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Preventing Child Abuse

Critical Roles and Multiple Perspectives

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DEDICATION

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His long record of leadership incudes being a Founding Member and Past-President of the Ray E. Helfer Society, an honorary international group of physicians working in the child maltreatment field. He has served two terms as Councilor for the International Society for the Prevention of Child Abuse and Neglect (ISPCAN) and on the national boards of the American Professional Society on the Abuse of Children (APSAC) and Prevent Child Abuse America. He received APSAC's *Outstanding Professional Award*, the Helfer Society Award for *Distinguished Contributions to the Field of Child Abuse and Neglect*, and the American Academy of Pediatrics Section on Child Abuse and Neglect *Award for Outstanding Service to Maltreated Children*.

Dr Dubowitz is a clinician, researcher and educator, and he is active in advocacy and policy, testifying in several arenas. His main interests are child neglect and prevention, and his is the first name that comes to mind now when physicians think about both of these topics. He has over 200 publications and has presented at national and international meetings around the world. He has led the development of the Safe Environment for Every Kid (SEEK) program,

which builds upon the opportunities in pediatric primary care to prevent abuse and neglect. He edited *Neglected Children: Research, Practice and Policy,* and ISPCAN's *World Perspectives on Child Abuse*, and he co-edited the *Handbook for Child Protection Practice* and *International Aspects of Child Abuse and Neglect* in which he and Dr Merrick described child welfare systems in different countries, illustrating several common themes such as the need for prevention, the lack of clear definitions, ambiguous policies, laws not being implemented, limited data on the extent and nature of the problem, and more.

Given all the children in the world who still continue to be maltreated, we choose to focus this book on what can be done to prevent child abuse and neglect. As his chapter reminds us, preventing the physical, cognitive, behavioral, emotional and social problems associated with child abuse and neglect is intuitively and morally preferable to intervening after the fact. We dedicate this book to Dr Howard Dubowitz, whose career has led the way for many of us to prevent child abuse and neglect in addition to treating its devastating harms. Thank you, Howard, for all you have done and will continue to do for children and families.

CONTENTS

Section I: Introduction **1**

Chapter 1 Introduction: The expanding case for prevention **3**
Vincent J Palusci, Frank E Vandervort, Donald E Greydanus and Joav Merrick

Chapter 2 The case for prevention: Epidemiology and impact of child abuse and neglect **11**
Vincent J Palusci

Section II: Universal strategies **39**

Chapter 3 The United Nations Convention on the Rights of the Child and the prevention of child maltreatment in the United States **41**
Frank E Vandervort

Chapter 4 Federal funding and the prevention of child maltreatment **59**
Frank E Vandervort

Chapter 5 Pathways to prevention: *Prevention Zones* as a strategy for making progress in child maltreatment prevention **73**
Debangshu Roygardner, Kelli N Hughes and Vincent J Palusci

Chapter 6 Economic supports for families **91**
J Bart Klika and Catherine A Murphy

Chapter 7 Home visiting to prevent maltreatment **101**
Timothy Hathaway, Jenn O'Connor and Erika Leveillee

Chapter 8 No Hit Zones in context: Changing norms through planned change **113**
Lucien X. Lombardo, Stacie Schrieffer Leblanc and Viola Vaughan-Eden

Chapter 9 Using technology in child welfare and child abuse prevention **125**
Joshua E Siegel and Vincent J Palusci

Chapter 10 The media and child maltreatment prevention **153**
Frank E Vandervort

Chapter 11 Creating a national foundation to end child abuse and neglect **167**
Richard D Krugman and Lori E Poland

Section III: Targeted problems and populations **179**

Chapter 12 Infant crying and the prevention of abusive head trauma **181**
Ronald Graham Barr and Ryan Steinbeigle

Chapter 13 Eliminating corporal punishment **199**
Joan E Durrant

Chapter 14 Disability and abuse: Some international aspects **217**
Joav Merrick

Chapter 15 A critical analysis of efforts to prevent the sexual abuse of youth **225**
Jon R Conte, June Simon and Ann Luetzow

Chapter 16 Child abuse prevention in the faith-based environment **249**
Angelo P Giardino, Victor Vieth, Shira Berkovits and Danielle Pitkoff

Chapter 17 Adolescent abuse: Selective issues including prevention **267**
Donald E Greydanus and Joseph R Hawver

Chapter 18 Preventing athlete harm in youth sports **285**
Aliza Lipman, Erin McConnell, Keith Kaufman and Angelo Peter Giardino

Chapter 19 Prevention of human trafficking in children **301**
Dena Nazer

Chapter 20 Child fatality review and programs to prevent child maltreatment deaths **313**
Robert Parrish, Abby Collier, Erich Batra, Vincent J Palusci and Frank E Vandervort

Section IV: Professional Issues **335**

Chapter 21 Health-based interventions **337**
Wendy Gwirtzman Lane, Howard Dubowitz and Rebecca Weinstein

Chapter 22 Preventing child maltreatment through medical-legal partnership **359**
Debra Chopp

Chapter 23 Prevention services through Child Protective Services **371**
Janet Rosenzweig

Chapter 24 Does mandatory reporting have a place in a more prevention-focused child maltreatment system? **385**
Kelli N Hughes and Frank E Vandervort

Section V: Acknowledgments **405**

Chapter 25 About the editors **407**

Chapter 26 About the Department of Pediatrics, New York University Grossman School of Medicine and Bellevue Hospital, New York, United States **409**

Chapter 27 About the Child Advocacy Law Clinic, School of Law, University of Michigan, Ann Arbor, Michigan, United States **413**

Chapter 28 About the Department of Pediatric and Adolescent Medicine, Western Michigan University Homer Stryker MD School of Medicine, Kalamazoo, Michigan, United States **415**

