programs — respite care, self-help programs, mentoring, and educational programs designed to prevent sexual abuse — do not fit under the broad category of family support, yet provide specialized services that may be an essential component of a community's secondary and tertiary prevention strategy.

1. Respite Care

(Source: ARCH National Resource Center for Respite and Crisis Care Services, 1992.)

Respite care — temporary relief for caregivers and families — is a service in which care is provided for children with disabilities or chronic or terminal illnesses, and to those at risk of abuse and neglect or who have already been found to be maltreated. Crisis nurseries, a type of respite care for infants at risk of abuse and/or neglect, were first developed in the early 1970s. They can provide services for children of all ages. Typically, their services are available free of charge, 24 hours a day, for a maximum stay of 72 hours (and a maximum of 30 days of service

per year). Services may be provided through a separate facility, through contracts with existing child care centers, and with families licensed as foster parents who can care for children in their homes for up to three days.

Respite centers often operate in conjunction with other service programs, such as family support programs, and offer an array of support services to the families and caregivers of these children. One evaluation of a crisis respite center found that a high percentage of participants reported a reduction in their stress levels and decreased feelings of isolation; there were no hospitalizations of children for abuse or neglect for 90 days after participating in the program.

Respite care for children with disabilities or serious health conditions may also serve to prevent abuse and neglect by relieving some of the stress of parenting a disabled child. These centers can care for disabled children when their parents are having difficulty finding baby sitters. With data to support the effectiveness of this program model, Congress passed the Temporary Child Care for Children with Disabilities and Crisis Nurseries Act in 1986, which established temporary child care (respite) demonstration projects, including crisis nursery services. Competitive grants have been awarded to states since 1988 to assist private and public agencies in developing crisis nursery services across the U.S. The majority of respite centers do not receive federal funding, although many that are now funded locally were begun with federal grants. Funding for respite child care has now been incorporated into Title II of the Child Abuse Prevention and Treatment Act.

2. Self-Help Programs

(Sources: Daro, 1989; Cohn, 1979).

Parents Anonymous and other self-help groups provide at-risk or abusing parents with support, friendship, child development information, education about positive parenting practices, and a chance to share and validate their frustration with the demands of parenting. Parents Anonymous groups are directed by members and aided by lay volunteer leaders. They have access to a clinical professional volunteer who can coordinate service referrals for group participants who may need more structured counseling or formal therapy.

In one of the first federally funded evaluations of child abuse treatment and prevention programs, lay services, such as lay counseling and Parents Anonymous, were found to be particularly useful for parents who were at risk of abusing their children, but who were not currently abusive (Cohn, 1979).

3. Mentoring Programs

Several types of parent mentoring programs seek to enhance parenting skills and achieve other objectives, such as school readiness or appropriate management of a child's disabilities by matching them with trained, experienced parents of disabled children. The two sets of parents meet or talk on the telephone about a variety of issues related to parenting a disabled child. Experienced parents share information about resources, help problem solve, provide tips on dealing with predictable challenges, and simply offer a listening ear.

The Home Instruction Program for Preschool Youngsters (HIPPO) has a parent-to-parent component as part of its curriculum to help low-literacy parents implement a school-readiness, home instruction program for their children. Paraprofessionals visit parents at home every other week to demonstrate how to use the curriculum materials with their child. In alternate weeks, parents meet in a group setting to review their progress and learn about adult education programs and other parent services.

4. Child Sexual Abuse Prevention Education

(Source: Daro, 1994).

While efforts to prevent emotional and physical abuse or neglect generally focus on changing the behavior of parents, child sexual abuse prevention programs usually seek to change children's behavior, generally through group instruction on personal safety. These prevention models are more often designed by those in the rape crisis movement, elementary or secondary education, or law enforcement rather than by mental health or social work professionals. Because child sexual abuse experts believe that many children are at risk yet are hard to identify, they developed a strategy of educating all children about the need for self-protection from sexual abuse.

A recent analysis of effectiveness studies of these educational programs by NCPA concluded that they resulted in significant gains in children's knowledge of sexual abuse and how to respond. They were most effective for children between the ages of 7 and 12. Unfortunately, there is some indication that despite the overall positive impact of these programs on children's knowledge, children who were better trained were not better able to limit the seriousness of the threats and assaults that they actually experienced. Instead, they were more likely to disclose to an adult what had happened to them after the fact.

Gaps in Services

Among the gaps in services that have been identified by child abuse prevention professionals are drug treatment services, domestic violence services, and programs for men at risk of abusing their children. While drug treatment programs are available in most communities, there is a particular lack of drug treatment services designed for parents and pregnant women. Few programs assist recovering substance abusers with child care or parenting education. In both drug treatment and domestic violence programs, staff regard themselves as advocates for their clients. They may be reluctant to become involved in their clients' parenting practices for fear of hearing of child abuse, which they would be required to report, thereby reducing their effectiveness with the client in dealing with the original issue of drug abuse or domestic violence.

IV. Federal Policy and Programs

(Sources: National Committee to Prevent Child Abuse, 1994; Center for the Study of Social Policy, 1994; U.S. Dept. of Justice, 1996; U.S. General Accounting Office, 1992; National Child Abuse Coalition, 1996; Spar, 1996.)

Federal investment in child abuse and neglect prevention is minuscule in comparison with its spending on foster care, which is usually a remedy for child abuse and neglect. Federal funds specifically targeted to child abuse prevention efforts — those made available to the states through the Child Abuse Prevention and Treatment Act, Title II, as amended in 1996 — are just over \$30 million. In contrast, federal funding for foster care now exceeds \$3 billion annually.

Programs that fund child abuse prevention activities are disconnected and scattered across the federal agencies. And it is impossible to ascertain precisely what portion of these program funds are used for child abuse prevention. In 1991, NCCAN listed 28 separate federal programs that funded programs dealing with child abuse and neglect (NCCAN, 1991). The 1994 *Funding Resource Guide*, published by the Healthy Families America program, lists 14 separate federal programs that have been used to fund home visitor programs (NCPA, 1994).

We briefly describe below both those federal programs focused explicitly on child abuse prevention as well as *some* programs designed for other purposes but can also be tapped to fund prevention activities.

Child Abuse Prevention and Treatment Act

The first federal activities directed specifically at child abuse prevention and treatment began in 1974 with the Child Abuse Prevention and Treatment Act (CAPTA), which authorized grants to states to help prevent or treat child abuse and neglect, directed research in this area, and required states to have mandatory child abuse reporting laws.

CAPTA established the National Center on Child Abuse and Neglect (NCCAN) to serve as the federal focal point for child abuse prevention and treatment efforts, including research. Since the mid-1980s, about \$5 million of NCCAN's grant funds each year have been set aside for Challenge Grants, which were to be used exclusively for child abuse prevention activities. States have used these funds to create Children's Trust Fund organizations, which provide monies for a variety of prevention activities using a combination of federal, state, local, and private funds.

CAPTA also established an independent advisory board of experts in the field of child abuse prevention and treatment — the U.S. Advisory Board on Child Abuse and Neglect. In 1988, Congress required the Secretary of the Department of Health and Human Services (DHHS) to establish a federal interagency task force to encourage more prevention and treatment efforts and to coordinate those already in place. In the reauthorization of CAPTA in 1996, however, Congress eliminated NCCAN, authorizing instead an Office on Child Abuse and Neglect within the Administration of Children, Youth, and Families. At the same time, the Interagency Task Force on Child Abuse and Neglect was eliminated, and the U.S. Advisory Board on Child Abuse and Neglect was defunded, although the Secretary retains the authority to appoint such a board.

