INVITED COMMENTARY

TWENTY YEARS LATER: WE DO KNOW HOW TO PREVENT CHILD ABUSE AND NEGLECT

JOHN M. LEVENTHAL

Department of Pediatrics, Yale University School of Medicine, New Haven, CT, USA

CAN FAMILIES STOP hurting their children? Can abuse and neglect be prevented? I contend that the answer to both of these questions is yes and that, in fact, we do know how to prevent abuse and neglect. The interventions that are needed are easy to describe but difficult and expensive to provide. I offer this commentary as a reminder of what is needed to prevent abuse and neglect and to suggest that the cogent question is not whether we, as clinicians, can prevent these types of maltreatment from occurring (because the answer is yes), but whether we, as a society, can afford the resources to provide the necessary preventive services to families.

Abuse occurs when an adult, usually a parent, uses a hand, object, or some other means to strike or hurt a child; neglect occurs when a parent provides inadequate nurturing, such as nutrition, shelter, clothing, or safety. Although the causes of parental dysfunction that result in maltreatment are complex (Belsky, 1993; Cicchetti & Toth, 1995; Finkelhor, 1995), in both abuse and neglect negative parental attitudes and feelings are at the core of how the parent views and cares for the child. If clinicians can help the parent view the child in a more positive way, then they will be able to help keep the parent’s hand from striking the child or help the parent’s hand be more nurturing, and thus, abuse and neglect can be prevented.

GENERAL AND TARGETED PREVENTIVE SERVICES

Effective preventive services can be classified as general services that support parents and families in general and targeted services that focus on the prevention of abuse and neglect. General services, such as good housing, adequate financial support, available and affordable...
quality child care, drug counseling, family planning services, early intervention programs for children with disabilities, family resource centers, and so on certainly can help parents provide better care to their children, which, in turn, is likely to decrease the rates of maltreatment. (I am aware of no clinical trials, however, that have examined the efficacy of these types of services in decreasing maltreatment.) Although the fundamental importance of these types of services and benefits to families and communities is underscored in Neighbors Helping Neighbors: A New National Strategy for the Protection of Children, a report of the U.S. Advisory Board on Child Abuse and Neglect (1993), the supportive framework for vulnerable populations is being slashed by conservative politicians in the United States in a mean-spirited attack on the poor and in an effort to save the government money. This attack, however, which is short-sighted and goes against empirical evidence, does not make good sense for families. For example, in developed countries, poverty clearly is associated with abuse and even more strongly with neglect (National Research Council, 1993; Pelton, 1994). Providing adequate financial support for families would likely help decrease the occurrence of maltreatment. Inadequate child care means that a single parent is unlikely to look for a job or to return to school and must care for the children every day without a break. In contrast, good child care can break this cycle, so that parents can work and feel better about themselves and even about their children. Thus, the provision of good child care, too, is likely to decrease maltreatment.

In addition to these general services, which provide a framework of support that is essential so that parents can provide adequate care to their children, targeted services to prevent abuse and neglect, particularly in the form of “home visiting,” have received increasing attention over the last few years (Olds & Kitzman, 1993; U.S. General Accounting Office, 1990; Center for the Future of Children, 1993). The frequency, content, level of skill of the visitor, and the targeted population of home visits vary widely among communities. Consequently, one needs to be careful when comparing such programs. In clinical trials of home visiting that target the prevention of abuse and neglect by providing regular services during pregnancy and the first few years of life, there have been modest but significant reductions in the rates of abuse and neglect in the intervention group versus the comparison group (Olds, Henderson, Chamberlin, & Tatelbaum, 1986; Hardy & Streett, 1989; Olds & Kitzman, 1993; MacMillan, MacMillan, Offord, Griffith, & MacMillan, 1994). Although home visiting as described in these reports should not be viewed as a panacea, it clearly is helpful to families and not surprisingly its effects extend beyond the prevention of maltreatment to the enhancement of the development of both children and parents (Olds, Henderson, Chamberlin, & Tatebaum, 1986; Olds, Henderson, & Kitzman, 1994; Olds, Henderson, Tatebaum, & Chamberlin, 1988; Olds & Kitzman, 1993).

**NINE INGREDIENTS OF A SUCCESSFUL HOME VISITING PROGRAM**

What are the ingredients of a successful home visiting program? Although there is no consensus yet in the literature, I believe that the prevention of abuse and neglect requires nine essential ingredients.

1. Services should begin early, preferably during the prenatal period or shortly after birth, and should extend through the first few years of a child’s life. Of course, no one knows what a “few years” means. The results from Olds’ Elmira study in which home visiting continued to the child’s second birthday showed that maltreatment occurred less frequently in a subset of the intervention group (Olds, Henderson, Chamberlin, & Tatebaum, 1986) (presumably those at greatest risk), but that this effect disappeared when the children were reevaluated at 25 to 50 months of age (Olds, Henderson, & Kitzman, 1994). Thus, like many human service interventions for high-risk families, home visiting should not be viewed as an
inoculation program that provides life-time protection, but rather as a service that may need to be continued (with varying degrees of intensity) for many years of the child’s life.