Chapter 29 About the National Institute of Child Health and Human Development in Israel **417**

Section VI: Index **421**

Index **423**

SECTION I: INTRODUCTION

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Chapter 1

INTRODUCTION: THE EXPANDING CASE FOR PREVENTION

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When we think of child abuse, we imagine several different forms of harmful parenting and injuries to children. Most are not visible to the naked eye, but can be seen if you look more deeply. X-rays can detect fractures and other imaging can identify internal injury and bleeding, but most maltreated children have more long-lasting harm that reveals itself through behavioral and emotional maladjustment, developmental delay, sadness, and destructive behaviors that manifest later in childhood, adolescence and into adulthood. These injuries to their personality, sense of self, relationship to society and mental health change the trajectory of their lives and dim their potential, with social and financial costs for safety, treatment and their lost personal

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growth. We think of these as affecting everybody's children and that the responsibility lies with everyone to respond. This is why we put together this book: to address prevention from a number of perspectives and a variety of professions. We hope that it successfully brings together a number of disciplines and perspectives to address child abuse and neglect among the world's families, governments and cultures. We hope that those reading these chapters will realize that there are replicable best practices that can be reliably implemented based on child and family experiences and needs rather than single approaches designed to attack single forms of maltreatment, and we look forward to the day that books like these are not needed.

INTRODUCTION

When people think of preventing child abuse, they often think about the egregious physical injuries, fatalities, or sexual abuse that periodically is in the popular press. Many bemoan that this occurs and voice their desire to "do something" to prevent it. It is often thought of as "someone else's problem." Sometimes these pleas turn to fault finding among Child Protective Services, police or individual professionals who "missed something" or "made a mistake," but the underlying premise of these concerns is that we all want child abuse to be prevented, reduced and eliminated.

When we think of child abuse, we imagine several different forms of harmful parenting and injuries to children. Most are not visible to the naked eye but can be seen if you look more deeply. X-rays can detect fractures and other imaging can identify internal injury and bleeding, but most maltreated children have more long-lasting harm that reveals itself through behavioral and emotional maladjustment, developmental delay, sadness, and destructive behaviors that manifest later in childhood, adolescence and into adulthood. These injuries to the child's personality, sense of self, relationship to society and mental health change the trajectory of their lives and dim their potential, with social and financial costs for safety, treatment and their lost personal growth. We think of these as affecting everybody's children and that the responsibility to respond lies with everyone.

These are the true harms we wish to prevent and the lives we wish to improve. To do this, we have to think broadly. What do we actually wish to prevent? Child abuse encompasses more than physical abuse. We have to include psychological abuse (also called emotional abuse) as well as psychological and other exploitation. We have to think about economic trafficking. In addition to sexual abuse and sexual assault, we have to think about the Commercial Sexual Exploitation of Children (CSEC) outside the family and around the world. We have to remember that most cases reported to Child Protective Services are reported for neglect, which can take many forms from medical, psychological, or improper supervision to inadequate food, clothing and shelter. And while all children can be affected, there are those who are more vulnerable. Lastly, we have to remember that how we define each of these in our work varies from profession to profession and sometimes from place to place within the US and throughout other parts of the world, where most children actually live. Chapter 2 in this book begins to make the case for prevention by describing what child abuse and neglect is and the extent of the problem reported to Child Protective Services (CPS).

We need to remember that reported cases of abuse and neglect are the proverbial "tip of the iceberg." While a third of children will be reported to CPS at some time before age 18 years,

most who are actually maltreated—perhaps 2 out of 3—are not (1). Furthermore, among those that are reported, there are screening processes and investigations that eventually lead to the outcome that fewer than 1 in 6 reports are 'screened in' and later confirmed by CPS in the US (2). Services provided by CPS are actually designed to prevent additional CPS reports, not necessarily prevent actual abuse and neglect. And we know that children whose maltreatment is not substantiated have similar risk profiles to those who are (3). So, as we think about prevention, we need to keep in mind that we wish to prevent child abuse and neglect among *all* children, not just for those reported to or confirmed by CPS.

The next important question is for whom we are preventing child abuse and neglect. *Who* is the target of the prevention effort? *What* is the specific population or, if not specific, what place or country? While the biology of child abuse and neglect is the same among all *homo sapiens*, the specific forms, non-biologic mechanisms, and non-biologic harms differ from place to place and are moderated (and perhaps mediated) by language, social practices, customs and taboos. Civil society also creates legal frameworks that are vastly different around the world even though all countries (except the US) have ratified the UN Convention of the Rights of the Child. Family structures and the roles of parents and society have elegantly been described in the ecological model (4) and the effects on children have been expanded to an ecobiodevelopmental model (5). The issue of population also becomes critically important as we measure the outcomes of interventions, which can only be generalized to other groups if we clearly define whom the study sample is composed of.

LEVELS OF PREVENTION

Levels of prevention were historically first described in a public health model to help us understand the populations being addressed. The original classification system of disease prevention was proposed by the US Commission on Chronic Illness in 1957 (6) and consisted of three types of prevention: primary, secondary, and tertiary.

- Primary: seeks to lower the rate of new cases of a disorder in a population over a certain period of time by counteracting harmful circumstances before they have a chance to produce problems.
- Secondary: seeks to lower the rate of established cases of the disorder or illness in the population
- Tertiary: seeks to decrease the amount of disability associated with an existing disorder or illness.

Decades later, Gordon (7) laid out another set of terms, also with three levels, with more of a "risk-benefit" approach:

- Universal: addresses the entire population (national, local community, school, and neighborhood) with messages and programs aimed at preventing the issue at hand; spends small amount of resources per capita.
- Selective: targets subsets of the total population that are deemed to be at risk for the issue at hand by virtue of their membership in a particular population segment which

may be identified on the basis of biological, psychological, social, or environmental risk factors; dedicates resources to those in need.
- Indicated: strategies designed to prevent the onset of the issue at hand in individuals who are showing early danger signs; requires significant resources to treat the effects and reduce further harm.