Federal discretionary activities include operating a national clearinghouse for information on child abuse and neglect, conducting an interdisciplinary research program, and creating time-limited demonstration programs related to training, improving practice, and innovative programs: CAPTA authorizes formula grants to help states support their child protective services programs and additional grants to improve investigation and prosecution of child abuse and neglect cases, especially sexual abuse and exploitation.

To receive Community-Based Family Resource and Support Grants, states must designate a lead entity to oversee the statewide network, which can be an existing public, quasi-public, or private nonprofit agency. (The 1996 reauthorization of CAPTA folded into this grant program the earlier Community-Based Resource programs under Title II, the Family Support Center programs under the Stewart B. McKinney Homeless Assistance Act, the Emergency Child Abuse Prevention Services Grant program, and the Temporary Child Care for Children with Disabilities and Crisis Nurseries Act). States are required to conduct an inventory of statewide family resource programs, respite care, child abuse and neglect prevention activities, and other family resource services, and to identify current unmet needs. The network is required to foster the development of preventive services for children and families through state and community-based collaborations and partnerships, including the public and private sectors.

Funds may be used to develop comprehensive family resource and support programs and specific services such as respite care, home visiting, or child abuse prevention activities identified by the state inventory as unmet needs. Parents are required to be involved in program oversight. States must develop a plan for providing technical assistance and training to community-based programs and take steps to advocate systemic changes in state policies and procedures to improve the delivery of prevention-focused family support programs.

The Family Preservation and Support Services Program

The Family Preservation and Support Services Program (FP/FS) under Title IV-B, Subpart 2, of the Social Security Act, provides funds for community-based preventive and supportive services needed to strengthen families, help them avoid crises, and improve their ability to cope when crises to occur. In 1995, \$150 million was made available to the states under this program. While family preservation services ordinarily come into play *after* an incident of abuse or neglect, family support services are prevention-oriented.

States were required in the FP/FS program to undertake an initial planning process designed to identify the needs, resources, and capacities in the state and its communities. They are expected to target the funds received under this program strategically to meet these identified needs. DHHS has awarded a contract to James Bell Associates to conduct a study of the implementation of the FP/FS program. The study has several components: an annual review of state applications and plans, case studies of ten states, and two community case studies in each of the ten states to include a survey of front-line workers, and a sample of case record reviews and client interviews. The initial authorization period for this program was five years, from 1994 to 1998.

In addition to these two federal programs — CAPTA and FP/FS — that focus on the prevention of child abuse and neglect, a variety of other federal programs have identified the prevention of

child abuse and neglect or the provision of family support services as important ways to meet their own program goals — whether preventing juvenile delinquency, improving children’s educational performance, or improving children’s health. In some cases, this direction has been the result of legislative mandate; in others, the family support or child abuse prevention focus has arisen in the course of administering a program.

For example, the Office of Juvenile Justice and Delinquency Prevention, which has identified child abuse and neglect as one of the causes — or correlates — of juvenile delinquency, has funded the development of child abuse prevention program models as a strategy for the prevention of juvenile delinquency. Most recently, it has disbursed demonstration grants to enhance community efforts to deal comprehensively with child abuse and neglect. The Parents Anonymous organization and the Boys and Girls Clubs have both been recipients of grant monies for child abuse prevention.

Federal programs that seek to prevent child abuse as a secondary goal use different funding mechanisms, including making grants directly available to community and private, non-profit organizations and channeling funds through state agencies. They also may use demonstration grants, block grants, capped entitlement or other mechanisms to provide funding for child abuse prevention and family support programs.

Other Federal Programs that Provide Funding Related to Child Abuse Prevention

Department of Health and Human Services

- **Title XX, Social Services Block Grant — Administration for Children and Families.** This is the largest single source of federal money for all social services. Money goes to the states for spending on a broad range of social services, which includes preventing neglect, abuse, or exploitation of children and adults.
- **Family Violence Prevention and Services Program — Office of Human Development Services.** This program funds demonstration grants to local agencies to prevent incidents of family violence and to provide shelter and related assistance to victims of family violence and their dependents.
- **Maternal and Child Health Bureau, Public Health Service.** The Maternal and Child Health Improvement Projects (MCHIP) program is authorized under the Maternal and Child Health Block Grant budget and funds programs to decrease the incidence of child abuse and neglect through home visiting and other services. In addition, a portion of the block grant is set aside for “special projects of regional and national significance” (SPRANS), federal projects that concentrate on developing early intervention training and services. The Bureau’s Community Integrated Service Systems (CISS) Set-Aside Grants are public-private partnerships, which use community resources to address community-identified health problems.
- **Demonstration Grants on Model Projects for Pregnant and Postpartum Women and Their Infants - Alcohol, Drug Abuse and Mental Health Administration.** This program promotes the participation of multiple organizations in the delivery of integrated,

comprehensive services to reduce the incidence of child abuse and neglect among children of parents who abuse alcohol or other drugs.

- **Medicaid — Health Care Financing Administration.** States may use Medicaid financing to pay for professional home visits for eligible families — for example, for some reimbursement of targeted case management of home visiting services.

Other Federal Agency Programs That May Support Prevention

- **Expanded Food, Nutrition, and Education Program (EFNEP) — Department of Agriculture, Cooperative Extension Department.** Using paraprofessionals and volunteers, the Cooperative Extension Service's education programs offer services to many pregnant women and teens on nutrition, health, and home management issues. In an interesting public-private partnership, the Cooperative Extension Service began a partnership with Healthy Families America to provide Extension Service paraprofessionals with more extensive training on parenting education and support, child development services, and school readiness for high-risk families.
- **Infants and Toddlers with Disabilities (Part H) Program — Department of Education, Office of the Assistant Secretary for Special Education and Rehabilitative Services.** Under the Individuals with Disabilities Education Act, Part H, the Department of Education awards grants to states to develop statewide, comprehensive, coordinated, multi-disciplinary interagency systems to provide early intervention services for young children with disabilities and their families. States may elect to incorporate child abuse and neglect as a risk factor for developmental delays, as well as provide services to already disabled children and their families.
- **Community Development Block Grant (CDBG) — Department of Housing and Urban Development.** Local programs may spend as much as 15 percent of their CDBG funds on social services, including family violence counseling and child abuse prevention programs. Low-to-moderate income individuals or neighborhoods must be served.
- **Safe Kids/Safe Streets Initiative — Department of Justice, Office of Juvenile Justice and Delinquency Prevention.** OJJDP, together with several other Justice Department entities, awards grants to several target communities to improve strategies for child abuse prevention and intervention. Funding will be used for systems reform and accountability (emphasizing cross-discipline training and coordination), development or strengthening of a continuum of family-strengthening services, evaluation, and prevention education and public information. The Justice Department has also funded demonstrations of home visiting programs, based on the Elmira Prenatal/Early Infancy Program, as a strategy to prevent delinquency by preventing abuse and neglect.

In addition to the specific programs described above, the importance of income assistance, housing, job training, child care, and other concrete services cannot be underestimated as *indirect* prevention strategies, since they are aimed at alleviating some of the stress and risk factors that contribute to child abuse and neglect.

V. State and Community Partnerships for Prevention

There has been no comprehensive review published of state child abuse and neglect prevention activities. The National Center for Children in Poverty recently published a useful state-by-state review — *Map and Track* — of special, state-initiated, comprehensive program and cross-system planning efforts affecting young children and their families (NCCP, 1996). While the importance of early intervention in promoting healthy child development underlies all of these efforts, the report does not identify how many of these state initiatives explicitly include child abuse prevention as a goal. Similarly, an in-depth study of ambitious efforts in four states to promote service integration as a strategy to improve services for young children and families does not reveal any explicit goals to prevent child abuse (Kagan et al., 1995)..

