FALL 2004 SPECIAL EDITION **Prevent Child Abuse Iowa**

Preventing Neglect: An Undertaking Riddled With Challenges, But Hope Remains

Child neglect is a pervasive problem in current American society. Recent statistics suggest that neglect occurred in 61 percent of reported cases of child maltreatment in the United States.[1] In Iowa, confirmed cases of neglect (termed denial of *critical care*) represented more than 70 percent of all abuse in 2003 (see Table 1). In the past five years, confirmed cases of neglect in Iowa have increased by 75 percent, while cases of physical or sexual abuse held steady or declined (see Chart 1).[2] Neglect may also be more prevalent than the statistics suggest due to a lack of clear markers indicating its occurrence.

Prevention Efforts

Researchers agree that early interventions directed at high-risk families are needed in order to mitigate the factors thought to influence neglect. Attempts to follow this directive resulted in numerous prevention-focused studies. Prevention efforts are, however, fraught with several challenges that have yet to be resolved. The lack of a standardized definition of neglect, combined with the nature of neglect (i.e., an act of omission of critical care that can vary along dimensions of severity and consequences), makes it difficult to identify, let alone, prevent child neglect.

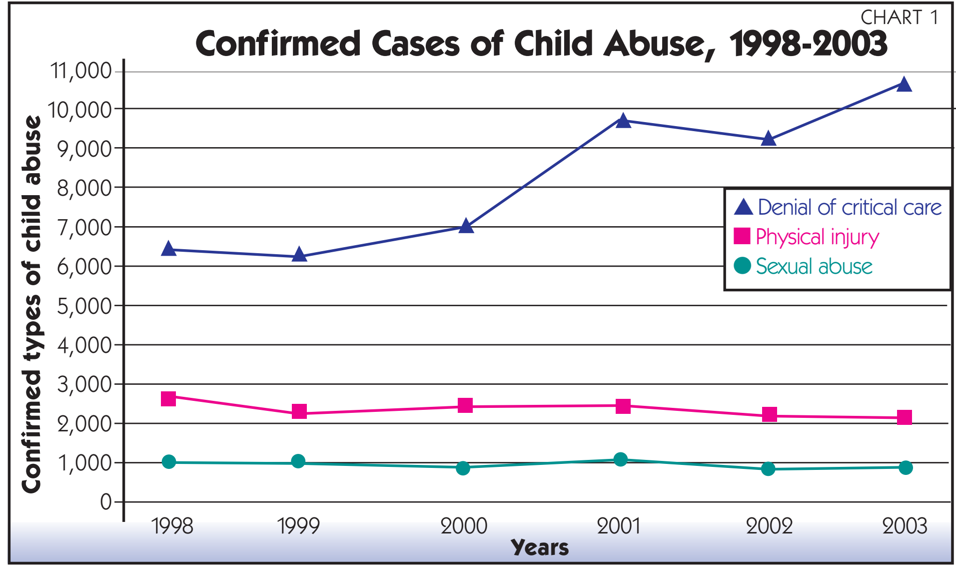
Much of the research related to the prevention of child neglect focuses on primary prevention. Following is a review of research on several prevention projects.

The Elmira project. The prenatal early infancy project, also known as the Elmira project, was the first primary prevention program that targeted child abuse and neglect.[4] The Elmira project had three specific aims. First, it sought to improve women's prenatal health behaviors with the goal of preventing low birth weight and pre-term delivery. Second, the program attempted to improve the quality of care provided to the infant – focusing on promoting parents' sensitivity and responsiveness to infant communicative signals, resulting in a more secure attachment between the mother and her child. The program's final goal was improving women's personal development by assisting them

TABLE 1

Confirmed Types of Child Abuse, 2003

TYPES	NO.	%
Denial of critical care	10,783	70.1%
Physical injury	2,132	13.9%
Presence of illegal drugs in a child's body	1,167	7.6%
Sexual abuse	929	6.0%
Manufacturing a dangerous drug in a child's presence	353	2.3%
Mental injury	16	0.1%
Forcing a child to engage in prostitution	3	0.0%



in planning future pregnancies, completing their education, and finding employment – thereby reducing their reliance on welfare.