Keeping these schemes in mind, we arranged the sections of this book to aid the reader's understanding of the scope of different strategies, what and whom they target, and the professional issues involved.

UNIVERSAL STRATEGIES

We chose to begin this book with strategies to prevent child maltreatment that can be used in the United States as well as around the world. There is increasing evidence pointing to the elements of successful interventions, the populations and programs that most benefit, and the best implementation and research to demonstrate that we have met our goals (8,9). These include using the uniqueness of the prenatal and perinatal periods for strategies such as home visiting, and returning to a public health approach (10,11). In this book, chapter 3 takes us to our international system of laws, the UN Convention on the Rights of the Child, as a framework to be used to guide us (12). Chapter 4 describes the current federal funding structure in the US for family support and child abuse services and how that is distributed to the states.

Some prevention efforts/advocates focus more on positive child/youth development and on building a system of community protective factors rather than on reducing risk (13). What's old is 'new again' as chapter 5 proposes community *Prevention Zones* to accomplish truly community-based approaches on a national level. Perhaps the most promising approach will be to reduce child poverty through direct family payments, which were long ago postulated by Ray Helfer to help families by reducing stress (14) and which have been shown conclusively to improve their health and education while reducing maltreatment and improving their earnings as adults (15). Chapter 6 reviews a number of economic supports for families that can reduce maltreatment. Moving to potentially large scale primary prevention, chapter 7 examines home visiting initiatives in New York and chapter 8 proposes *No Hit Zones*. These have been used in hospitals, courthouses and entire communities to prevent physical abuse. Some strategies focus more on technology facilitated acts of abuse/harm/exploitation with technological breakthroughs as revealed in chapter 9. When all is said and done, our strategies will need the support of the population, and changing social norms will actually be needed to reduce child maltreatment; chapter 10 describes how working with the media can affect this change. Yet, we all also realize that, while eventually cost saving, our prevention efforts will only succeed with sufficient resources on a national scale. Chapter 11 shows us one example of an ongoing effort to do just that in the United States**.**

TARGETED PROBLEMS AND POPULATIONS

Several chapters in the book look specifically at maltreatment types and vulnerable populations needing prevention, either because they have been shown to have increased risk or there are

practices associated with potential child abuse or neglect. Each of these "at-risk" populations can be "selected" for prevention, yet *how* maltreatment is to be prevented takes several forms using different strategies. Chapter 12 reviews infant crying and the prevention of abusive head trauma. Chapter 13 reviews the harms associated with corporal punishment and physical discipline while chapter 14 focuses on the international aspects of disabled populations. Chapter 15 turns our attention to young children and preventing sexual abuse, and chapter 16 looks specifically at maltreatment by clergy and in faith-based populations. Chapter 17 looks at issues among adolescents, who are a population with increased risk for maltreatment and exploitation. Delving further, chapter 18 focuses on harm in youth sports programs, while chapter 19 expands the discussion into human trafficking. We next turn to child fatality prevention (16) and programs to prevent child maltreatment deaths in chapter 20.

PROFESSIONAL ISSUES

Prevention is explicitly not the responsibility of any single agency, profession, or program. Rather, it is best framed as the responsibility of all to create a society more aware of child maltreatment and less conducive to its occurrence. In this paradigm, individual skill development, community and provider education (through the wise use of both traditional and social media), coalition building, organizational change, and policy innovations are all part of the prevention solution. Child protective services serves as the basis for many community actions, but others can and should work on parent education/supports for healthy families, community education, or professional training to leverage health and legal services. Chapter 21 reviews the vital role that primary medical care can play in health-based settings to engage all families to reduce child abuse and neglect. Chapter 22 extends this further by discussing the value of medical-legal partnerships to expand prevention outside of health settings. Chapter 23 discusses the role of CPS in providing prevention, and chapter 24 asks provocative questions about the role of mandated reporting, the now traditional response to child abuse and neglect, in a more prevention-focused child maltreatment system.

CONCLUDING THOUGHTS

The COVID-19 pandemic and our growing recognition of systemic racism in our society and child welfare systems are issues which were not at the forefront of our thinking when we planned this book. While some authors have included information about these, we have not included a dedicated discussion. Getting prevention to isolated families can be challenging in the best of times (17,18). Children with increased maltreatment due to poverty, religious practices and racism suffer more yet receive fewer services and resources. Human capital is often not taken into consideration by child protection systems (19), and disproportionate numbers of Black children and other racial/ethnic groups have found themselves in the child welfare system (20). Cultural factors result in increased reporting (21). Varying associations between race and CM have been reported in administrative data, and a number of studies have examined the role of social factors in moderating this relationship. We now know that racism is a core social determinant of health that is a driver of inequities with health effects similar to,

if not more than, traditional adverse childhood experiences (22). Bias has been recognized within the medical community since the 1970s, and it has been suggested that it accounts for at least some of these effects since it can result in significant diagnostic errors that lead to CM reporting (23). When reported, Black children are more likely to be screened in, confirmed, and brought to court, and these effects are not limited to the US (24). Racism affects not only the children reported to CPS but also how children receive prevention services (25).

So where do we go from here? We hope that this book successfully brings together a number of disciplines and perspectives to address child abuse and neglect among the world's families, governments and cultures. We hope that those reading these chapters will realize that prevention science has matured to the point where there are replicable best practices that can be reliably implemented based on child and family experiences and needs rather than single approaches designed to attack single forms of maltreatment. We believe we are entering a time for what we call *precision prevention*, where we tailor our strategies to individual and family history, risk profiles and genetics. Recent events again emphasize that we need to expand our discussions regarding the intersection of culture, racism and child maltreatment prevention.

