Scanning the child maltreatment landscape

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TAKEAWAYS

Child maltreatment arises most frequently when families experiencing adverse experiences are living in communities with adverse environments.

Child maltreatment prevention calls for multiple levels of evidence-based policies and practices.

An effective approach to prevention requires the expansion of organizational capacity to deliver family-based interventions while addressing adverse community environments.

A prevention science lens can help analyze pathways to adding proactive features to what have historically been reactive health and human services systems.

Effective prevention strategies include early childhood care and education, home visitation, clinic-based programs, school-based programs, and community education and mobilization initiatives.

Risk factors for child maltreatment are varied and often overlapping. As a result, preventing child maltreatment calls for a broad range of policies and practices. Effective maltreatment prevention strategies exist despite limited implementation through federal and state child welfare systems. Prevention efforts that use prevention science approaches seek to expand organizational capacities for providing evidence-based prevention programs while addressing the adverse family and community experiences that amplify risks for child maltreatment.

Risk factors for child maltreatment emerge in various forms—from the individual to societal levels—and include aspects of parental mental health, intimate partner relationships, intergenerational caregiving experiences, community characteristics, and systemic influences of community and socioeconomic contexts. Interdisciplinary work in behavioral science, early childhood care and education, sociology, pediatric primary care, developmental psychology, and other fields have contributed to an increasingly robust availability of effective and proactive programs and prevention services. While widespread implementation of effective maltreatment prevention strategies has been slow and uneven, scholars and practitioners in the field of maltreatment are progressing toward an enhanced understanding of the opportunities and barriers in establishing programs and bringing them to scale.[1]

Prevention science

Recent decades have seen advances toward understanding childhood brain development, a renewed interest in primary prevention strategies, and efforts to increase coordination across child-serving systems. Prevention science integrates many strands of research, including life course development, community epidemiology, etiology of disorders, intervention trials, and dissemination research.[2] Prevention science research is grounded in the ideas that developmental growth, mental health, and lifespan outcomes are attributable to a variety of risk and protective factors. To be effective, prevention strategies should be designed to reduce risk factors and enhance protective factors among individuals, families, and communities.

Protective factors buffer children from abuse or neglect. Risk factors provide information about who is most at risk for being a victim or a perpetrator of child maltreatment. It is important to note, however, that risk factors are not direct causes and cannot predict who will be a victim or a perpetrator.[3] The Centers for Disease Control and Prevention (CDC)[4] has adopted a four-level model regarding the interplay between protective and risk factors at the (1) individual, (2) relationship, (3) community, and (4) societal levels to inform prevention strategies.[5] Although the factors contributing to the most commonly studied forms of child maltreatment (i.e., physical abuse, sexual abuse, neglect, and emotional abuse) may differ, we argue that such factors are layered and often commonly shared.

