The prevention of child abuse and neglect

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Introduction

The maltreatment of children and adolescents is a problem that reaches well beyond the victims and perpetrators directly affected by these behaviours. It affects the lives of professionals who are charged to care for the health and well-being of families and children, as well the government officials and private citizens who are concerned with the quality of life in their communities. Child maltreatment erodes social capital and the social cohesion that binds communities. An effective approach to the prevention of child abuse and neglect must reflect the complexity of the causes of the problem and the diverse interests and needs represented by all persons who are affected by it. In a report from the United States' National Research Council, the goals of prevention efforts in the field of child maltreatment are viewed as efforts "to reduce risk factors associated with child abuse and neglect, to improve the outcomes of individuals or families exposed to such risk factors, and to enhance compensatory or protective factors that could mitigate or buffer the child from the effects of victimization" [1].

Alongside efforts to improve systems for detecting and treating maltreated children and maltreating families, prevention must be viewed as part of a comprehensive approach to the total problem of child maltreatment in countries and communities. Ideally, efforts at detection and child protection should share the same philosophical approach with prevention efforts in terms of optimizing child and family well-being. But an over-emphasis on detection and secondary prevention has at times diverted attention away from primary prevention strategies that are focused on providing support and assistance to families who are distressed or not functioning effectively [2].

The developmental/ecological and public health models

The multiple approaches to the prevention of child abuse and neglect reflect the complex causes and consequences of this social problem, from the level of the individual parent and child to the larger society (Table I) [3]. Researchers and practitioners from different disciplines have developed various frameworks for characterizing prevention efforts in this field. Perhaps the two prominent frameworks are the developmental/ecological model and the public health model.

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A developmental/ecological model of the aetiology of child maltreatment is a useful framework for discussing the multiple efforts that are needed to prevent child abuse and neglect in

Table I: Targets for child abuse and neglect prevention efforts (adapted from ref [3, 11]).

Parent
- Emotional distress, learning impairments, personality problems
- Emotional arousal and reactivity to child provocation; poor anger control
- Inadequate/inappropriate methods of teaching, discipline and child stimulation
- Rigid or limited beliefs about child rearing
- Unrealistic expectations of child development
- Negative lifestyles such as substance abuse, prostitution and crime

Child
- Problems related to poor attachment formation, the development of empathy and social judgment, and affective expression
- Poor school performance
- Problems in self-control and aggression

Family
- Marital discord and/or coercive family interactions
- Partner violence
- Chronic economic problems and associated socio-economic stressors
- Social isolation and inability to establish or utilize social supports

Societal level
- Slow implementation of the provisions of the United Nations Convention on the Rights of the Child
- Poor monitoring of child abuse and neglect cases
- Inadequate housing, safety and schools
- Underdeveloped support and educational services to disadvantaged families
- Lack of suitable employment opportunities
- Inadequate child-care resources
- Support for corporal punishment
- Lack of parent education, preparation and support opportunities
- Absence of training and education for professionals
- Inadequate legal, health, and child welfare response systems and alternative care placements for children

diverse communities [4-6]. This framework views maltreatment as arising from a complex interaction of risk and protective factors operating at the levels of individuals, families, communities, and within the broader society and culture. It suggests that single-faceted interventions that focus on single risk factors (e.g. parenting classes to impact knowledge about child development) are unlikely to have much impact on the prevention of child maltreatment unless combined with other interventions that address the multiple conditions that compromise parental ability to care appropriately for their children. It also recognizes that prevention programmes will vary in approach depending on the developmental period of the children and adolescents who are focus of the programme.

Complementing the developmental/ecological model is a public health model that organizes prevention into primary, secondary and tertiary efforts. Primary prevention efforts seek to reduce the occurrence of risk factors or increase protective factors at the individual, family or community level prior to onset of abuse or neglect. Secondary prevention efforts seek to reduce the severity or continuity of maltreatment among those already identified as at-risk, such as parents abused as children. Tertiary efforts take place once maltreatment has occurred and seek to reduce the consequences of maltreatment or its reoccurrence and to restore the affected individuals to optimal functioning.