We look forward to the day that books like these are not needed. Until then, we are thankful to the authors, editors and reviewers for their help in bringing this book to fruition. We especially acknowledge Ms Kaitlan Moe for her organizational and editorial skills which kept us on track, as well as our family and friends, who tolerated our stress and realized the value of the work we were all doing.

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Chapter 2

THE CASE FOR PREVENTION: EPIDEMIOLOGY AND IMPACT OF CHILD ABUSE AND NEGLECT

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ABSTRACT

Since the passage of "The Children's Charter" during the Hoover Administration and ratification of the U.N. Convention on the Rights of the Child, the subject of child maltreatment has become a universal topic not restricted to one professional community, one type of professional, or one country for its identification, treatment and prevention. Any strategy addressing child maltreatment must first begin by examining the nature and scope of the problem. This chapter will begin with definitions and then serve as an introduction to the incidence, recurrence, risk factors for and effects of what we now call child maltreatment or child abuse and neglect using administrative data and studies of its various forms and specific aspects of particular types so that we can better understand how to approach, reduce, and prevent it and its harms to children and families.

ABBREVIATIONS

AAP	American Academy of Pediatrics
ACEs	Adverse Childhood Experiences
CM	child maltreatment
CPS	child protective services
CRC	U.N. Convention on the Rights of the Child

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CSEC	commercial sexual exploitation of children
HMO	health maintenance organization
ICD	International Classification of Disease
MN	medical care neglect
NCANDS	National Child Abuse and Neglect Data System
NIS	National Incidence Study
PA	child physical abuse
PM	psychological maltreatment
SA	child sexual abuse
STI	sexually transmitted infection
TBI	traumatic brain injury
WHO	World Health Organization

INTRODUCTION

Since the passage of "The children's charter" during the Hoover Administration (1) and later ratification of the UN Convention on the Rights of the Child (CRC) (2), the subject of child maltreatment has become a universal topic not restricted to one professional community, one type of professional, or one country for its identification, treatment and prevention (3). With four million reports and more that 675,000 substantiated victims of child maltreatment annually, the United States Child Abuse And Neglect Reporting System (NCANDS) continues to document the effects of maltreatment and violence on children (4). Mental and physical injuries place a heavy burden on children and society (5, 6). The Adverse Childhood Experiences study has noted the powerful relationship between adverse childhood experiences and several conditions of adulthood including risk and attempted suicide, alcoholism, depression, illicit drug use, and other lifestyle changes which have direct and indirect costs (7-9). Childhood abuse is thought to adversely affect adult health through the pathway of toxic stress, leading to increased risk for depression and post-traumatic stress disorders, participation in harmful activities, difficulty in forming and sustaining healthy relationships, and negative beliefs as well as attitudes towards others (10). The annual direct and indirect costs in the US alone have been estimated in the many tens of billions of dollars annually (11).

Any strategy addressing child maltreatment must first begin by examining the nature and scope of the problem. This chapter will begin with definitions and then serve as an introduction to the incidence, recurrence, risk factors for and effects of what we now call *child maltreatment* or *child abuse and neglect* using administrative data and studies of its various forms and specific aspects of particular types so that we can better understand how to approach, reduce, and prevent it and its harms to children and families.

DEFINITIONS

Five major categories of child maltreatment are reported in the U.S.: physical abuse, sexual abuse, neglect, medical neglect and psychological maltreatment (4). The World Health

Organization (1999) broadly defines several types of maltreatment for data collection and intervention (see Table 1) (12).

Table 1. World Health Organization definitions (12)

Child abuse - Child abuse or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development, or dignity in the context of a relationship of responsibility, trust or power.
Physical abuse - Physical Abuse of a child is that which results in actual or potential physical harm from an interaction or lack of an interaction, which is reasonably within the control of a parent or person in a position of responsibility, power or trust. There may be single or repeated incidents.
Emotional abuse - Emotional abuse includes the failure to provide a developmentally appropriate, supportive environment, including the availability of a primary attachment figure, so that the child can establish a stable and full range of emotional and social competencies commensurate with her or his personal potentials and in the context of the society in which the child dwells. There may also be acts towards the child that cause or have a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development. These acts must be reasonably within the control of a parent or person in a position of responsibility, power or trust. Acts include restriction of movement, patterns of belittling, denigrating, scapegoating, threatening, scaring, discriminating, ridiculing or other non-physical forms of hostile or rejecting treatment.
Neglect and negligent treatment - Neglect is the failure to provide for the development of the child in all spheres: health, education, emotional development, nutrition, shelter and safe living conditions, in the context of resources reasonably available to the family or caretakers and causes or has a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development. This includes the failure to properly supervise and protect children from harm as much as is feasible.
Sexual abuse - Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend or is unable to give informed consent to, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to: • The inducement or coercion of a child to engage in an unlawful activity • The exploitative use of a child in prostitution or other unlawful sexual practices • The exploitative use of children in pornographic performances and materials
Exploitation - Commercial or other exploitation of a child refers to the use of the child in work or other activities for the benefit of others. This includes, but is not limited to, child labour and child prostitution. These activities are to the detriment of the child's physical or mental health, education, or spiritual, moral or social-emotional development.

In medical systems, a variety of codes are available for medical and mental health diagnosis and counseling, and patterns of ICD 9 and ICD 10 diagnosis and external injury codes have been identified for child abuse and neglect (see Table 2) (12-15).