Women pregnant with their first child were screened in private obstetric offices and free antenatal clinics and were included in the research protocol if they were less than 19 years of age, planning to be a single parent, or socioeconomically disadvantaged. The intervention employed was home visiting by nurses.

Results from the project indicated that women who received home visits during pregnancy improved their diet, smoked fewer cigarettes, and had fewer pre-term deliveries. In addition, very young adolescents (aged 14-16) who received home visits had babies who were approximately 400 grams heavier.

Women in the home visiting group also had fewer reported incidences of child abuse to social service agencies than non-visited women. Specifically, outcome results obtained when the child was two years of age indicated that four percent of women in the home visiting group had a reported incidence of child maltreatment, in contrast to nineteen percent of the women not receiving home visits.[5] The project also found treatment gains in its home observations of parent-child interactions and measurement of home environmental hazards and emergency room visits due to injury or ingestion of non-edible substances.

These positive results were maintained across the first fifteen years of the children's lives. At the fifteen-year follow-up, women involved in home visitation were identified as the perpetrators of child abuse and neglect significantly less often than women who did not receive the intervention.[6]

The Memphis Project. The director of the Elmira project conducted a second trial in Memphis during the early 1990s in order to examine the effectiveness of a home-based visitation program in an urban setting. In another design difference, the Memphis project involved predominantly African-American women, compared to the primarily Caucasian sample included in the Elmira project.

Unlike the results of the original Elmira study, women enrolled in the Memphis project who received home visitation did not have a significantly lower rate of reported child abuse and neglect. Since the overall rate of reported child abuse and neglect in Memphis is comparatively lower than in Elmira, there may have been too few cases to distinguish between the two groups.

Results from other measures, such as home observations and observations of parent-child interactions, replicated the results found in the Elmira project. Namely, children of women who received in-home visits had fewer emergency room visits and fewer diagnoses resulting from injuries and ingestions than women who did not receive in-home visits.[4]

The Hawaii Healthy Start Program. The Hawaii Healthy Start Program (HSP) was another primary prevention project that utilized home visiting as the intervention method. The Hawaii program differed from the programs conducted in Elmira and Memphis, however, in that paraprofessionals, rather than nurses, implemented the home visiting intervention. The specific goal of the Hawaii project was to reduce the likelihood of child neglect by improving family functioning and parenting behaviors.

The project identified possible participants through a population-based screening of parents of newborns using previously identified risk factors for child neglect (i.e., the Family Stress Checklist).[7] Parental psychosocial risk factors included: poverty, single parenthood, parental mental illness, substance abuse, domestic violence, and maternal abuse as a child. In addition, the project examined parent-child relational risk factors, including unwanted birth, unrealistic expectations for the index child, and difficulty bonding with the index child.

According to the HSP model, home visitors provided a wide range of therapeutic services (e.g., development of a trusting relationship, crisis intervention, modeling of problem-solving skills, and aid in accessing community services). The project individually tailored the techniques and goals for home visits in order to address each family's specific needs and concerns.

INSET 1

Whereas prevention efforts share the common goal of reducing the incidence of child neglect, they differ along a number of dimensions.[3] A primary prevention effort is defined as any service provided to the population at large (or a sub sample of the population) designed to reduce the incidence of neglect. An example of a primary prevention program would be a public service message, which is broadcast to the population via radio or television and is designed to increase awareness of child neglect.

Secondary prevention efforts attempt to identify cases of neglect early with the goal of truncating the duration of neglect or providing services to a targeted, high-risk group, often before neglect occurs. This type of prevention would, for instance, include intensive home visiting to high-risk families. Secondary prevention efforts are most clearly represented in human service programs used to identify and provide services to maltreated children in the hopes that such services will result in the cessation of child maltreatment within the home.