The developmental/ecological and public health models each have strengths and limitations in helping provide a framework for describing a community's or country's prevention efforts, identifying gaps in existing approaches and planning future initiatives. For example, although an ecological model is useful in distinguishing programmes at the individual child or family level compared to initiatives at the community level, it often provides little insight as to how programmes at one level (e.g. the neighbourhood) translate into effects at another level (e.g. the child). Likewise, the public health model often does not adequately describe efforts that represent a mixture of primary, secondary and tertiary approaches, or fails to consider the role of context in shaping the nature and effectiveness of prevention efforts.

The Haddon Matrix is a useful tool for organizing prevention planning and policy development in child maltreatment that incorporates both the ecological model and the public health model [7]. This matrix has been suggested for use as an organizing framework for a variety of prevention programmes as it suggests multiple intervention points. Haddon originally proposed that the prevention of motor vehicle injuries

could be organized into: i) primary prevention or prevention prior to the occurrence of the event; ii) secondary prevention or prevention that came into place at the time of the event; and iii) tertiary prevention or rehabilitation after the event. Haddon suggested that prevention could be directed alone or together at the host (child), at the agent (caregiver) or the environment. The intersection of these two dimensions produces a matrix with 9 cells. A multi-faceted prevention programme requires the development of strategies for every cell of the matrix. Careful parenting education and home visiting can be seen as primary prevention directed at the caregivers. Teaching a parent to pick up the phone or walk away when he or she is angry with a child is secondary prevention. Post-maltreatment parenting classes or the use of foster care constitute tertiary prevention. Teaching a child to avoid situations that could be risky is primary prevention while education to say "no" is secondary prevention and instructing the child to tell an adult if someone has touched her or him is tertiary prevention. Providing social support and income support for new parents is a primary environmental strategy and making sure that medical providers recognize maltreatment is a tertiary environmental strategy for prevention. Other prevention strategies that fit into this matrix include altering social norms for acceptable parenting behaviour, increasing recognition of the potential harm from shaking a child, and ensuring the availability of counselling services for victims. Interventions that target "high-risk" groups prior to the occurrence of maltreatment should be considered primary prevention.

Children's Rights as a framework for prevention

In the last decade, an important new international framework has gained momentum with direct implications for child maltreatment prevention efforts. International awareness of protecting children from abuse and neglect has increased since the United Nations Convention on the Rights of the Child [9, 10]. Article 19 states that countries should "take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence injury or abuse, neglect of negligent treatment, maltreatment or exploitation, including sexual abuse." It goes on to say that such measures should include "effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as other forms of prevention (…)." The Convention of the Rights of the Child (CRC) places child maltreatment prevention efforts into a human rights framework and, as the most widely ratified of all United Nations conventions, provides a moral and legal starting point for comprehensive community approaches to prevention that are sensitive to the cultural and economic differences among developed and developing countries. It is difficult to document the impact of the CRC on the global prevention of child abuse and neglect [11]. There are clear examples in some countries of prevention efforts that have begun as a result of the CRC, although in many other countries, such as in sub-Saharan Africa, the implementation of CRC provisions remains a distant goal because of poverty, war, HIV/AIDS and corruption [12].

The Convention of the Rights of the Child (CRC) places child maltreatment prevention efforts into a human rights framework and provides a moral and legal starting point for comprehensive community approaches to prevention.

Recent reports from the World Health Organization (WHO), such as the Report of the Consultation on Child Abuse and Neglect Prevention [13] and the World Report on Violence and Health [11], discuss child abuse and neglect prevention efforts from an international perspective, including recommendations for needed actions by governments, health care workers, teaching and legal professionals, and other groups invested in preventing child abuse and neglect. Those reports are referred to as appropriate.

Prevention programmes, especially those where some adequate evaluations have been conducted, have focused mostly on secondary or tertiary efforts with at-risk families or victims and perpetrators of abuse and neglect. Fewer well-designed and evaluated primary prevention efforts have taken place. Some of the more common approaches are reviewed below.