The United Nations Convention on the Rights of the Child (2) states that a child is "[e]very human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier" and that child maltreatment consists of "all forms of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse." It also includes "intentional use of physical force or power, threatened or actual, against a child, by an individual or group that either results in or has a high likelihood of resulting in actual or potential harm to the child's health, survival, development or dignity." Thirty years hence, the CRC continues to be monitored and enhanced (16). Children who are harmed in armed conflict generally fall outside these child maltreatment regulations but are covered under other local and international statutes and the mandate of the Office of the Special

Representative of the UN Secretary-General for Children and Armed Conflict. It should be noted that the US is the only nation that has not ratified the CRC.

In the US, the Institute of Medicine (17) notes that the US federal code defines child *physical abuse* (PA) as: "non-accidental physical injury (ranging from minor bruises to severe fractures and or death) as a result of punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap, or other object), burning, or otherwise harming a child, that is inflicted by a parent, caregiver, or other person who has responsibility for the child." The WHO (12) has emphasized harm in its definition, stating that physical abuse of a child is that which results in actual or potential physical harm from an interaction or lack of an interaction, which is reasonably within the control of a parent or person in a position of responsibility, power or trust. There may be single or repeated incidents.

Sexual abuse (SA) has been defined by the WHO (12) as sexual contact or exploitation of children by adults, which cannot be consented to by the child and which violate social laws or taboos. *Sexual assault* is a comprehensive term encompassing several types of forced sexual activity, while the term *molestation* means non-coital sexual activity between a child and an adolescent or adult. *Rape* is defined as forced sexual intercourse with vaginal, oral or anal penetration by the offender. A*cquaintance* or *date rape* applies when the assailant and victim know each other. *Statutory rape* involves sexual penetration of a minor too young to consent by another person who is of legal age of consent as defined in state law, regardless of assent (18). *Drug-facilitated sexual assault* (DFSA) is a sexual assault (rape or otherwise) carried out on a person after the person has become incapacitated as a result of being under the influence of any mind-altering substances, such as having consumed alcohol or been intentionally administered a 'date rape' drug.

Table 2. International classification of disease codes applicable to child abuse and neglect

ICD-9-CM (12)	**ICD-10-CM (13)**
995.5 Child maltreatment syndrome	T74.92X Child maltreatment, confirmed, unspecified T76.92XChild Child maltreatment, suspected, unspecified
995.50 Child abuse, unspecified	Z63.8 Other specified problems related to primary support group
995.51 Child emotional/psychological abuse	T74.32X Child psychological abuse, confirmed T76.32X Child psychological abuse, suspected
995.52 Child neglect (nutritional)	T74.02XChild neglect or abandonment, confirmed T76.02X Child neglect or abandonment, suspected
995.53 Child sexual abuse	T7422X Child sexual abuse, confirmed T7622X Child sexual abuse, suspected Z04.42 Encounter for exam and observation following alleged child rape (ruled-out)
995.54 Child physical abuse	T7412X Child physical abuse, confirmed T7612X Child physical abuse, suspected Z04.72 Encounter for exam and observation following alleged child physical abuse (ruled-out)
995.55 Shaken infant syndrome	T74.4 Shaken infant syndrome
995.59 Other child abuse and neglect	Z63.32 Other absence of family member Z62.21 Child in welfare (foster care) custody

Commercial sexual exploitation of children (CSEC) involves "crimes of a sexual nature committed against juvenile victims for financial or other economic reasons. These crimes include trafficking for sexual purposes, prostitution, sex tourism, mail-order-bride trade, early marriage, pornography, stripping, and performing in sexual venues such as peep shows or clubs." Many also include "survival sex" in this definition (e.g., exchange of sexual activity for basic necessities such as shelter, food, or money), a practice commonly seen among homeless/runaway youth. When CSEC involves minor US citizens or legal residents victimized on US territory, this is termed *domestic minor sex trafficking* (19). *Transnational trafficking* involves victims transported across national boundaries for the purposes of commercial exploitation (e.g., an adult American travels to other countries were sex with children or youth is not illegal).

Neglect is the failure to provide for the development of the child in all spheres: health, education, emotional development, spiritual development, nutrition, shelter and safe living conditions, and supervision. It is especially important to note that definitions of neglect usually specified is that the omission occurs in the context of resources reasonably available to the family or caretakers and which is causes or has a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development. This includes the failure to properly supervise and protect children from harm. It is in this context that a family's economic resources have been inextricably tied to our studies of CM. Continuing attempts to understand the relationships of poverty to neglect given that a number of studies have shown the stresses of financial, food and housing insecurity have shown that poverty, while often sufficient, is not a necessary condition for neglect to occur, and a large proportion of poor families do not neglect their children.

Defined in various ways, *medical care neglect*, or simply 'medical neglect', generally involves the failure of the parent to heed obvious signs of serious illness, to seek medical or dental assistance or mental health care in a timely fashion, or to follow a physician's instructions once medical advice is obtained (20,21). Medical neglect is often overlooked, in part, due the relatively small numbers of reports for MN when compared to neglect in general. In 2018, while there were 15,160 reported victims of medical neglect in the US, this was much fewer than more than the 500,000 neglect victims, making up only 2.2% of total maltreatment victims (4). At the federal level, medical neglect is legally defined as "the failure to respond to the infant's life-threatening conditions by providing treatment (including appropriate nutrition, hydration, and medication)", however, states vary in their interpretation of this law, providing wide-ranging standards (21). They also differ in their language regarding religious exemptions, court intervention, and mandatory reporting. Three distinct groups of state laws have been identified based on their definition of neglect: minimal states, who used the fewest factors in their definitions of neglect; cornerstone states, who included key basic needs in their definitions; and expanded states, who also included emotional factors in their definitions. The American Academy of Pediatrics has offered a working definition for physicians with five standards for diagnosing medical neglect: 1) a child is harmed or is at risk of harm because of lack of health care; 2) the recommended health care offers significant net benefit to the child; 3) the anticipated benefit of the treatment is significantly greater than morbidity, so that reasonable caregivers would choose treatment over non-treatment; 4) it can be demonstrated that access to health care is available and not used and 5) the caregiver understands the medical advice given (20). Paradoxically, the overprovision of medical care has been the subject of

evolving recognition and research into Munchausen by proxy syndrome, factitious disorders imposed on children, and medical child abuse.