There is substantial evidence on the impact of individual characteristics on child maltreatment, the first level of the CDC framework. Key individual factors associated with child maltreatment include parent anger/hyper-reactivity, depression, substance use, low social support, young parental age, unemployment, single parenting, large family size, and low family socioeconomic status.[6] At the CDC's second level—relationships—many studies highlight that parent-child dynamics and parenting are inextricably part of physical abuse, sexual abuse, emotional maltreatment, and child neglect.[7]
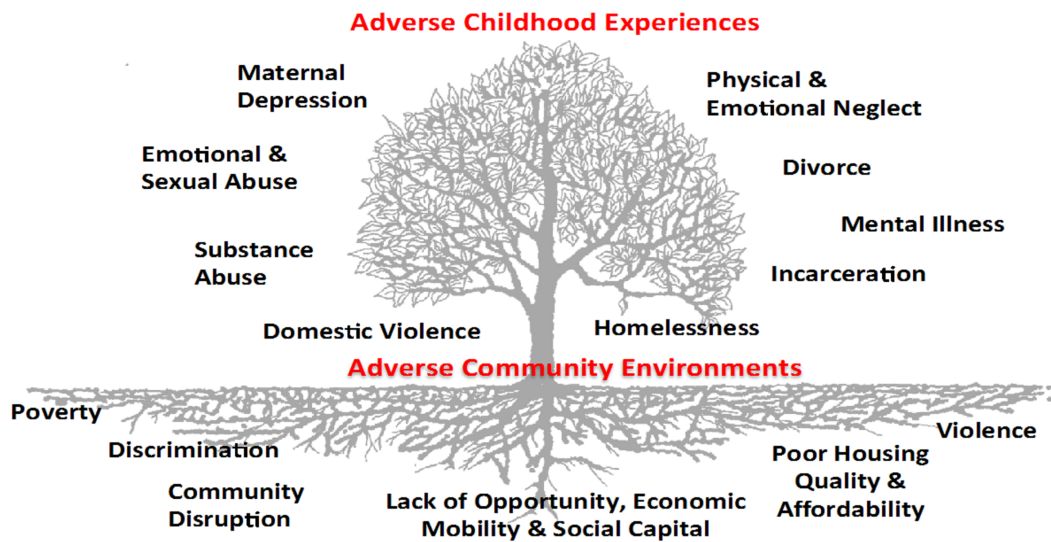
A growing number of studies have identified risks for child maltreatment at the CDC's third level—community—including neighborhood characteristics and social dynamics.[8] Neighborhood qualities such as social cohesion, informal social control, mutual trust, social organization, and community violence can enhance or weaken the likelihood of parents providing safe and consistent care for their children.[9] Neighborhoods and other community factors almost certainly interact with child and family characteristics. For example, supportive neighborhoods appear protective for African American girls insofar as they are associated with less exposure to adverse childhood experiences.[10]

The CDC's fourth level—societal factors—includes social norms about the acceptability of child maltreatment and social benefit programs that strengthen household financial security. Social norms in the United States tend to reject child maltreatment, support the growth of prevention efforts, and see prevention as positive and possible.[11] Also operating at this level are local, state, and federal programs supporting basic human needs. For example, a few recent studies have evaluated the effects of providing economic assistance to families with limited resources; results demonstrate that increases in income via state-level Earned Income Tax Credit programs are associated with significant reductions in abusive head trauma hospitalizations[12] and family involvement with Child Protective Services.[13] Conversely, a small but growing body of evidence indicates that state-level restrictions on access to Temporary Aid to Needy Families (TANF) are associated with statistically significant increases in child protection reports, victims of child maltreatment, and foster care placements, even after controlling for changes in incarceration and the nation's opioid epidemic.[14] Participation in nutrition assistance programs, expanded Medicaid eligibility, and supportive housing experiments are also associated with a range of positive child and family outcomes. Yet the child maltreatment prevention landscape in the United States does not build upon universal social and health programs common to other Western nations.

A multi-level approach to addressing child maltreatment applies a prevention science lens to what have historically been reactive rather than proactive systems.

Beyond the CDC's model, some researchers have characterized discussions of health disparities in two broad clusters of problematic influences co-occurring with child maltreatment. General influences have been framed as the "two ACEs"—adverse childhood experiences (commonly called ACEs) and adverse community environments (see Figure 1).[15] Child maltreatment is a specific adverse childhood experience often occurring in the context of, and in combination with, multiple other adverse childhood experiences. It is also more likely to occur for children living in adverse community environments.[16] Adverse childhood experiences can affect individuals' short- and long-term health[17] in significant and overlapping ways, thus making a multi-level approach to maltreatment prevention pertinent and logical.

Figure 1. The Pair of ACEs.

Adverse Childhood Experiences

Maternal Depression

Physical & Emotional Neglect

Emotional & Sexual Abuse

Divorce

Substance Abuse

Mental Illness

Incarceration

Domestic Violence

Homelessness

Adverse Community Environments

Poverty

Violence

Discrimination

Poor Housing Quality & Affordability

Community Disruption

Lack of Opportunity, Economic Mobility & Social Capital

A multi-level approach to maltreatment prevention

A multi-level approach to addressing child maltreatment applies a prevention science lens to what have historically been reactive rather than proactive systems. Such a framework entails a three-tiered orientation (i.e., primary, secondary, and tertiary prevention) to address key points in the trajectory of maltreatment where interventions occurs, as well as accounting for the target populations (i.e., universal, selected, or indicated).[18] (See Table 1).