Public awareness campaigns

Public education and information campaigns, as universal primary prevention efforts, represent important tools for raising public awareness of the problem of child abuse and neglect, for reinforcing community standards regarding the care of children, for raising funds for community initiatives, and as a means for exerting public pressure on governmental bodies to institute policies and programmes to support the healthy development of children.

The targets of educational campaigns are often parents, but also at times children themselves. For example, a large public awareness campaign in the US has focused on the shaken baby syndrome [14]. The national campaign named "Don't Shake the Baby" relies on local and regional partners and seeks to reach parents and professionals in contact with children such as physicians, nurses and teachers in an effort to increase awareness of the dangers of shaking young infants. Another innovative public awareness effort by Prevent Child Abuse America developed collaboration with Marvel Comics to produce a series of Spider-Man comic books that teach children about sexual abuse and other child safety issues. A multi-media campaign in the Netherlands in the early 1990's was aimed at increasing disclosure by victims and by adults caring for children [11, 15]. It included a televised documentary, short films and commercials, a radio programme and printed materials such as posters and booklets. The result was an increase in calls to the National Child Line service.

Improving the data collection infrastructure in developing countries is an important step in mounting effective prevention efforts and has been advocated by international organizations such as the WHO but also by other NGOs.

Although public awareness campaigns must be considered part of a comprehensive approach to the prevention of child abuse and neglect, their effectiveness is often difficult to judge and they are likely to affect only a sub-population of persons who are part of the targeted audience and motivated to change [1]. For persons who are not literate or who are isolated from the media, other locally based efforts that directly reach parents must be employed.

An important prerequisite for raising public awareness is adequate research on the scope and nature of the problem of maltreatment in countries and regions, the consequences of maltreatment, and the network of existing services, laws, and interventions in place to address the problem. Improving the data collection infrastructure in developing countries is an important step in mounting effective prevention efforts and has been advocated by international organizations such as the WHO but also by other non-governmental organizations (NGOs) such as Childwatch International. Surveillance data may come from health, judicial, police or other administrative systems. Countries that include child abuse and neglect data as part of national health statistics tend to have more highly developed professional training and have invested more resources in prevention and treatment than countries whose only source of information comes from police or judicial systems [13]. In addition to national statistics based on administrative records, national and local surveys of professionals in the general population and special at-risk groups (e.g. prisoners, runaway youth and persons using mental health clinics) can yield important information that assists in the targeting of prevention programmes. To the extent that such research efforts involve participation of local service providers, appropriate government officials and families, they can be a tool for building public support for community-

wide prevention efforts, including the recruitment of citizen volunteers in prevention programmes.

Family support approaches

Perhaps the most widely used approaches to prevent child maltreatment involve attempts to provide support directly to families and improve parenting practices. Some of these are universal approaches aimed at a broad population of parents (e.g. rooming-in policies at hospitals for all parents having babies as a way to enhance parent-child attachment), but many are targeted programmes designed for parents deemed at some risk for poor parenting practices. The most promising approaches address multiple risk factors for poor parenting and use a variety of types of support (e.g. information, emotional support and tangible aid) [16]. Such programmes may not even be labelled as child abuse and neglect prevention programmes, but more broadly as "family support and education" or "early intervention" programmes [17].

A variety of issues are addressed with programmes such as positive parenting practices and appropriate discipline techniques, learning developmental milestones for children of various ages, promoting positive parent-child attachment and interactions, and assisting the parents with their life course development in part by linking them to relevant community services. One of the most well researched approaches that has received considerable attention in recent years are home visitation programmes for new parents.

Home visitation to new parents

Although home visitation has been commonly integrated into perinatal health services in many European countries for decades [18], recently there has been an upsurge of such programmes in the US following the widespread dissemination of findings from clinical trials and sustained advocacy efforts.

A growing body of research points to a number of benefits of well-designed and well-administered home visitation programmes for both children and parents [19-21]. Home visitation to new parents is well suited as a child maltreatment prevention strategy [22]. It reaches high-risk parents who lack the skills or confidence to engage in formal service settings or who might be unable or unwilling to attend group meetings. It relies on the special attention given by a caring, non-judgmental adult in a setting familiar and comfortable to the parent. Home visitors are also in a position to directly observe factors in the home and family that might compromise effective parenting and place children at risk (e.g. unsafe physical conditions).