2. Home-based services need to occur frequently enough so that the home visitor gets to know the family, and the family gets to trust the person entering the home. Frequent contact also enables the home visitor to recognize problems early and to provide the necessary services. In Olds’ study, on average during the first 2 years of the child’s life, each family received 23 visits (Olds, Henderson, Chamberlain, & Tatelbaum, 1986). In the Hawaii Healthy Start program, which screens families at birth and provides home-based preventive services to almost 50% of the state’s high-risk families (until the child is 3 to 5 years of age), the frequency of visits is weekly at first and then is adjusted according to the family’s needs (Breakey, Pratt, & Elliot, 1994; Department of Health, Hawaii, 1992). Although there will be a tendency to try to achieve the same results with fewer visits (usually because one is not given quite enough money), at least for now the successful models suggest that frequent contacts are important.

3. The primary goal of the home visitor should be to develop a therapeutic relationship with the parents. In the context of a trusting, helping relationship, parents will be able to feel better about themselves and in turn feel better about their children. One of the best descriptions of how this relationship develops was written by Selma Fraiberg who called home-based mental health care “psychotherapy in the kitchen” (Fraiberg, Adelson, & Shapiro, 1975). To help achieve this therapeutic relationship, home visitors need to be trained to work with vulnerable families and will need ongoing mental health supervision to help the visitor understand the dynamics of the relationship.

4. The home visitor, believing that maltreatment can occur in families and knowing the early signs of abuse and neglect, can provide a watchful eye in the home. This is different from the kind of oversight provided by a relative, such as a grandparent, who may be helpful to the family but who is untrained in this field and often needs to deny the early signs of maltreatment because of the difficulty in believing that a loved one could abuse a child. Unusual bruises on an infant will be discussed by the home visitor with the family. Signs of spousal abuse will not be ignored. Frustration and anger related to raising a child will be addressed before such feelings escalate and lead to abuse.

5. The home visitor should be able to model effective parenting. Modeling is a process of observing behaviors and then suggesting alternative ways of managing the situation (e.g., a crying child or a toilet training accident) and even of demonstrating how to hold a fussy infant. It does not mean taking over the care of the child or being overly critical, and it is best done after the home visitor has developed a relationship with the parent.

6. The home visitor should not lose sight of the child’s needs. Of course, the balance between the parents’ needs and the child’s can be a difficult one in certain families. In many high-risk families, parents have substantial problems, such as domestic violence, depression, substance abuse, or unemployment. If the home visitor’s focus is only on the parents’ problems, then the child’s needs, such as those related to appropriate safety, immunizations and health care, nutrition, and stimulation will be ignored. On the other hand, if the home visitor only helps with the child’s needs and ignores the parents’ problems, it is less likely that the parents will make the necessary life changes so that they can provide good enough parenting without the intensive help from the home visitor.

7. The home visitor needs to be able to provide concrete services to the family. High-risk families often need help with the organization of their lives, transportation, housing, and so on. Helping the family receive these services can make a substantial difference while the relationship and the modeling develop.

8. If home visiting is going to have any impact on the occurrence of serious physical abuse, strategies will need to be developed to include fathers (or boyfriends) as well as mothers.
Clinical experience suggests that the majority of the perpetrators of serious abuse are not the women, but rather the men in the household (Bergman, Larsen, & Mueller, 1986; Starling, Holden & Jenny, 1995; U.S. Advisory Board on Child Abuse and Neglect, 1995).

9. Home visiting should not be provided in a “one size fits all” approach, but rather should be tailored to the family’s needs. This means that assessments of the family’s status and the level and types of services need to be made on a regular basis and appropriate adjustments made periodically in the goals for the family and in the services offered. It also means that home visiting may not be appropriate for some families in which the dysfunction is too great and thus, the children would be better served by placement outside the home.

Can these ingredients actually come together in a person who makes home visits and thus prevents maltreatment in a family? Of course! If one well-trained and experienced home visitor worked intensively with only one high-risk family, it is almost certain that maltreatment could be prevented, the parents would become more effective parents and adults, and the child's development would be enhanced. Although the assignment of one home visitor per family is certainly not cost effective, such a program will likely be very successful; at the other extreme, a program of one visitor for 200 high-risk families will not be very costly per family, but it is unlikely to make a difference.

THE NEED FOR ADDITIONAL RESOURCES

So, we do know how to prevent abuse and neglect, but the resources available are woefully inadequate to provide home visiting at the intensity that is likely necessary for a program to be successful. In addition, even with home visiting available, very few communities have adequate general services that provide critical support to vulnerable families.