The first tier of this framework includes primary and universal approaches. Primary strategies aim to prevent the onset of maltreatment; universal strategies target entire populations or vulnerable subgroups (e.g., low-income families with no evidence of maltreatment). Thus, primary and universal prevention approaches aim to reduce the incidence of maltreatment and related outcomes by implementing population-based programs using strategies to reduce population-level risk factors for child maltreatment, such as poverty and community violence, while promoting positive outcomes in vulnerable subgroups of families and children (e.g., families living in poverty).

Secondary and selective intervention strategies also aim to prevent maltreatment by reducing risk factors for both potential perpetrators and victims. Selective interventions focus on individuals who have demonstrated elevated risks for maltreatment. Thus, secondary and selective interventions are designed to address maltreatment risks, such as parental physical and mental illness; low levels of parenting knowledge and skills; family social isolation; child physical, emotional, and psychological disabilities; and inadequate basic resources;[19] as well as the double ACEs mentioned above.

Tertiary and indicated prevention approaches aim to prevent the recurrence of maltreatment and its adverse outcomes or to mitigate the effects of maltreatment. Indicated preventive interventions focus on parents who have maltreated their children or children who display symptoms emanating from exposure to maltreatment. As such, these

Table 1: Three pathways to prevent child maltreatment.

Type	Who	What	When	How
Primary	All families	Decrease poverty and structural disparities. Promote community and social well-being	All programs for all persons all the time	Community-based public health, universal education, and income support approaches
Secondary	Families at risk for maltreatment	Reduce risks for child maltreatment	Before maltreatment occurs	Parental mental health, IPV, substance abuse, and parenting programs
Tertiary	Families with maltreatment history	Interventions for maltreated children and their families	Before maltreatment recurs	Mental health treatment, trauma-focused interventions, parenting interventions

Source: Jones Harden, B., Simons, C., Johnson-Motoyama, M., & Barth, R. (2020). The child maltreatment prevention landscape: Where are we now, and where should we go? *The Annals of the American Academy of Political and Social Science*, 692(1), 97–118.

interventions are designed to counteract the effects of abuse and neglect on maltreated children and their families and may have family preservation or placement prevention as a goal.

Services and programs to prevent maltreatment

Given the strong association between maltreatment and poverty, emerging research suggests that an important lever for prevention is the range of policies and programs that improve families' economic situations; specifically, the receipt of social safety net programs such as the TANF, SNAP, EITC, housing, and childcare subsidies has been found to reduce maltreatment.[20]

We focus herein on direct intervention with birth parents to prevent and reduce maltreatment, at the primary, secondary, and tertiary levels.

Primary prevention of maltreatment

Primary prevention strategies aim to avert maltreatment by promoting protective factors that optimize family well-being. Primary strategies are often universal programs (i.e., geared to an entire population of families) but may also be targeted to families at risk (e.g., low-income families) who do not necessarily display specific risks for maltreatment. Strategies include early childhood care and education, home visitation, clinic-based programs, school-based programs, and community education and mobilization initiatives.

Early childhood care and education

Young children and their families benefit from early care and education programs. These programs tend to serve low-income families with children under five years old. Enhanced child development is often a major goal. Many such programs are comprehensive and multi-generational (i.e., targeting both caregiver and child development), with an explicit focus on promoting positive parenting and parent-child interactions. Programs may include services providing full-time childcare for young children as well as home-based services. Supportive services to parents are also often available (e.g., general parenting education, self- sufficiency services, case management and referral to public income supports, etc.), but do not necessarily provide family-specific, intensive interventions to improve parenting. However, the family support provided by these programs may help reduce maltreatment.

Home visitation

High-quality home visitation programs represent another primary preventive strategy.[21] These programs tend to recruit parents during the prenatal or early postnatal period and provide preventive services during infancy and early childhood. Nurses, developmental specialists, or social workers typically act as service providers, often meeting with parents weekly, though frequency may vary. Fueled to a great extent by the Maternal, Infant, and Early Childhood Home Visiting legislation of 2010,[22] research has documented the positive impact of several high-quality home visiting programs on global parenting and maltreatment-specific outcomes.[23]

Clinic-based programs

Pediatric care clinics have proliferated as sites for primary prevention programs focused on early childhood. These models supplement conventional pediatric preventive medical services with a child development specialist or social worker providing developmental and parenting guidance to parents as well as case management services. Additionally, health care personnel may be trained to understand early childhood development and mental health. Clinic-based models of primary prevention show promise regarding maltreatment prevention and promoting positive parenting practices.