Most confidence in particular home visitation models can be given to those that have produced outcomes from clinical trials involving random assignment of families to home visitation services *versus* routine community care. For example, in an experimental study of home visitation by nurses in a semi-rural community (Elmira, NY, USA), at-risk mothers (young, poor and unmarried) were visited by nurses during pregnancy and until their children were two years of age (average of 32 visits). The nurses provided teaching and support to improve health behaviours, achieve competent parenting skills, plan future pregnancies and address their socioeconomic needs [23]. Nurse-visited women, compared to those not receiving home visits had improved pregnancy outcomes such as: i) better use of community services, such as attending 30% more childbirth education classes; ii) smoking 25% fewer cigarettes; iii) greater informal support by fathers and companions; iv) among women who smoked, 75% had fewer preterm deliveries; and v) young adolescents gave birth to babies that were 400 g heavier. During the first four years after delivery of their first child, improved postnatal outcomes for the mothers and children included: i) 43% fewer subsequent pregnancies; ii) the birth of a second child postponed an average of 12 months; iii) 82% greater employment rate; iv) 84% fewer emergency room visits by the children for injuries and ingestions of toxic substances; v) among the poor, unmarried teen mothers, fewer child maltreatment reports forwarded during the first two years (19% *vs* 4%) and safer home environments, such as the use of more appropriate discipline strategies observed; and vi) IQ scores 4-5 points higher for children of women who smoked during pregnancy and were in the "risk group" [24].

These findings have been reinforced in a recent follow-up to the Elmira study that provides some of the first evidence for the long-term effects of prenatal and early infancy home visitation by nurses [25]. This 15-year follow-up has shown that women who were unmarried and low income when the study began, and who were visited at home by nurses during pregnancy and when their child was an infant, had 47% fewer subsequent pregnancies, had a 27 month longer interval between the first and second children, reported 30 fewer months use of welfare, had 78% fewer impairments due to drugs and alcohol and had a third of arrests compared to the mothers in the comparison group. Nurse-visited women had an incidence of verified child maltreatment reports during those 15 years that was less than half that of the women who were not visited at home. Among the poor, unmarried women, this effect was even greater, with the incidence being five times greater among the women not visited compared to nurse-visited women [25]. The adolescent children also benefited, with children born to mothers who were nurse-visited showing less than half the incidence of running away and arrests and an incidence of convictions that was one-fifth that of adolescents born to mothers without nurse visitation. They also reported fewer sexual partners and less alcohol use [26]. The Elmira study also has been replicated in an urban, primarily African-American population, in Memphis, TE, USA. Early findings suggest some comparability with results from the Elmira study, e.g. at 24 months *post-partum*, nurse-visited mothers had significantly fewer second pregnancies than mothers who were not visited, and there were fewer hospital visits for injuries and ingestions of toxic substances [27].

Programme characteristics associated with positive outcomes

Home visiting programmes vary considerably in terms of the families being served, the timing of visits, the background of the home visitors, the length and number of visits, the amount of supervision home visitors receive and the content of the visits [28]. Although few experimental studies have varied programme components directly, comparisons across studies suggest that home visiting programmes are more likely to be successful in preventing dysfunctional parenting and child maltreatment if they have certain characteristics [19, 29] (Table II).

Table II: Elements of successful home visiting programmes for preventing child abuse and neglect (adapted from ref. [29]).

– Focus on higher risk families
– Begin visits during pregnancy
– Continue through at least the child's second year of life
– Use nurses as home visitors
– Visit frequently (30 or more times)
– Use various change/support techniques (e.g. teaching, modelling, rehearsal and referrals to community agencies)
– Employ a comprehensive service model that addresses maternal life course development and child health outcomes

Despite the promising findings from a small number of experimental studies of home visiting, it is also clear that home visiting services alone cannot meet all the needs of at-risk families. These services are most likely to succeed when combined with a range of prevention and intervention services in communities, such as high quality child-care services [21, 30].