No state has created a comprehensive, statewide child abuse prevention strategy. However, many states and communities have established and helped to fund community-based programs, such as Healthy Families America, family support centers, or parent education programs designed in whole or in part to prevent child abuse. More recently, a few states and communities have been developing more comprehensive approaches to prevention in efforts to integrate reformed child protective services systems into a community-based continuum of prevention-oriented services for children and families.

The following are a few examples of child abuse prevention-oriented activities underway in states and communities:

Children's Trust Funds

(Source: National Alliance of Children's Trust Funds, 1995.)

The concept of Children's Trust Funds originated with Dr. Ray E. Helfer, a nationally recognized pediatrician in the field of child abuse and prevention. Dr. Helfer saw that trust funds existed to care for our nation's highways, and proposed that similar trusts should be established to care for our nation's children. Kansas was the first state to establish a special fund dedicated to the prevention of child abuse and neglect. Today all 50 states and the District of Columbia have passed legislation to establish trust or prevention funds.

State children's trust and prevention funds receive revenue from a variety of sources. Some states have placed a special check-off on state income tax returns; others impose surcharge fees on marriage licenses, divorce decree filings, or vital statistics records. Many trust funds conduct individual and corporate fundraising, and a few receive a line-item appropriation in the state's general revenue budget.

States also receive federal funding under Title II of the Child Abuse Treatment and Prevention Act based on a formula related to the child population in each state and the amount of state dollars dedicated for the prevention of child abuse and neglect.

Children's Trust Funds have been enormously successful in leveraging the \$6 million available in federal funding in 1994 to the current level of \$35 available for child abuse prevention activities

in their states. Most of these funds are used to provide small grants to a variety of programs in the states, including child abuse prevention and awareness activities, education programs, and direct prevention services to high-risk families. Some also fund systems reform advocacy activities and evaluations of prevention programs.

Arizona's Child Abuse Prevention Initiative

Under legislation adopted in 1994, Arizona has begun a multi-pronged approach to child abuse prevention and to the improvement of other outcomes for children. The legislation includes three components: Healthy Start, a prenatal outreach program; Healthy Families, a child abuse prevention program of home visiting for high-risk families with infants and preschoolers; and expanded Head Start for three- and four-year-olds using state funds. In addition, a family literacy component has now been added to the program.

Each of these programs had existed as small pilot programs in existing state programs and had proven successful before the state legislature decided to expand their reach. Healthy Start's prenatal outreach program uses trained lay workers to go out into the community to do prenatal outreach and education. This was found to be especially important in rural areas. The Healthy Families program is based on the home visiting approach described earlier in this paper. The state contracts with local community-based organizations to conduct assessments of child abuse potential following the birth of new babies. They provide home visitation services to high-risk parents until their children reach age five.

The Healthy Start and Healthy Families programs have funding authorized at \$3 million per year over four years. Funding must be reauthorized in 1998. In addition, an initiative was passed in November of 1996, which would provide \$17 million of state lottery funds to these programs, as well as to a teen pregnancy program. That funding is not yet available due to legal challenges to the initiative. Approximately five percent of Arizona's at-risk families receive these services under current funding levels.

Community Level Public/Private Partnerships for Prevention

In an increasing number of communities, collaborations of concerned professionals, public and private agency administrators, and business and community leaders are coming together to place the prevention of child abuse and neglect high on their action agendas. In some communities, these new partnerships have formed spontaneously, sometimes in response to the publicity surrounding media reports of child deaths or injuries. In other communities, interest in prevention has been sparked primarily by the community's involvement in the planning process generated by the state's response to the federal Family Preservation and Support Services Program. In other states, such as Washington and Ohio, growing community interest in child abuse prevention was catalyzed or reinforced by state-initiated family policy reform initiatives (see Hutchins, 1998).

Washington: Community Health and Safety Networks

(Source: *Coming Together for Children and Families*, 1998.)

In the state of Washington, the Washington Family Policy Council, made up of five Cabinet secretaries, a representative of the Governor, and four legislators has overseen the development of 53 Community Health and Safety Networks directed by citizen-dominated boards. Each network has been charged with improving seven “problem behaviors” (or outcomes) identified by the state, including child abuse and neglect as one targeted behavior. They do this by assessing strengths and concerns in their community, prioritizing the problem behaviors, identifying risk and protective factors, researching effective strategies, and devising local solutions. By December 1996, 51 out of the 53 networks had submitted plans; of these, 49 (96 percent) identified child abuse and neglect as one of the three top problem behaviors.

Ohio: Dayton Community-Wide Task Force on Child Abuse

(Source: Child Protection Task Force, 1995; Family and Children First Council, undated.)

After six child deaths from abuse and neglect in a four-week period in 1994, the President of the Montgomery County Board of Commissioners in Dayton, Ohio, appointed a Child Protection Task Force, chaired by the President of the University of Dayton, to examine what the community could do better to prevent child abuse and to protect children — without pointing fingers and assessing blame. After 18 months of work, the Task Force made 56 recommendations with three overarching goals: to create an integrated child protection system, to initiate a comprehensive families and children services network, and to start an ongoing community issues forum.

Most of the recommendations dealt with the first goal — improving the response of the child protection system (including the child protection agency, courts, and a variety of other public agencies) to reported cases of child abuse or neglect. The second and third goals were more preventive in nature. The Task Force recommended that the County Board of Commissioners plan a comprehensive families and children services network, and start an ongoing community issues forum.

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The Task Force recommended that the newly created collaborative include both public and private agencies, along with community members. Ohio had earlier passed legislation requiring each county to create a Families and Children First Council, with membership representative of

a number of public agencies. This Council, under state law, is charged with approving local use of certain state block grant funds and with reviewing cases of children and families with multiple service needs.

The Task Force recommended using this structure, but enlarging it to create the community collaborative it envisioned. As a result, membership in the Families and Children First Council includes representatives of the United Way and other private and community organizations as well as the state-mandated public agency representatives. In addition to its state-mandated purposes, the Council was designed to develop programs to improve local service delivery and to pool funds or develop other financing strategies to maximize the use of state, federal, and local resources for children and families.

The Task Force also recommended that the new Council create a Family Support and Intervention Work Group to work out detailed protocols and decision criteria needed to integrate services across the community. They also suggested that family support and intervention services be focused on “red flag” cases — those in which a risk factor, such as teen pregnancy or school absenteeism, suggested a risk of child abuse and neglect.

The ultimate goal was the creation of a Comprehensive Families and Children Services Network by the year 2000. To participate in it as a service provider, an organization would have to meet standards of proficiency, reliability, and capacity. Providers must be able to provide services reliably in accordance with a case plan. The Network would keep track of available service resources on an ongoing basis.

Two years after the initial report and recommendations, 42 of the original 56 recommendations have been implemented. The new governance structure — the collaborative Families and Children First Council recommended by the Task Force — is in place and functioning well. Under its guidance, the following components of a comprehensive continuum of family support and intervention services targeted to “red flag” families at risk of abuse or neglect are being implemented:

- **Healthy Start.** Healthy Start, a program that was already in place when the Task Force made its recommendations, provides prenatal care to teen mothers and four home visits to the parent(s) in the first year of a child’s life and annual follow-up until the child is five years old. Parenting issues and other concerns are addressed before there is a reported incident of abuse or neglect.
- **Early Start Initiative.** A new program, the Early Start Initiative, will provide home-based family support services to children from birth to age three and their families. The program can make referrals to other services and coordinate services based on the needs identified by the family.
- **Start Right.** The Start Right Project, which has been in existence for several years, uses school attendance records to identify chronic absenteeism, which has been identified by the community as a “red flag” for potential child abuse or neglect. The Project offers home visits to assess family situations, arrange social and health services, and monitor school progress

as a means of preventing deterioration of a child's circumstances. Americorps volunteers are some of the home visitors used in this program.