Tertiary prevention involves preventing the recurrence of maltreatment and providing treatment to reduce the likelihood that impairment will result from abuse.

A study of the HSP project found no significant overall reduction in risk factors or in mothers' interest in or use of community services resulting from the prevention effort. The researchers linked the null findings to home visitors' failures to recognize parental risk factors and to coordinate community services for families in need.

One explanation for this finding may relate to the use of paraprofessionals; paraprofessionals have been found to refer families to community resources less frequently than nurses.[8] Paraprofessionals have also been found to be less effective in some studies in treating high-risk samples, such as the one targeted by the Hawaii project.[9]

The HSP evaluation further points out the importance of the availability and quality of community resources. If the community does not have adequate resources to meet the demands of a prevention effort such as the Hawaii project, referrals to community services are ineffectual.

As a result of the disappointing findings, the Hawaii project is revamping its methodology in an attempt to offer more efficacious services in the future.[10]

The Healthy Families D.C. Program. The Healthy Families D.C. program used a home visiting system similar to that of the Hawaii Healthy Start Program.[11] The D.C. program identified first-time parents who were overburdened and provided them with parental support during weekly home visits as well as referrals to community resources. Children in this program were given routine immunizations and attended well child visits with physicians. Notably, families enrolled in the treatment program generated no cases of child abuse or neglect.

The Healthy Families D.C. program did not have a comparison group. As a result, it is not possible to determine whether the positive outcomes resulted from specific programmatic methods or from the participation of parents who were not that likely to maltreat their children anyway.

Parenting Education. Another approach to child neglect prevention involves parenting education. For example, one study evaluated the effectiveness of a prevention focused on bolstering parenting skills in areas associated with abusive and neglectful outcomes.[12] The experimental group received education in the areas of child development, child-rearing attitudes, mother-infant interactions, and parenting skills. Trained student nurses provided the educational services during the women's hospital stay and during the first four weeks postpartum. The nurses provided both education and support for the mothers.

Compared with women in the study's control group, those receiving program services employed more democratic child-rearing strategies, verbalized more with their infants (i.e., showed greater sensitivity), and displayed greater problem-solving abilities.

Private Welfare Agencies. A group of clinicians in Germany noted the technical and ethical difficulties in screening and contacting high-risk families for child neglect.[13] As an alternative to seeking high-risk families, they established the Child Protection Center in Lubeck, Germany, a private welfare agency. Trained family therapists provide the clinic's services, which are free and open to all families seeking help. The clinic offers an array of services, including family therapy, crisis intervention, home visits, individual psychotherapy for children and adolescents, group therapy, individual counseling for sexual abuse offenders, counseling for reporters of child maltreatment, and education.

The main aim of the center is to restore families' trust in knowing that aid is available to them. Therefore, the center does not release information to social services, youth welfare offices, or police officials without informed consent.

Over a two-year period, more than half of the families attending the center were self-referred. About a fifth of the families attending the center received help prior to the occurrence of any child maltreatment. The authors concluded that a nonpunitive, nonstigmatizing system of free, open family service centers is effective in preventing child maltreatment.

INSET 2

Denial of Critical Care

Under Iowa law and DHS practice, *denial of critical care* encompasses a wide range of potential harm to children, including:

- **Failure to provide adequate food and nutrition, adequate shelter, or adequate clothing** to such an extent that there is danger of the child suffering injury or death.
- **Failure to provide adequate health care** to such an extent that there is danger of the child suffering serious injury or death.
- **Failure to provide the mental health care** necessary to adequately treat an observable and substantial impairment in the child's ability to function.
- **Gross failure to meet the emotional** needs of the child necessary for normal development evidenced by the presence of an observable and substantial impairment in the child's ability to function within the normal range of performance and behavior.
- **Failure to provide proper supervision** of a child which a reasonable and prudent person would exercise under similar facts and circumstances, to such an extent that there is danger of the child suffering injury or death.