Should we give up and say that prevention does not work? Of course not, and recently, just the opposite has happened. Despite the national atmosphere of budgetary restraint, state agencies, legislators, and private groups have begun to advocate for and to plan preventive services, and new resources have begun slowly to trickle forth. The National Committee to Prevent Child Abuse, for example, in collaboration with the Hawaii Family Stress Center and Ronald McDonald Children’s Charities, has put forth a national program ‘‘Healthy Families America,’’ that is attempting to create a nationwide home visiting program for new parents in all communities throughout the country (National Committee to Prevent Child Abuse, 1995). The Federal government has allocated almost one billion dollars over 5 years (U.S. General Accounting Office, 1995) toward family preservation services and community-based family support services. Some of these monies will likely go towards prevention programs that begin early in a child’s life.

This attention to prevention is encouraging, yet there is a need for a substantial outpouring of additional resources. Estimates of the cost of home visiting for 1 year are $1,500 to $3,500 per family. If universal home visiting were made available for all newborns in the United States, one estimate is that the cost of such a program would be about $9.2 billion (based on 4.2 million births per year and $2,200 per family) (Gomby, Larson, Lewit, & Behrman, 1993). The cost would still be substantial if home visiting were only provided to high-risk newborns. Based on the high-risk criteria used in Hawaii (Department of Health, Hawaii, 1992), approximately 20% of the newborns would be identified as high-risk, which would result in a cost of $1.8 billion. These costs seem overwhelming, but at least in the Elmira study, Olds showed that the costs of the preventive services for low income families were equivalent to the governmental savings that occurred because of reductions in expenditures for Aid to Families
with Dependent Children, Food Stamps, Medicaid, and child protective services (Olds, Henderson, Phelps, Kitzman, & Hanks, 1993); thus, it may be a break-even proposition.

Perhaps home visiting for high-risk newborns and their families should be covered by medical insurance (or managed care plans) just as are the costs of medical care. For instance, the total 1-year costs of kidney, bone-marrow, or liver transplantations in the United States are about one billion dollars each (Anders, 1995). The costs for these expensive, life-saving interventions, which are provided to a very small percentage of the population, are mostly covered by private and governmental insurance. Home visiting, which clearly has the same potential to be life-saving for some children and to improve markedly the developmental course of many others, is relatively inexpensive per family compared to a transplantation. Surely, if the United States has the resources to provide transplantations for the few, it can provide home visiting to the many. In the course of a child’s lifetime, a successful preventive service should be viewed as a modest investment to ensure that the child’s first few years of life are spent in a safe and nurturing environment.

A NEED FOR CAUTION

As new resources are being developed and attention is focused on prevention, however, there needs to be appropriate caution so that prevention is not over or undersold. In particular, there should be concern about the number of reports of abuse and neglect, the inevitable claims that programs in certain communities are not helping, and the wish, and even claim, that home visiting can solve all of the problems.

Once money is being spent on prevention, legislators will expect fewer reports of maltreatment and smaller budgets for protective services. Why else invest in prevention? But a few (or even several) moderate-sized prevention programs in a state are unlikely to have an impact on the overall reporting of cases of maltreatment. For example, if a successful home visiting program for 1,000 high-risk newborns reduced reports during a 1-year period from 8% of the children to 0% (or 80 to 0), this difference would be impossible to detect in statewide data in Connecticut where there are approximately 50,000 births a year and 30,000 reports to protective services. One also has to keep in mind that the presence of a home visitor may actually have a paradoxical effect on the number of reports, particularly when working with high-risk families; reports may increase because a professional is in the home and may observe concerning behaviors that need to be reported. If no one were in the home, such episodes would go unrecognized. Finally, if politicians are counting reports, they need to be reminded that since 1976 when national data about reports to the states’ child protective service agencies were first collected, reports of maltreatment have increased every year. The first sign of success, then, might be smaller increase in reports of maltreatment, rather than a true decline.

My second caution has to do with claims that the prevention of abuse or neglect will be viewed as hopeless because of the failure of a specific prevention program in a community. Programs that have paid insufficient attention to the nine ingredients described or that are providing services without adequate community supports for families are unlikely to be successful. Also, if a community decides to target only the most dysfunctional families, it is unlikely that home visiting will prove effective unless major changes are made in the intervention strategies (such as increasing the intensity of services).

My third concern is that overselling this type of intervention to gain initial support will result in broken promises. Home visiting will not be the answer for all families; maltreatment will still occur (but hopefully at a reduced rate), and children will still need to be placed in
THE CHALLENGE FOR THE NEXT 20 YEARS

In Volume 1 of *Child Abuse & Neglect*, Gray, Cutler, Dean, and Kempe (1977) described a randomized clinical trial to prevent abuse by providing regular pediatric care and weekly home visits by public health nurses to high-risk families. Although children whose families received the intervention had fewer serious injuries than comparison children, reports to protective services were the same in both groups. Since that publication, the field has learned much about working with families. Clinicians know how abuse and neglect occur, what high-risk families need, and which preventive strategies help such families. I think it is time to say clearly that we do know how to prevent abuse and neglect. Our challenge, then, for the next 20 years, is to develop the resources and the programs so that the number of reports begins to fall. When that happens, we will know that families are better off because of our efforts.

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REFERENCES