School-based approaches

Schools are important settings for child abuse prevention efforts given the amount of time children spend in these settings and their educational role in society. Teachers also play a crucial role in the early identification of children at risk for maltreatment. In the Third National Incidence Study of Child Abuse and Neglect (NIS-3) in the US, teachers reported more children to child protective services than any other professional group [31]. School-based programmes are also one of the most widely used preventive strategies. For example, in Ireland the Stay Safe programme is implemented in almost all primary schools [32].

Several curricula designed for younger children have been developed and evaluated that focus primarily on the prevention of sexual abuse and abduction [33-35]. Approaches typically involve some combination of videos, printed matter and instruction by adults. Some programmes have tried to involve parents by including parent education meetings and sending materials home. Key concepts covered by these materials include: children own their bodies, there are different kinds of touches (good and bad, safe and unsafe), secrets about touching can and should be told, and children have people they can tell about touching problems [36].

Educational interventions, especially those that employ concrete concepts and an interactive experience that includes rehearsal and modelling can be effective in improving children's knowledge as assessed through interviews using role-playing or hypothetical situations and vignettes. Older children (e.g. 10-12) of course tend to learn and retain more information than younger children (e.g. 4-5) [33]. Few studies, even those involving parents, have measured or have shown effects on a direct reduction in child sexual abuse. One national survey in the US showed that exposure to assault prevention programmes was not associated with a reduced incidence of victimization or injury, although it was associated with a great likelihood that children would disclose the victimization and not blame themselves [37]. There is still much to learn as to whether the knowledge gains demonstrated with these programmes translate into fewer incidences of sexual abuse in the general population over a long period. Questions also have been raised as to the effectiveness of such programmes when the perpetrator is someone known and trusted by the child *vs* a stranger, and whether it is realistic or fair to expect children to protect themselves from abuse [38].

These universal sexual abuse prevention programmes also may not effectively target families and children who are at increased risk for sexual abuse or other forms of maltreatment [39]. More comprehensive approaches that target high-risk children as they enter school and are designed to promote more general developmental competencies in these children, while actively involving teachers and parents, may hold more promise for the future. For example, the Fast Track Prevention trial combines universal and selected approaches to others designed to prevent conduct disorders in elementary schools [40, 41]. Although not designed specially as a child abuse prevention programme, it is likely to indirectly target maltreated children who are beginning to show behaviour problems in the early grades. The intervention involves curriculum, parent groups, home visiting, children social skills training groups, parent-child sharing time, child peer pairing, and academic tutoring. Some school-based components are available to all students, while more intensive interventions are available to the 10% of families of children displaying the most behavioural problems. Early evaluations have shown the programme effective in increasing the social competence of children, including a reduction in the use of aggression as a conflict resolution strategy. For parents of high-risk children, the intervention was associated with more effective use of discipline strategies (e.g. less physical punishment and more warmth and positive involvement), more parenting satisfaction and more involvement with school.

The Chicago Child-Parent Center (CPC) programme is an example of a comprehensive early intervention programme beginning in pre-school for children in high poverty neighbourhoods. It provides a variety of family support services inside and outside the schools. Particular emphasis is on increasing parental involvement with their children in school and at home. Long-term evaluations of the CPC programme showed positive effects on school achievement and reductions in juvenile offences when these children reached adolescence [42]. Children involved in the programme were also less likely to be maltreated as measured by court petitions and child protective services' involvement [43].

In addition to intervening in the early grade, another important role of schools is in providing education to adolescents before they leave school on the meaning of parenthood. In Singapore, for example, such education begins in secondary school with "preparation for parenthood" classes that includes direct experience in working with young children [13].

Prevention in medical settings

Health professionals providing direct service to children and families also can play several important roles in the prevention of child abuse and neglect. There are few citizens who are held in such high esteem by the public or who have such opportunities to engage families during important and potentially stressful life transitions such as the birth of a child. Indeed, the modern era of concern about abuse and neglect resulted from research by C. Henry Kempe, a physician, who published in 1962 his findings about "battered children" in a medical journal [44]. Direct involvement with patient care and research can raise the consciousness of the medical and broader communities to the scope and seriousness of the problem of child maltreatment, reinforce community standards of care for children and advocate for community action to prevent maltreatment [45].