- **Family Stability Program.** A Placement Diversion Team, comprised of staff members from several child-serving agencies, seeks to prevent unnecessary out-of-home placements once the safety of children has been assured. Services are voluntary to families in crisis, and parents must agree with any plans that are developed. Referrals are made to this program both by community professionals and by child protective services staff who have investigated a report but decided not to open a formal child protection case.
- **Wellness Block Grant/Teen Pregnancy Prevention Program.** A teen pregnancy prevention program targeting the siblings of pregnant and parenting teens will be placed in neighborhoods with high rates of teen pregnancy. Neighborhood residents, agency staff, and other service providers will work together to develop a number of family-centered, neighborhood-based, collaborative strategies for teen pregnancy prevention.

VI. Toward a New Vision: Communities Sharing Responsibility for Child Abuse Prevention

In communities like Dayton, a more comprehensive vision for the future of a reformed child protective service system is emerging — in which the formal child welfare authorities share responsibility for protecting children with community action. This new vision is being articulated by leaders in the field and is attracting attention and support from private foundations and national membership associations. For example, in 1996 the Clark Foundation awarded demonstration grants to pilot projects in four cities — Cedar Rapids, Iowa; Jacksonville, Florida; Louisville, Kentucky; and St. Louis, Missouri — to develop Community Partnerships for Protecting Children. The mission of the partnerships is to keep children safe, strengthen families, and increase community participation in child protection.

In seeking to change the way in which systems respond to reports of suspected child abuse and neglect, these initiatives divert families away from the formal investigatory procedures if a child is not in immediate danger. Instead, families receive the services they need to provide better care for their children from informal community resources. Because the community shares responsibility for the families' well-being, the assessment process includes people who know and have been involved with the family: neighbors and relatives, home visitors, family support workers, teachers and guidance counselors, medical professionals, religious leaders, law enforcement officers, and others.

The Child Welfare League of America (CWLA) is launching its own initiative, Protecting America's Children: It's Everybody's Business, to be tested over the next five years in three demonstration sites — Alameda County, California; Montgomery County, Maryland; and a site that has not yet been selected. The CWLA initiative, partially funded by the Clark Foundation and the Freddie Mac Foundation, has a goal of reducing the overall occurrence and re-occurrence of child abuse and neglect by developing a child-focused, family-centered, multi-tiered, community response to the prevention of child abuse and neglect, and the protection of children who are abused or neglected, or at imminent risk of maltreatment.

This project goal addresses the growing gap between circumstances in which child protection agencies intervene and the community's expectation for child safety. It responds to the escalating concerns expressed in communities across the nation — children whose abuse could have been prevented and children who should be protected from further harm but are not receiving the help they need. This will be accomplished via the following objectives:

- **Objective #1:** more effective responses to severe and life-threatening child abuse and neglect using an aggressive, timely and effective response to each case through wellintegrated responses involving police, child welfare services, county and state attorneys, the courts and others.
- **Objective #2:** more effective responses to moderate and serious cases of child abuse and neglect using coordinated intake protocols with assessments and services delivered primarily by the child welfare agency in coordination with other public agencies and community organizations.

- **Objective #3:** more effective responses to less serious cases of child abuse and neglect using coordinated intake protocols with assessment and services delivered primarily by community-based organizations.
- **Objective #4:** improved awareness and participation of the community — including consumers, business, civic and community organizations — in developing an overall strategy for the prevention of child abuse and neglect.

VII. Challenges for State and Federal Policies

(Sources: American Public Welfare Association, 1991; National Commission on Children, 1991; Allen, 1992; U.S. Advisory Board, 1991.)

Over the past decade, numerous national organizations, task forces, and commissions have called for shifting the focus from investigation of child abuse reports and out-of-home placement to investment in prevention and treatment services. The major barrier to achieving this goal, however, is that no one authority assumes responsibility over the fragmented prevention efforts dispersed among many agencies. Clearly, partnerships are needed to pool resources, share ideas, and coordinate activities.

In its 1991 report, the U.S. Advisory Board on Child Abuse and Neglect called for a national, comprehensive, child-centered, family-focused, and neighborhood-based strategy for protecting children. In 1990, the American Public Welfare Association's National Commission on Child Welfare and Family Preservation proposed a universal system of family support services as the first tier of a three-tiered framework to strengthen and preserve families.

The first tier, made up of community-based, prevention-oriented, family support programs available to all families, would promote family well-being and prevent problems from developing. The second tier, composed of family-focused community services provided collaboratively by multiple agencies, would assist families already having significant problems to prevent the problems from re-occurring and becoming more serious. The third tier would include reforms of the child protective services system to assure that the full range of services would be in place to achieve the goals of child safety, preventing unnecessary placement, reunification, and permanent placements, including adoption. The National Commission on Children, a 34-member bipartisan body appointed by the President and Congress, recommended a similar approach to family services in its 1991 report, *Beyond Rhetoric: A New American Agenda for Children and Families* (1991: 295-6).

The National Commission to Prevent Infant Mortality recommended home-visiting programs as an important strategy for reducing infant mortality and improving the health of pregnant women and new mothers. The U.S. Advisory Board on Child Abuse and Neglect also has recommended home-visiting programs as an important tool for preventing child abuse and neglect.

Challenges for the Future

As states and communities struggle to develop comprehensive prevention agendas, they will face many questions to which there are no clear answers. For example, should new prevention programs be created or should existing programs add an emphasis on prevention — for example, by including a home visiting or family support component to an early childhood or parent education program? Should services be provided universally or targeted to high-risk families? Should child abuse prevention be addressed separately or as part of a broader agenda, such as improving health outcomes and school readiness for young children? Should funds be made available through government agencies or directly to community organizations as well?

How can states and the federal government encourage the creation of services and insure that needed services are continued? Should primary prevention efforts be expanded, especially those that have the potential to change the public's attitudes, and ultimately, behaviors regarding child abuse?

There is a growing consensus among experts that policymakers at both state and federal levels and community leaders need to address the following difficult challenges:

- **Increased public and private investment in activities explicitly designed to prevent child abuse and neglect.** New sources of prevention dollars need to be identified — for example, managed health care may be able to pay for birth-related activities, such as home visiting programs. In the absence of new dollars, policy officials will need to find ways to shift resources from other activities, such as foster care. More than a dozen states have already have received Title IV-E waivers to mount demonstrations of innovative child welfare approaches, including redirecting foster care dollars into more preventive services to reduce the need for foster care.
- **Invest in prevention approaches that have been demonstrated to be effective.** Impressive results are being achieved by home-visiting demonstration programs, especially when targeted to families deemed to be at high risk. But researchers caution against unreasonably high expectations about “going to scale,” because it is very difficult to get similar results in large scale replications, as key components are frequently diluted. Any expansion of successful program models should invest heavily in staff training and quality controls.

No single model, however effective, can by itself prevent child abuse and neglect.

- Family support programs should be offered in a variety of settings. A continuum of specialized services must be available as well, including adequate drug and alcohol treatment programs, mental health services, domestic violence services, services for disabled children, respite care, teen parent programs, crisis services (such as child abuse hotlines and crisis nurseries), homeless services, education on sexual abuse for children, and public education regarding child abuse.
- Empower and enable community stakeholders to develop comprehensive approaches to prevention and child protection, building on existing local resources. Community partnerships can benefit from more flexible federal and state funding, yet the issue remains how to provide increased flexibility while maintaining accountability for reducing the incidence of child abuse and neglect.
- Make the prevention of child abuse and child protection everybody's business. Effective prevention is not the sole responsibility of any one public agency. It is the result of concern and collaboration among an array of informal and formal supports and services provided by many different sectors of the community, and is tailored to meet the specific cultural needs of the community.