Psychological maltreatment (PM) is defined "as a repeated pattern or extreme incident(s) of caretaker† behavior that thwart the child's basic psychological needs (e.g., safety, socialization, emotional and social support, cognitive stimulation, and respect) and convey a child is worthless, defective, damaged goods, unloved, unwanted, endangered, primarily useful in meeting another's needs, and/or expendable" (22). The term psychological, instead of emotional, is used because it better incorporates the cognitive, affective, conative (involving volition; i.e., decision making, acts of will), and interpersonal aspects of this form of child maltreatment. It includes acts of commission (e.g., verbal attacks on the child by a caregiver) and acts of omission (e.g., emotional unresponsiveness of a caregiver). Most of the state legal definitions are labeled in state laws as mental injury or emotional abuse, and these refer to the impact on the child, not the caregiver acts that may have led to such a result.

INCIDENCE

Using a disease model, child maltreatment can be thought of as the second most common chronic disease of childhood, following asthma/allergic disorders, based on incidence and prevalence in the pediatric population. In 2018, there were 678,000 substantiated victims of child maltreatment in the US, with 70,000 victims of physical abuse alone, 48,000 victims of sexual abuse alone, more than 100,000 with multiple forms of abuse and neglect, and 1,770 deaths (4). Recent national data from the US showed a mixed set of trends, with neglect slowly declining, sexual abuse remaining unchanged and physical abuse and fatalities rising (23). More than one-third (37.4%) of all US children will be the subject of a CPS investigation by age 18 years (24).

Two large administrative sources provide information about the extent in the problem in the US: the National Child Abuse and Neglect Data System (NCANDS) and the National Incidence Studies of child abuse and neglect (NIS). NCANDS contains aggregate and case-level data on child abuse reports received by state Child Protective Service (CPS) agencies, and almost all US states and territories provide information annually about the outcomes of child abuse reports, types of maltreatment, child and family factors and services being provided (4). National estimates of the overall numbers of confirmed victims (substantiated or indicated CPS reports) as well as victims identified with physical abuse show decline over the 25+ years of nationally collected data in the US with recent increases in number (see Figure 1) and rate (see Figure 2).

Physical abuse remains an all too common occurrence. In the United States, 1–2 per 1,000 children are confirmed victims each year, and young children and infants have the highest rates. Maltreated children suffer from a variety of behavior problems and mental disorders in addition to physical injuries (25). There were 125,794 child victims with confirmed physical abuse among 731,896 total child maltreatment confirmations in NCANDS in 2018. This represents a decrease from a high of 261,605 cases in 1996, following similar trends in other national crime statistics. Unlike the reported incidence of sexual abuse, for which it has been suggested that at least some of the decrease is real, it is not clear why physical abuse rates have actually declined. While economic indicators improved in the 1990s, the number of cases continued to fall in

NCANDS during 2008-2011 during an economic recession in the U.S. but later increased (23). This may indicate that states are changing how they count child maltreatment or how they are delivering that information to NCANDS, as could occur with differential response systems. Further studies are needed to ascertain whether the number of physical abuse cases will continue to decline and the causes why this is occurring. This could also be related to the decreasing public acceptance of the use of corporal punishment (26).

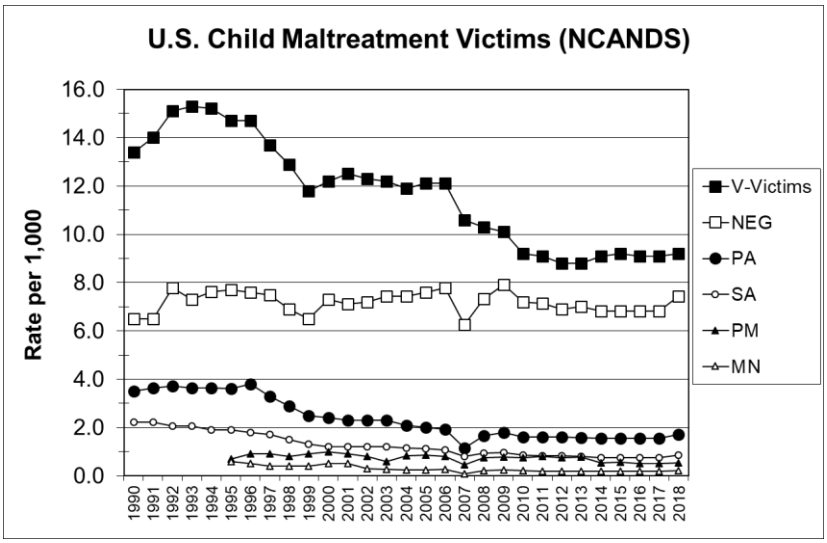

Figure 1. Confirmed United States child maltreatment frequencies, by type, NCANDS 1990–2018.