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Two primary prevention roles (*vs* secondary prevention or the medical management of the consequences of maltreatment) for primary care health providers can be derived from the ecological model of maltreatment [45]. First, careful assessment of the home environment can identify modifiable and non-modifiable risk factors for maltreatment, such as evidence of social isolation and lack of social supports. Risk factors can include child disabilities that place added stress on the care-taking environment in the family and can place children at greater risk for maltreatment and rejection by parents. Second, health professionals often have knowledge of triggering situations that can contribute to maltreatment incidents, such as crying and toilet-training. Materials and programmes for parents (e.g. home visits, "warm lines", printed materials, counselling and parents groups) can help parents anticipate and better handle such situations. These roles are consistent with the recommendations of the Task Force on the Family regarding the need to improve the training of paediatricians in "family pediatrics" [46]. In paediatric settings, supplemental services can be delivered by child development and parent support specialists. This is the approach taken by the Healthy Steps for Young Children programme supported in part by the American Academy of Pediatrics [47].

Existing techniques for measuring maltreatment and its consequences should be used across countries so that cross-cultural comparisons can be made and reasons for cultural variations in child abuse and neglect explored.

A form of child neglect often associated with a medical diagnosis is failure to thrive in children younger than 18 months [48, 49]. Although failure to thrive can arise from medical causes, the majority of children seen in outpatient settings have a psychosocial aetiology to the condition that presents care giving challenges to parents. Tertiary prevention of a continuation of developmental deficits presented by these infants requires more than improvements to the physical and nutritional status of the infants [50]. The development of active and long-term contact between caseworkers and parents are important to reinforce positive parenting practices and standards of care, create a hopeful attitude about the child's future and maintain support and advocacy for the parent as the child develops and other parenting challenges present themselves.

Conclusions

The WHO World Report on Violence and Health [11] has proposed several recommendations for actions that need to be undertaken by governments, researchers, health care and social workers, NGOs and others with an interest in preventing child abuse and neglect. These reinforce many of the recommendations made by the WHO Report of the Consultation on Child Abuse and Neglect Prevention [13]. Better research is key to improved prevention efforts. Many countries still do not have adequate systems for monitoring cases of abuse and neglect. Better data are needed that document the health burden of child maltreatment in each country, risk and protective factors, existing systems for responding to known cases and evaluation of prevention efforts. In addition to improvements in the collection of official records, periodic population-based surveys conducted by academic institutions, health care systems or NGOs are needed. To the extent possible, existing techniques for measuring maltreatment and its consequences should be used across countries so that cross-cultural comparisons can be made and reasons for cultural variations in child abuse and neglect explored [51].

Training in child abuse and neglect needs to be developed further within the appropriate disciplines, particularly the health, education, social work and legal professions. These professionals work directly with at-risk children and families and they also can work to attract resources for broader prevention efforts and advocate for governmental policies that protect children and support parents.

Governments should provide the needed support to localities to ensure that effective, efficient and safe systems are in place to respond to abused and neglected children and to initiate and sustain prevention efforts. These include efforts to improve the response of hospitals and clinics to abused and neglected children and efforts to improve the criminal justice systems. The prevention of child abuse and neglect should be incorporated into national public health policies, goals, programming and budgets.

Although many approaches to child abuse and neglect prevention have been developed and tried, relatively few have been evaluated rigorously. This is a great need, in both developed and developing countries, to ensure that prevention efforts are evaluated thoroughly for effectiveness. Over the longer term, the political and social will for prevention efforts can be undercut when ineffective approaches are instituted and little progress in preventing new incidents of maltreatment can be demonstrated.

Ultimately, the most effective approaches will address the root causes of maltreatment by addressing issues of poverty, housing, employment, schools, health care and other community and neighbourhood systems that build financial, human and social capital.

A comprehensive approach to the prevention of abuse and neglect will involve many coordinated efforts across different sectors of society. But ultimately, the most effective approaches will address the root causes of maltreatment by addressing issues of poverty, housing, employment, schools, health care and other community and neighbourhood systems that build financial, human and social capital [52] and support parents in the job of raising young children.

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