Organizational Resources

American Academy of Pediatrics

601 13th Street, NW
Suite 400N
Washington, DC 20005
(202)347-8600; fax: (202)393-6137

American Humane Association

63 Inverness Drive East
Englewood, CO 80112-5117
(303)792-9900; fax: (303)792-5333

The American Humane Association is the nation's oldest agency dedicated to protecting children from abuse and neglect. It currently has a project to identify and study front-line practices that link families, communities, and agencies together to protect children.

American Professional Society on the Abuse of Children

407 S. Dearborn Street
Suite 1300
Chicago, IL 60605
(312)554-0166; fax: (312)554-0919

ARCH National Resource Center for Respite and Crisis Care Services

800 Eastowne Drive
Suite 105
Chapel Hill, NC 27514
(800)473-1727; fax: (919)490-4905
Email: HN4735 @ connectinc.com; Web: <http://chtop.com>

Beach Center on Families and Disabilities

Parent-to-Parent Project
3111 Haworth
University of Kansas
Lawrence, KS 66045

Childhelp USA

120 N. Lee St.
Falls Church, VA 22046
(703)241-9100; fax: (703)241-9105

Child Welfare League of America

440 First Street, NW
Suite 310
Washington, DC 20001
(202)638-2952; fax: (202)638-4004

Children's Defense Fund

25 E Street, NW
Washington, DC 20001
(202)628-8787; fax: (202)662-3550

Family Resource Coalition of America

20 N. Wacker Drive
Suite 1100
Chicago, IL 60606
(312)338-0900; fax: (312)338-1522

The Family Resource Coalition of America, the association of family support programs, provides information and technical assistance on family support services. It also undertakes public education and advocacy efforts and conducts research on family support programs.

Military Family Clearinghouse (MFC)

4015 Wilson Boulevard
Suite 903
Arlington, VA 22203-5190
(703)696-5806; fax: (703)614-3375

The Military Family Clearinghouse was established in the early 1980s to support the professional community that helps families cope with the unique challenges of military life. Specific information related to child abuse and neglect is available, as well as information on aspects of military life that are stressful for parents, such as family separations, reunions, and occupational hazards.

National Alliance of Children's Trust and Prevention Funds

c/o June Green
Children's Trust Fund
1730 K Street, NW
Suite 304
Washington, DC 20006
(202)296-6645; fax: (202)331-3759

National Center for Education in Maternal and Child Health (NCEMCH)

P.O. Box 2345
Rockville, MD 20847-2345
(800)729-6686; fax: (301)468-6433

The National Center for Education in Maternal and Child Health (NCEMH) provides information, education, and technical assistance on maternal and child health issues. The Center also offers technical assistance aimed at reducing child injuries caused by abuse, suicide, homicide, sexual assault, and family violence.

National Children's Advocacy Center

2204 Whitesburg Drive
Suite 200
Huntsville, AL 35801
(256)534-6868; fax: (256)534-6883

This resource center provides technical support to professionals who work with sexually abused children and their families, including training and technical assistance. The resource center addresses prevention of child sexual abuse as well as intervention, investigation, prosecution and other topics.

National Maternal and Child Health Clearinghouse (NMCHC)

8201 Greensboro Drive
Suite 600
McLean, VA 22102-3843
(703)821-8955, ext. 254; fax: (703)821-2098

The Clearinghouse, a sister organization to the above listing, collects and disseminates current information on maternal and child health topics, including selected titles relating to child abuse and neglect.

National Clearinghouse on Child Abuse and Neglect Information

P.O. Box 2345
Washington, DC 20013-1182
(800)FYI-3366 or (703)385-7565
Email: prevent@calib.com

The federally funded National Clearinghouse on Child Abuse and Neglect Information is the major national resource of information on the prevention, identification, and treatment of child abuse and neglect. The Clearinghouse collects, stores, organizes, and disseminates information on all aspects of child maltreatment. The Clearinghouse also promotes cooperation, coordination, and collaboration among organizations working to end child maltreatment.

National Committee to Prevent Child Abuse

200 S. Michigan Avenue
Suite 1700
Chicago, IL 60604
(312)663-3520; fax: (312)939-8962

Founded in 1972, the National Committee to Prevent Child Abuse (NCPCA) now has chapters in most states. Major activities include public awareness campaigns, advocacy, and research. In addition, it directs the Healthy Families America (HFA) initiative, with a fast-growing network of local home visitation programs.

National Women's Resource Center for the Prevention and Treatment of Alcohol, Tobacco, and Other Drug Abuse and Mental Illness

515 King Street, Suite 420
Alexandria, VA 22314
(800)354-8824 or (703)836-8761; fax: (703)684-6048

The Center serves as a federally funded central information source on alcohol, tobacco, and other drug abuse prevention, intervention, and treatment for women. Issues related to pregnant and parenting women, female adolescents, and women in life crises are also addressed.

Parents Advocacy Coalition for Education Rights

4826 Chicago, Avenue S.
Minneapolis, MN 55417-1098
(612)827-2966

Parents United

P.O. Box 608
Pacific Grove, CA 93950-0608
(408)453-7616; fax: (408)453-9064

Parents As Teachers National Center, Inc.

9374 Olive Boulevard
St. Louis, MO 63132
(314)434-4330

The Parents As Teachers program (PAT), which began in four Missouri communities in 1981, is available in school districts statewide in Missouri and in more than 200 sites in 36 states and foreign countries. The National Center provides training for all parent educators in these programs. It also provides support services, technical assistance, and supervision for PAT administrators.

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Highlights of the Seminar

Held February 21, 1997, 1100 Longworth House Office Building, Washington, DC

Introduction

Family Impact Seminar consultant Diane Dodson noted that this seminar on prevention was timely, particularly considering current concerns over child deaths resulting from abuse and neglect and increases in the number of abuse and neglect cases. However, she pointed out that far more federal money is spent on foster care (\$3 billion annually) than on explicit child abuse prevention programs (\$30 million annually) — a ratio of 100 to 1.

Anne Cohn Donnelly

Anne Cohn Donnelly, Executive Director of the National Committee to Prevent Child Abuse from 1980-1997, has a doctorate in public health and has published widely on child abuse prevention.

Getting an exact count of the prevalence of child abuse is difficult for two reasons: it happens behind closed doors and definitions of abuse and neglect vary, according to Donnelly. The Carnegie Corporation's *Starting Points* report several years ago suggested the 25 percent of all children under the age of three had been exposed to abuse or neglect of one kind or another. Using the report's popular (rather than legal) definition of abuse and neglect, about 900,000 children in their first year of life are abused each year.

The U.S. Department of Health and Human Services estimates abuse based on reports from professionals and others in the community who have contact with children. Other estimates come from the number of reports of suspected abuse and neglect made to child protective service agencies around the country each year. That number is around three million cases per year. Out of that number, child protective service agencies find that about one million cases per year are substantiated or validated. And we know that at least three children die, on average, each day as a result of child abuse. She added, "But whatever your definition or perspective, child abuse and neglect is a major public health problem." (See the discussion of the incidence of child abuse and neglect on pages 5-6.

Contrary to the public perception based on sensationalized media reports, said Donnelly, "More than half of all substantiated reports of child abuse are neglect, about 25 percent are physical abuse, and only 11 percent are sexual abuse. The rest fall into a combination of underlying presenting factors, primarily emotional abuse or neglect."