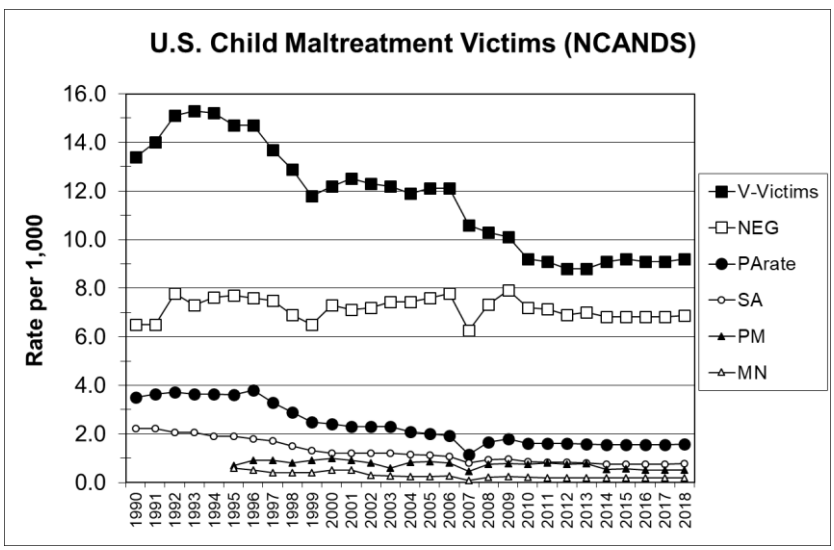

Figure 2. Confirmed United States child maltreatment rates, per 1,000 children, NCANDS 1990–2018

In contrast, the NIS sampled sentinel counties to identify cases under two standards: the harm standard (relatively stringent in that it generally requires that an act or omission result in demonstrable harm in order to be classified as abuse or neglect), and the endangerment standard (which allows children who were not yet harmed by maltreatment to be counted if the CM was confirmed by CPS or identified by professionals outside CPS or their parents or other adults) (27). The Fourth National Incidence Study of Child Abuse and Neglect (NIS–4) showed an overall decrease in the incidence of maltreatment since the NIS–3, as well as decreases in some specific maltreatment categories and increases in others. Using the Harm Standard definition, more than 1.25 million children experienced maltreatment during the NIS–4 study year (2005–2006). A large percentage (44%) or an estimated 553,300 were abused, and most of these abused children experienced physical abuse (58%). "Harm Standard" physical abuse cases decreased from an estimated 381,700 at the time of the NIS–3 to an estimated 323,000 in the NIS–4 (a 15% decrease in number and a 23% decline in the rate). Under "Endangerment," the estimated number of physically abused children decreased from an estimated 614,100 children to 476,600 (22% decrease in number, 29% decline in the rate) (27).

While the overall reported number of child physical abuse cases has declined in national statistics, a number of smaller samples have suggested a rise in more serious child physical abuse. Berger and colleagues (28) noted that the abusive head trauma rate increased from 8.9 to 14.7 per 100,000, and Huang and colleagues (29) noted a doubling from 0.7 to 1.4 per month during the recession. Wood and colleagues (30) noted increasing rates of children admitted to hospitals for physical abuse over 10 years 2000–2009, rising from 0.8% to 3% annually. Sharkey and colleagues (31) noted that the incidence of abusive fractures was 2.7/10,000 children <36 months of age. The incidence rate for emergency department visits was 2.5/10,000. In this single institution review of fractures in children < 36 months of age, the incidence of abusive fractures has remained relatively constant over a 20-year period, 1979-2002. In a hospital database, Medicaid insurance payer status was associated with higher rates of traumatic injuries than private insurance. Black race, male sex, and high-income-quartile were independent factors associated with increased cost (32). Zhou and colleagues (33) found that infant maltreatment can best be predicted when there are young mothers less than 20 years, who are unmarried, with inadequate prenatal care, are poor, who smoke during the pregnancy, or when there are three or more siblings. In a NCANDS sample, parent emotional problems, alcohol abuse and other family violence were found to be associated with the recurrence of physical abuse before age 3 years (34). High proportions of naturalized and Asian/Pacific Islander families were positively related to the frequency of physical abuse, and higher levels of neighborhood social disorder were related to more frequent physical abuse in a study looking at these factors and alcohol outlets (35).

It has been consistently estimated that 1–3 per 100,000 U.S. children annually are fatally maltreated (see Figure 3) (4). More than three-quarters (78%) of these deaths are in children under 4 years of age, and 44% were among infants. Physical abuse, alone or in combination with neglect, causes most of these deaths. There have been persistent concerns about a systematic underascertainment of these fatalities (36-38). Using an inpatient hospital database, there were 6.2 per 100,000 children, (300 deaths) with higher rates for infants and children receiving Medicaid (39).

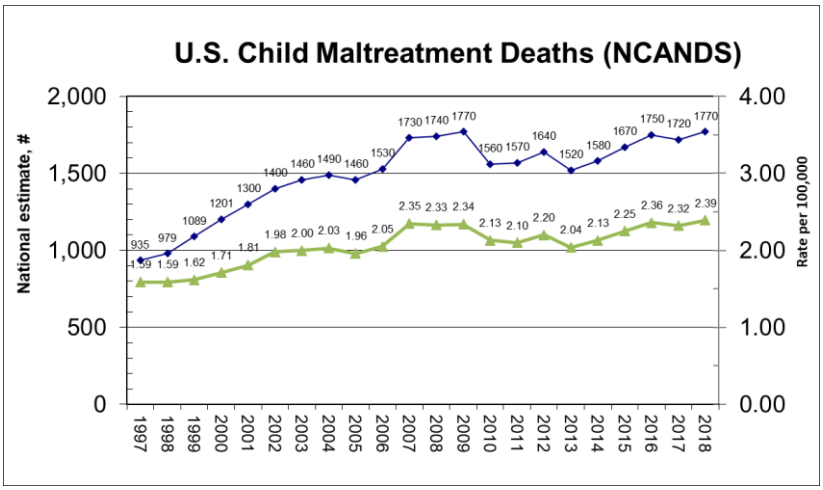

Figure 3. Confirmed United States child maltreatment fatality frequencies and rates, per 100,000 children, NCANDS 1990–2018.