Source: Iowa Department of Human Services, *Child Abuse: A Guide for Mandatory Reporters*, p. 19

Complexities to Neglect Prevention Research

Studies that have examined primary prevention efforts' effectiveness at

preventing child maltreatment have produced mixed results. Most have demonstrated some improvement in family functioning. Home visitation programs have also produced remarkable health care gains. For example, nearly all home visitation programs effectively achieve their goals pertaining to children's physical health (i.e., routine immunizations, healthy weight gain, and attendance of well child exams).

These same programs have, however, generated less impressive results in the domain of preventing child neglect.

Several factors make it difficult to design a neglect prevention effort. First, neglect is hard to define because it generally involves acts of omission (failure to perform an action) that may be less noticeable or more vague than other forms of child maltreatment – such physical and sexual abuse – that usually involve acts of commission. Secondly, neglect encompasses a broad range of actions, usually involving the failure to meet a bare minimum standard of care in a wide range of domains. Defining all of the domains of neglect presents challenges of complexity and vagueness. Finally, since each state defines neglect its own way, what constitutes neglect in one state may not be neglect in another. Given this inconsistency, it is difficult to generalize conclusions from a study conducted in one state to other locations.

Another problem arises in the identification of participants for the prevention programs. Most of the studies included in this review identified subjects thought to be at an increased risk to engage in neglect. Yet, despite examining a range of personality, familial, and cultural factors, research has failed to generate a list of clear markers that identify what factors or interactions of factors most significantly lead to the onset of child neglect.

For instance, two consistent markers of child neglect are single-parent status and low socioeconomic status. Those identifiers describe, however, a large, diverse group of individuals, most of whom will not commit acts of child neglect.

The type of services provided to the families presents an additional area of complexity. While most of the studies reviewed used home visitation, the nature of those visits differed markedly. Furthermore, many of the studies provided vague and unsatisfying descriptions of the content of the visitations.

Suggestions for Therapeutic Implementation and Future Directions

The range of prevention services is wide, including home visits, parent education, parent support, referrals to outside clinical services, mental health services, crisis intervention, and practical, concrete assistance.[12] In general, prevention programs have been effective at implementing positive changes across a number of child health variables and overall family functioning.

Positive outcomes have been reported in reducing child behavior problems, parent/caregiver mental illness and psychosocial concerns, and foster care placement/child protective services reports. Studies have also found program-related improvements in child health status, developmental progress, well-being, parenting skills (e.g., appropriate stimulation, physical care, psychological care, discipline), social support, knowledge of children's development, and positive behavior management.[12]

What has produced these positive results is, however, unclear. Prior prevention efforts suggest that certain techniques are more effective than

others. For example, techniques that encouraged an emotional connection between the child and parent and promoted parental responsiveness and sensitivity demonstrated better results than home visitation programs that were aimed at increased access to resources.

Nonetheless, identifying what features of programs specifically prevent child neglect remains a challenge, due to difficulties in empirically studying and measuring the construct and the lack of definitive research in the area. Future research is needed to determine what particular therapeutic techniques are efficacious either by themselves or in combination.[11, 13]

Much of the work has focused on using home visitations as a primary means of intervention, an approach commended by the United States Advisory Board on Child Abuse and Neglect. The home visitation paradigm raises additional questions, however, because of uncertainties about what level and type of services should be provided, given practical limits to finances and resources. Most of the reviewed studies failed to provide enough information about the frequency and duration of their interventions to determine what frequency and duration of visits is optimal.

Future studies are needed to clearly and consistently address the needs of children at risk for neglect. Prevention efforts would benefit from a more standardized definition of neglect across researchers and states, as well as better identified markers of those at high risk for child neglect. It is hoped that these innovations will encourage researchers to utilize innovative approaches to preventing child neglect, an oft occurring, yet evasive, public health problem.

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