Why does abuse happen? "There is not one simple answer," Donnelly replied. "Child abuse and neglect are the result of a complex set of problems. There are many different kinds of abuse and neglect and different underlying causes in every case; there is no single profile. Yet there are some common factors associated with abuse and neglect," she noted. Parents who abuse and neglect are more likely to have been abused or neglected as children themselves. They are likely to have poor parenting skills and low self-esteem. They tend to be isolated, lacking the support and assistance that parents desperately need. Even when other adults are around, they are often

unable to trust them or share their problems with them. These are parents who are overburdened. Typically, they are the only adult in the household and are quite alone. Substance abuse, most often alcohol abuse, economic difficulties, and domestic violence are often significant precipitating factors. While child abuse and neglect cut across all income groups and occur in all neighborhoods, parents who abuse and neglect their children are most likely to be living in communities that are overburdened, fragmented, and subject to endemic violence and other social problems, as well.

Who are the victims of abuse and neglect and how are they affected? In general, abused and neglected children tend to be younger, Donnelly suggested, although both teenagers and school-age children are more likely to suffer serious damage. About half of the children who die as a result of child abuse are under the age of one.

Research shows that abused children suffer early learning problems, socialization problems, difficulties relating to peers and adults, and difficulties in school. Abused or neglected children are more likely to run away from home or get into trouble with the law. Youthful alcoholism and drug abuse and mental health problems, including suicidal tendencies, are often associated with earlier abuse or neglect. Children who are abused are six times more likely to abuse their own children some day. These effects are not inevitable, but the rates for each of these problems are much higher for children who have been abuse, she reported.

Child abuse is the lynch pin of many other social problems, Donnelly said. Not only should children not be hurt in this way, but we should not allow ourselves to bear the costs of the aftermath of abuse, she contended. For both humane and economic reasons, it makes sense to focus on prevention. Several decades of research and numerous pilot programs and demonstration projects have taught us a lot about preventing child abuse and neglect. Although this is a complex problem with a variety of underlying causes, there are many things we can do, she said. We need to address the issues of violence both on television and in society. We need to address our tolerance of people living in chronic unemployment. At the same time we seek to ameliorate these broad social problems that contribute to child abuse, we should also address aspects of individuals' lives and their communities.

The research suggests that there are things we can do at every stage in the family life cycle that will decrease rates of child abuse and neglect, she reported. When a new baby is born, we can make sure that the parents get off to a good start by teaching them parenting skills so they never cross the line into abusive behavior. When they are old enough, children can be taught to protect themselves from abuse and seek help in the early stages of abuse. We can make sure that all families have access to different kinds of supports when crises erupt — such as hotlines, help lines, drop-in centers, family resource centers, and homemakers who can help out in the home when a parent is sick or cannot cope.

We need to provide real treatment for parents who abuse their kids and *are* identified by the authorities, said Donnelly. Even when there is confirmed child abuse, parents rarely get the therapeutic and other support they need to alter their behavior. Even more significantly, children need therapeutic support. With only a few exceptions related to sexual abuse, no state mandates

that the victims of child abuse be provided therapy to help heal the scars of abuse, which is invaluable in breaking intergenerational cycles of abuse.

Where will an investment of dollars make a real difference in the size and scope of this problem? Two bodies of research — on early brain development and parent support — suggest directions to pursue. The importance of the earliest months and years of life on brain development has been highly publicized recently. In simple terms, healthy brain development depends on good basic care in the earliest years — love, nurturance, support, and stability — so that children’s brains develop in healthy ways, allowing them to achieve their potential later in life. When children are instead assaulted by abuse and neglect or other negative forces in the environment, their brains do not have the chance to develop in healthy and normal ways. For some children, the effects are permanent and will cost them for the rest of their lives, Donnelly said. However, the research of Drs. Henry Kempe and David Olds and others tells us that if we can intervene with parents at the time their babies are born to offer comprehensive and intensive support to those who need it, we can dramatically diminish the likelihood that they will abuse their children. The convergence of these two bodies of research — on early brain development and on effective intervention with new parents to prevent child abuse and neglect — tell us where to invest our resources to prevent child abuse, she said.

Donnelly cautioned, however, that not all supports for new parents work to prevent abuse. Research has identified several critical components of effective services. For high-risk parents who are socially isolated and have difficulty getting help for themselves, services should be delivered in the home, at least in the beginning. The intervention needs to be intensive — once a week or even more frequently. Services should be both comprehensive and flexible, addressing each family’s needs and building on its strengths. A couple of months of intervention is not enough to prevent child abuse; support must be long-term.

Five years ago the National Committee to Prevent Child abuse, with support from the Ronald McDonald Children’s Charities, launched an initiative called Healthy Families America, Donnelly reported. These programs reach out to new parents when their babies are born, flagging the most overwhelmed and overburdened while they are still in the hospital. These families receive intensive, comprehensive, long-term home visitation services on a voluntary basis. If all new parents received one or two visits to get them off to a good start, followed by voluntary, comprehensive services for the most overburdened, Donnelly predicted it would be possible to reduce abuse and neglect of children under age five by 75 percent.

Healthy Families America programs are now in place in 250 communities nationwide, funded by \$35 million a year raised mostly from the private sector, with the Freddie Mac Foundation and Corporation in a leadership role, and including the Carnegie Corporation, the Kellogg Foundation, Prudential, and the National Basketball Association. There are now over 20 national Healthy Families America partners, including the American Academy of Pediatrics and the National Head Start Association. Almost every state has a Healthy Families America task force to bring together public and private agencies (including public health, education, criminal justice, and social services) to make home visiting services universal. A credentialing process for these

programs has been developed through the National Council on Accreditation of Services for Families and Children. Researchers who are studying these programs have formed a network to keep in touch with each other.

While federal and state government agencies have important roles in Healthy Families America, Donnelly is not convinced that a specific piece of Healthy Families legislation is needed. Instead, she recommended opening up a variety of funding streams that already touch families with young children, including maternal and child health and various social services programs, to be used for Healthy Families-type early intervention.

Brother Raymond Fitz

Brother Ray Fitz has been President of the University of Dayton in Dayton, Ohio, for more than 17 years. An electrical engineer by background, and a member of the Society of Mary, he recently chaired a community-wide Child Protection Task Force following the deaths of six Dayton children from child abuse within four weeks.

Twelve years ago, Fitz said he didn't know much about child abuse and neglect. However, as President of the University of Dayton, he chaired a youth and family collaborative as part of the Casey Foundation-funded New Futures project, which led to his being asked to chair the Child Protection Task Force after the highly publicized children's deaths. The broad-based task force of 35 members included the severest critics of the child welfare system, the leaders of that system, the sheriff, the prosecutor, and a wide range of community members. Spending 18 months leading the Dayton community in addressing this very difficult situation was a lifechanging experience for him, Fitz said.

Dayton has a track record of dealing with difficult social issues, according to Fitz. A special human services levy has provided funds for over 12 years for high-priority needs, such as children's services or drug and alcohol addiction services. Dayton had begun looking at integrated services issues under the Casey Foundation New Futures project and a Ford Foundation/Dayton Foundation-funded self-sufficiency project.

Several factors allowed for community ownership of the child abuse issue and the task force process, said Fitz. The first was community leadership. Three or four people with stature in the community, including Fitz, have taken on the work of this task force as a mission. Secondly, the task force committed to releasing annual Valentine's week reports on the status of families and children in the community, which have garnered good press coverage.

The task force developed a community process for listening and learning together. They moved from fault-finding and finger-pointing to a shared sense of community accountability: A child's death is not an agency's fault, but a shared responsibility across the community. They developed a process in which the whole community could participate in a review of the children's deaths, create a shared awareness of what was going on in the community, develop a common appreciation of the issues, and take some actions together, experimenting with new ways of doing things.