School-based programs

Many sexual abuse prevention programs are based in schools. Schools are an excellent context because teachers and pupil personnel services providers and community school providers can reach a wide audience of children before they are affected by maltreatment. Almost all school-based programs involve discussions, and many involve modeling and interactive learning with role-play or behavioral skills rehearsal. School-based programs can have positive effects on self-protection, personal safety knowledge, awareness of others' behavioral intentions, and knowledge about abuse behaviors.[24] However, findings regarding disclosure of abuse, a key outcome, have been inconclusive.[25] Longer programs

Research to Watch

Research by Kristen Slack and Lawrence Berger, both IRP affiliates and professors in the University of Wisconsin–Madison's Sandra Rosenbaum School of Social Work, looks to determine whether access to more and better economic resources can reduce involvement with child protective services (CPS). Project GAIN (Getting Access to Income Now) is designed to shed light on links between economic resource constraints and child maltreatment, and to see if reducing financial stress may lead to less CPS involvement.

Project GAIN is based on three main elements: a family assessment to ensure they are aware of various public and private economic supports, with assistance accessing them; financial counseling to identify and strive towards economic goals; and, when necessary, one-time emergency cash supplements to lessen financial stressors. The per-family cost of the project averages to about $1,800.

The target population for Project GAIN are families in Milwaukee, Wisconsin, who have been reported to and investigated by CPS but do not have a current open case. Approximately 800 families were identified and randomly assigned to either a control group—which were simply given a referral to a local warmline for support—or a treatment group that is offered participation in Project GAIN. The families were assessed for 24 months using administrative data (e.g., income sources, indicators of economic well-being, further involvement with CPS, etc.). A subset of families was also assessed via in-home baseline and 12-month follow-up surveys.

Outcomes of the evaluation include whether a family has seen further CPS involvement, and if so, the severity and type of complaint; the extent to which the Project GAIN participants experienced any lessening of financial stressors and/or net increase of monthly income; how different subgroups respond to participation; and whether the cost of the program is outweighed by benefits gained. Initial results are scheduled for release in Fall 2021.

(i.e., four or more sessions) and programs that had an experiential component for children seem more effective.[26]

Community education and mobilization

Representing a further removed primary prevention approach, community education and mobilization have been employed to prevent maltreatment at a population or community level. These strategies include media campaigns and targeted messaging, general parenting education provided in community settings, and community mobilization efforts. For example, public education campaigns in many states seek to address a specific form of infant maltreatment—abusive head trauma (i.e., Shaken Baby Syndrome)— but have yielded inconclusive results.[27] Integrating these strategies into other primary prevention programs such as home visits, while addressing parental affect and targeting male caregivers who are often perpetrators of this form of maltreatment, may strengthen program effectiveness.[28]

Strategic communication campaigns for the primary prevention of maltreatment have also been launched by scholars and practitioners. Universal campaigns to reduce physical abuse—broadcast to a wide, general audience—have been associated with enhanced parental self-efficacy and knowledge of concepts and actions relevant to preventing child abuse, but less so with measurable reductions in physical abuse.[29] Similarly, findings from evaluations of media campaigns to prevent child sexual abuse are somewhat mixed.[30]

Community mobilization efforts to prevent child maltreatment often enlist volunteers and community members to support families at risk for maltreatment. Although relatively common, many such initiatives have not been subject to rigorous evaluation. One exception is the Strong Communities for Children program, which was designed to prevent the maltreatment of children from birth through adolescence and which yielded many benefits for families including decreases in parental stress, substantiated child maltreatment, and childhood injuries related to maltreatment, as well as enhanced social support, collective efficacy, child safety, and parenting practices.[31]

Addressing child maltreatment from a prevention science lens seeks to help organizations build capacity for implementing evidence-based prevention programs and promoting policy changes that support family well-being.