Listening to actual stories of abuse and neglect opened the eyes and hearts of the task force members in ways that analysis of the numbers could not, Fitz reported. To aid the work of the task force, Fitz developed an analytical model for looking at systems that support families and children. It has three overlapping dimensions: (1) a normative level — the community’s beliefs and convictions about valuing children and families, (2) a process and systems level — the courts, the child abuse and neglect reporting system, the structure of service delivery in the community, and (3) the day-to-day practice level — the ways services are actually provided in the community.

With that model in mind, the task force held hearings — some confidential — over a six-week period, which let the community express its anguish and anxiety about abuse and neglect. At first, people were pointing fingers and laying blame. Then, Fitz tried to move the task force toward a notion of shared responsibility by asking them to identify their core beliefs about children and families in their community. They soon found that critics of the child welfare system and workers in the system shared some common beliefs. With some careful wordsmithing, the task force came up with 32 shared beliefs about what to do about children in their community.

The task force used a process map that describes how the child protection system works, which made it possible to talk about different points in the process, to classify problems and work with them, and eventually to take actual cases and walk them through the system from initial report through adoption. When they went to a juvenile court to track a couple of cases, they found it “eye-opening” that the court couldn’t even find the children’s case files. Over 85 percent of their recommendations came just from identifying problems and thinking about how to overcome them.

Fitz reported that three guiding ideas began to emerge as the task force worked: (1) the need for a continuum of services, (2) the value of a collaborative network of family- and child-serving organizations, and (3) the importance of strengthening families and rebuilding community structures. The task force’s model for the continuum of services went from child protection to family intervention services to family support service, according to Fitz. The task force found that the idea of a collaborative network of family- and child-serving organizations was hard to sell and to explain in the community. Many agencies are involved with at-risk families, including public service agencies, United Way agencies, police jurisdictions, and courts. Each has a mandate. Each has a funding stream. Each has its own governance. It was hard to see how they could come together to provide services, he said.

He illustrated his point with a story about a drug-dependent, single mother whose child welfare worker told her that unless she dealt with her drug problem, she would lose her child. Facing that moment of truth, the mother sought treatment. However, when she tried to find a spot in a drug treatment program, she found she faced a six-month wait. In the meantime, multiple agencies were involved with the family, including not only child welfare and the drug treatment agencies, but also the juvenile court, the Family Services Association (which helped the mother learn parenting skills), and the police departments.

In the end, said Fitz, the task force decided to focus attention on creating really strong families and rebuilding important community structures. They made 56 recommendations; 42 of those have been implemented within the last two years.

Fitz reported that the community now uses a pragmatic approach to prevention issues in which certain easily observed “red flags,” which indicate that a family might be in distress, trigger an intervention. For example, one “red flag” is excessive absenteeism by a child from school. While unexcused absences do not necessarily mean that there is distress in the family, they can indicate a problem. Dayton uses Americorps volunteers, in conjunction with the public schools, to visit the homes of children with excessive absences to find out if the families need services.

A number of community initiatives related to prevention are underway in Dayton, including a Healthy Start Program, an Early Start Initiative, and a Family Stability Program. Dayton is using its wellness block grants from the State of Ohio to work with pregnant teens identified as at high risk of abuse or neglect (see pages 30-32 of the background briefing report).

Another important outgrowth of the work of the Child Protection Task Force is a new Families and Children First Council, Fitz reported. The Council has tried to take a comprehensive approach to addressing a variety of issues in the Dayton community related to families and children. By connecting community leaders and directors of public and private agencies, the Council is a place where the community can form a vision of what it wants and then get the agency directors to work toward that vision in a systems change process. Thus far, in working on its vision, the group has identified six desired outcomes for families and children. They will track outcome measures for annual reports to the community about how well families and children are faring — to be released during Valentine’s week, just like Fitz’s Task Force reports.

Barbara Pryor

Barbara Pryor has worked for Senator Jay Rockefeller (D-WV) since 1985. As senior staff member on the National Commission for Children, which Rockefeller chaired, she helped prepare the Commission’s 1991 report, *Beyond Rhetoric*, which proposed a detailed policy agenda for America’s children and families, including recommendations for programs to strengthen vulnerable families.

The National Commission on Children was a unique opportunity to take a long-term strategic look at the status of children and families, said Pryor. A bipartisan group, with members ranging from Marian Wright Edelman of the Children’s Defense Fund to Bush Administration appointees, the Commission took a developmental approach to looking at children and families. At the time of the report, much attention was paid to the \$40 billion income support recommendations, said Pryor, but other recommendations were relevant to child abuse prevention, including those on strengthening families and on protecting vulnerable children. Both are important components of a comprehensive community strategy, she noted. Supporting and stabilizing families so that abuse and neglect does not happen should be the goal.

The rhetoric about kids and policy over the past few years has been like a roller coaster, said Pryor. But when Rockefeller looks at what has happened since the Commission published its report in 1991, there is reason to be optimistic: (1) the passage of the Family and Medical Leave Act, which fits with the Commission’s call for family-oriented policies in the workplace, (2) the expansion of the Earned Income Tax Credit, targeted to the working poor, and (3) enhanced child support enforcement to get additional financial resources to families who need them.

Rockefeller is also very proud of his work on the Family Support and Preservation Program, passed as part of the Budget Reconciliation Act in 1993. A five-year program, the Family Support and Preservation Act provides almost \$1 billion to the states as flexible seed money for family preservation and family support initiatives. In West Virginia, family support and family preservation dollars have been used to support family resource networks. Communities have come together to figure out how to serve families in comprehensive ways. Each family resource network is doing things differently because they are responding to different needs in their communities.

The reauthorization of the Child Abuse Prevention and Treatment Act in 1996 was another important step, said Pryor. The 1996 minimum wage bill also included an adoption tax credit, including a special tax credit for kids with special needs. While these pieces of legislation by no means address all of the problems, they do represent a gradual, step-by-step approach to moving forward on the idea of building community support and helping abused and neglected kids, she said.

Welfare reform will also have an impact on child welfare. Rockefeller voted for the federal welfare reform bill, hoping for the best and planning to watch it like a hawk to be sure children do not get hurt, said Pryor. He felt that the existing system was not working when a family of three in West Virginia was getting only \$257 a month in assistance plus \$300 in food stamps. It was time to move on to something new, according to Pryor. During the welfare reform debates, child welfare was a highly contentious issue. Members of the House supported a block grant approach to child welfare and were willing to limit or end the foster care entitlement. Their underlying assumption was that if states had more flexibility, they would do a good job. But with more than 20 states already under court order for *not* doing a good job, Rockefeller got a bipartisan group in the Senate to agree that child welfare was a very different system that should be treated separately.

Today, Senators Rockefeller and Chafee are working on a bipartisan initiative (since passed as the Adoption and Safe Families Act of 1997) to address some of the concerns in child welfare. Many of the provisions came from the senator's early work in the National Commission on Children. The focus will be on increasing safety for children, improving reunification efforts, and building on permanency planning. They also will work on the President's adoption initiative.

Next year, when the Family Support and Family Preservation Act is up for reauthorization, Rockefeller will look at the evaluations of the program very seriously, said Pryor. He wants to maintain those programs and their funding to the states, especially because the system is already under a lot of stress. The Government Accounting Office studies say the populations served by these programs are becoming more complicated and difficult, and they are growing. Rockefeller will pay particular attention to how welfare reform is affecting these families, so the Congress can figure out how to address some of the other issues that are looming. (Congress reauthorized the Family Support and Family Preservation Program with a modest increase in funding as part of the Adoption and Safe Families Act.)

Discussion

Before the floor was opened for discussion, Michael Ambrose of the Children's Bureau briefly described the first waivers that have been granted under the Title IV-E of the Social Security Act (the foster care program). Up to ten such waivers are authorized by Congress. Recalling the contrast between the billions spent on foster care and the millions on prevention, he noted that these waivers give states an opportunity to use foster care dollars more flexibly, and, in some cases, on preventive services. Ohio will test a managed care approach to child welfare. Oregon and North Carolina will use foster care monies for prevention, reunification, or other family services, hoping to achieve a better result with the same dollars. Illinois and Delaware are approved to use IV-E funds for subsidized guardianships.

Donnelly commented on the uncertainty about funding for the Healthy Families programs and other exciting early childhood and family support initiatives, such as Parents as Teachers. Most of the 250 Healthy Families sites have been funded so far as demonstration and pilot projects. The national infrastructure to ensure program quality for this initiative has been funded by private sources. She asked Pryor whether she expected new governmental support to ensure the long-term, stable funding for services and for the infrastructure needed for such an initiative.

Pryor answered that Rockefeller would love to have a long-term, stable, and larger source of support for such programs. He was pleased the states had \$1 billion through the Family Preservation and Family Support Program, although it was less than the \$2.5 billion he had originally proposed. She cautioned that child advocates need to remember the pressure in Washington for a balanced budget amendment and the huge potential impact of such an amendment on all discretionary programs. Next year there will be a focus on getting flexible dollars out to communities, she said.

Fitz asked Pryor whether there was legislation under consideration that would increase flexibility for funds at the local level. Pryor mentioned current demonstration projects and new provisions in the Rockefeller-Chafee child welfare bill (which became the Adoption and Safe Families Act) that would increase flexibility in providing reunification services. However, she noted Rockefeller's ongoing concerns about maintaining accountability, especially when many state child welfare systems are currently operating under court orders.

A representative from the National Association of State Alcohol and Drug Abuse Directors raised concerns about the lack of funding for drug abuse treatment, noting that some who need such services will shortly be thrust into the workforce. Fitz responded that the Dayton task force had identified access to timely drug treatment services as important to the prevention of child abuse and neglect. Communities can find ways to solve these problems in part by using their own funds more flexibly, he noted. For example, Dayton uses funds from a special human services levy to match federal and state dollars for alcohol and drug treatment services.

A representative of the American Academy of Child and Adolescent Psychiatry (AACAP) suggested that more attention be paid to the mental health needs of both parents and children.

Child abuse is to mental health what cigarette smoking is to medical health, he said, because it causes so many other problems. He also raised concerns that in-home service providers are often inexperienced and inadequately supervised. Those who make decisions about families in their homes need at least five years of experience in treating such families, as well as knowledge about child development, family therapy, and substance abuse and other problem areas, he said. In cases he sees where children have been abused repeatedly, red flags have usually been missed due to inadequate supervision. Program plans should provide for adequate supervision, limited caseloads, and expert backup from professionals, he argued. Guidelines on typical family problems and effective treatments are also needed.

Donnelly described the types of qualified professionals used by several home visiting programs, including pediatricians in the Healthy Steps Programs of the Commonwealth Fund and nurses in the Elmira Prenatal/Early Infancy Project. The Cooperative Extension Service's home visiting programs use child development specialists to do home-based assessments, screenings and referrals. Many Healthy Families programs do use paraprofessionals as home visitors, but ensure they have small caseload sizes, get good supervision, and are complemented by specialists, she reported.

The AACAP representative also remarked that he would like to see the media sell parenting skills. Donnelly agreed about the importance of using media to educate parents about nonabusive ways of disciplining kids and reported some success in doing so. However, it is not clear that public service announcements for television meet the needs of the most overburdened families at greatest risk of abusing their children, she added.

Fitz noted the lack of support for families from extended families, neighbors, Boy and Girl Scout troops, and other informal mentoring sources in distressed urban neighborhoods. He stressed the importance of rebuilding these community structures even as we intervene with individual families.

A representative from Zero to Three — the National Center for Infants, Toddlers and Families spoke of the importance of providing professionals working with infants, toddlers, and families needed support as well. Several programs, including the Cornerstones Project in the District of Columbia, the Early Childhood Initiative in Pittsburgh, and the Child Witness to Violence Project in Boston, bring together people from several disciplines who work with young children and their families or provide a mechanism for making expert backup available to front-line child care staff.

In response to a question from a Justice Department staffer, Pryor indicated that the focus on prevention in the 1994 crime bill did not get the attention it deserved. Public education should emphasize helping these kids on the front end rather than paying for their prison time or building drug courts. Fitz deplored fragmentation in the court system that can result in a single family dealing with two or three ongoing cases, each with different workers and different procedures.

A seminar attendee from the Center on Effective Services for Children asked how to quantify the benefits of the successful programs so that their value could be communicated more effectively to constituencies with power over funding. Donnelly said that there is no research to prove that the \$3 billion we spend on foster care annually responding to child abuse after the fact makes a

whit of difference. It is amazing the high degrees of proven effectiveness required of preventive programs, she said, particularly when no research has ever shown any negative impact on families at all. She said that 50 or so researchers looking at Healthy Families America programs are discussing protocols, outcome measures, and the questions being asked by funders, so they can plan their research better. Fitz said he is often told by members of the business community that money spent on prevention is useless. He argued that we are chasing after the wrong paradigm — that is, it's only important or valuable if you can measure it — and that we should use qualitative research methodologies to supplement the emphasis on quantitative results.

A representative of the Board on Children, Youth, and Families of the National Academy of Sciences and the Institute of Medicine emphasized the need for information systems with common sets of data, which could pinpoint improvements and identify trends in families or communities over time, even if they were not linked with specific interventions. She asked about the data sets Dayton was using to measure outcomes and suggested the federal government could do more to create data sets that would be helpful to communities in pinpointing trends. Fitz responded that this was a complicated issue because many outcomes are difficult to trace. It is hard to prove that a child's school performance improved as a result of the drug treatment his mother received. Data on trends and patterns and individual stories may be more helpful than co-relational methodologies, he said. Dayton is working on a family-specific information system that will include information from both public and private agencies and will track families as well as individuals. In addition, Dayton already may be using some national data sets broken out by region to see whether there is a change over time.

A seminar attendee from the Heritage Foundation asked why, if there are so many privately funded organizations already involved in child abuse prevention, should we try to switch it to federal government money, with all the extra paperwork involved. Donnelly offered examples of several kinds of successful public-private partnerships delivering home visiting services. In Hawaii's Healthy Start program, which had been the model for Healthy Families America, services are delivered entirely by private agencies but are funded by contracts with the state health department.

Donnelly also suggested that even when and if big health care providers, in an effort to avoid future health costs, covered part of these home visits, home visiting programs would still need public support. A seminar attendee reminded the group that most of the Healthy Families group projects were started as pilot projects, using seed money from private groups and foundations like the Freddie Mac Foundation. It was now time for the public sector to step in and become involved in long-term funding.

Fitz suggested that we are not critical enough of the quality of foster care in our country, because we believe we cannot afford to pay for rigorously certified, high quality care. In his view child abuse could be occurring in as many as 20 to 30 percent of the foster care placements.

A staffer from the Health Care for the Homeless Branch of the Department of Health and Human Services noted that this nation has not had so many families with children who are homeless

since the Depression. Usually headed by single mothers, families with children account for one-third of the homeless population. He asked how child abuse prevention services could effectively be delivered to this population, which is often disconnected from the community and has many domestic violence issues. Fitz said that, although they were not doing as well as they should in Dayton, they have been tracking what happens to children and families evicted from public housing for not paying their rent. It is important to get serious about these families, he said, because in two years, when those without work are thrown off welfare, communities are going to be inundated with families with children who have no way to take care of themselves.

In closing, Donnelly heralded a new public willingness to tackle the problem of child abuse and neglect. Public opinion polls show that the public wants to do something themselves rather than simply rely on the government, which fits with the philosophy of the Healthy Families America program.