Secondary prevention of maltreatment

Secondary prevention strategies focus on families that have been identified as at-risk for maltreatment. Programs of this type are designed to enhance the parenting skills of potential perpetrators of maltreatment, focus on risk factors for maltreatment, and are often evidence-based parenting interventions.

Home visitation

A different set of home visiting programs address the functioning of families who have displayed risk for maltreatment. Like programs in the primary tier, these programs may be quite comprehensive; geared toward improving family, parenting, and child outcomes; and longer in duration (e.g., two to five years). However, unlike programs in the primary

tier, they are designed to address the needs of families who have displayed particular risks for maltreatment, such as parental depression or substance abuse. An example of this approach is Healthy Families America (HFA), which uses an eligibility screener for families to determine risks of maltreatment. HFA evaluations have documented reductions in child maltreatment,[32] more positive parenting practices,[33] improved home environments, and decreased violence in the home.[34]

Other home visiting programs can be intensive in terms of content and format yet tend to be brief in duration (e.g., 10–20 weeks). These programs often employ active coaching to promote positive parenting behaviors. Some integrate video feedback to facilitate participants' observation, awareness, and progress of behavioral change. New research identifies several high-quality home visiting models focused on sensitive and responsive parenting, reducing physical punishment, improving child safety, and reducing child abuse recidivism.

Interventions to address parental risks

Because secondary prevention programs address risk factors for maltreatment, it is important to identify specific caregiver risks when designing programs. For example, substance-using mothers participating in parenting interventions displayed more sensitive and responsive caregiving[35] and reported reductions in their child abuse potential.[36] Mothers affected by intimate partner violence who participated in a risk-specific parenting intervention were more likely to show a decrease in their use of corporal punishment over the course of the intervention than those who did not participate.[37]

Parent management interventions

Parent management interventions are grounded in social-cognitive theory and aim to reduce maltreatment by increasing parenting skills. Such interventions may be delivered in settings such as the home, early childhood centers, schools, or clinics. Parent management programs typically focus on both behavior change and relationship building. Programs typically last several weeks, are conducted in individual or group formats, and are administered by therapists or other qualified individuals. They are often geared toward children from 2 to 12 years old. Such interventions can be effective in preventing new reports of physical abuse and reducing child welfare recidivism, as well as increasing the use of appropriate discipline and praise/incentives among families at risk of neglect.

Tertiary prevention of maltreatment

Third tier prevention programs focus on avoiding the recurrence of maltreatment or associated maladaptive outcomes. Due to their focus on preventing maltreatment among families with the most acute needs, these programs often have an intensive, therapeutic component that seeks to reduce harmful parenting behaviors. They may include a relationship-based approach in which providers intervene with nurturance and reflection, or may have a parent management orientation, in which providers actively coach parents to alter negative parenting patterns. Programs with a relationship-based approach have shown increases in secure attachment and decreases in disorganized attachment among maltreated children, reductions in behavior problems and trauma-related symptoms, and decreases in parenting stress, maternal psychopathology, and family involvement with the child protection system. Parents who participated in a parent-management intervention experienced reductions in disruptive child behavior, dysfunctional parenting, parental distress and relationship conflict, negative parental attribution for children's misbehavior, potential for child abuse, unrealistic parental expectations, rates of reports to child protection systems, foster care placement, and abuse/neglect related medical injuries.[38]

Conclusion

Research and practice in child welfare and other disciplines have contributed to progress in the design and implementation of programs and services that hold promise for reductions in child maltreatment. Child maltreatment prevention programs require a varied and robust landscape of research, policy, and applied strategies. Addressing child maltreatment from a prevention science lens seeks to help organizations build capacity for implementing evidence-based prevention programs and promoting policy changes that support family well-being. While doing so, adverse community experiences must also be addressed to reduce varied and overlapping risk factors for child maltreatment. Interventions designed to optimize parental mental health, intimate partner relationships, intergenerational caregiving experiences, community characteristics, and systemic influences of community and socioeconomic contexts are also critical for improving the parenting of families at risk for maltreatment. This multi-level approach holds promise for preventing maltreatment and optimizing the well-being of children and families overall.■

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