RECURRENCE

Even after being reported and investigated, CM can recur. When a child remains with their family, studies have shown recurrence rates of child maltreatment ranging from 1-2% for cases deemed low risk to over 50% for high risk families followed more than 5 years (40). Patterns of recurrence were often based on location, culture, financial resources, and type of prior victimization (41). For child sexual abuse, for example, children were more likely to be revictimized when they were younger, had developmental delay or another mental health diagnosis, and their families were more likely to have multiple psychosocial risk factors, including domestic violence (DV), substance abuse, parental history of sexual abuse and financial concerns (42).

Using CPS reports in the US, a series of studies has found that psychological maltreatment recurs more frequently than does physical or sexual abuse, or medical neglect (34, 43-45). However, the risk factors for recurrence and the effects of CPS services vary widely across difference types of victimization, and the types of services offered after victimization differed based on maltreatment type, with recurrence rates only sometimes improved by certain CPS services (see Table 3). It is difficult to separate the effects of the services offered from the increased likelihood of their being used based on underlying risk.

While confirmed CPS cases are generally provided with CPS services and referrals, the types of services and referrals offered varies by CM type. Using annual datafiles from NCANDS for 2018 (4), we identified that not all children were offered services, with those having confirmed SA almost half as likely to have CPS service referral of any kind as compared to other forms of confirmed CM (see Table 4). Family support and family preservation are more likely to be offered for neglect, while adoption, case management, health mental health and others are offered after PA. Neglect was responded to with a variety of supportive services such as counseling, education, housing, mental health, home-based services, substance abuse, respite and others to keep the family together, although there was also increased use of foster care,

adoption and court representation and petition. Housing, information, case management, mental health, transportation and disability services were more likely offered after PM.

Table 3. Same type recurrence rates for specific CM types

CM type	5-Year Recurrence	Risk Factors	Helpful CPS services	Ref
Physical Abuse	1.9%	Child and family emotional problems, child behavior problems, other family violence, prior physical abuse	None identified	(34)
Sexual Abuse	3.6%	Female gender, older child, family hearing and vision problems, other CM, and other family violence	Substance abuse services	(43)
Medical Neglect	8.1%	Medical or legal report source, older child (3-18 years), Black race, other medical problem, physical abuse or neglect	Foster care, case management, counseling, court-appointed representative, daycare, family preservation, juvenile court petition, mental health, and substance abuse services	(44)
Psychological Maltreatment	9.2%	Family poverty, drug or alcohol problems, and other family violence.	Counseling	(45)

Table 4. CPS service referrals by child maltreatment type

	Factor present in victims with physical abuse, # (OR)	Factor present in victims with sexual abuse, # (OR)	Factor present in victims with neglect, # (OR)	Factor present in victims with psychological maltreatment, # (OR)
Any CPS service referrals	67970 (1.04)***	23318 (0.44)***	307946 (1.60)***	29233 (3.24)***
Family support services	9228 (0.78)***	3468 (0.54)***	54661 (1.49)***	3641 (NS)
Family preservation services	12421 (0.68)***	3097 (0.32)***	82405 (2,78)***	5162 (NS)
Foster care services	26319 (0.91)***	6292 (0.34)***	135846 (2.37)***	8363 (NS)
Juvenile court petition	21773 (0.87)***	5786 (0.36)***	128096 (2.45)***	9175 (1.28)***
Court-appointed rep.	9944 (0.81)***	2775 (0.38)***	61668 (2.22)***	3853 (0.92)***
Adoption services	1843 (1.30)***	446 (0.54)***	7313 (1.74)***	717 (1.60)***
Case management services	43535 (1.32)***	13521 (0.53)***	182387 (1.22)***	21985 (2.96)***
Counseling services	9047 (0.77)***	4069 (0.61)***	53596 (1.60)***	3087 (0.90)***
Daycare services	3688 (0.72)***	645 (0.20)***	26439 (3.49)***	1172 (0.73)***
Education and training	2719 (0.96)*	826 (0.51)***	10723 (1.17)***	443 (0.39)***
Employment services	454 (1.71)***	82 (0.49)***	1347 (NS)	52 (0.54)***
Family planning services	258 (0.73)***	123 (0.67)***	1777 (1.53)***	218 (1.90)***
Health/Home health services	7638 (3.0)***	1433 (0.70)***	13066 (0.56)***	1720 (1.72)***
Home based services	2185 (0.79)***	521 (0.33)***	13841 (2.30)***	767 (0.89)**
Housing services	1055 (0.91)**	435 (0.66)***	5277 (1.16)***	536 (1.51)***

	Factor present in victims with physical abuse, # (OR)	**Factor present in victims with sexual abuse, # (OR)**	**Factor present in victims with neglect, # (OR)**	**Factor present in victims with psychological maltreatment, # (OR)**
Independent living services	521 (NS)	288 (NS)	2358 (1.13)**	171 (NS)
Information and referral	6784 (0.66)***	2551 (0.46)***	45408 (1.51)***	3558 (1.99)***
Legal services	1775 (0.87)***	447 (0.38)***	10439 (2.44)***	405 (0.60)***
Mental health services	8466 (1.21)***	2636 (0.60)***	32788 (1.06)***	2889 (1.36)***
Pregnancy & parenting services	1659 (1.09)**	254 (0.28)***	8207 (1.94)***	93 (0.15)***
Respite services	807 (0.57)***	188 (0.28)***	6311 (2.85)***	180 (0.50)***
Special disability services	722 (0.60)***	345 (0.53)***	5856 (2.25)***	414 (1.26)***
Juvenile delinquency services	133 (NS)	120 (1.72)***	583 (NS)	31 (NS)
Substance abuse services	7517 (0.74)***	965 (0.16)***	49215 (2.83)***	1906 (0,65)***
Transportation services	4237 (1.21)***	806 (0.36)***	17686 (1.51)***	2945 (3.15)***

Note. Table derived from NCANDS Child File 234 (v1) (65). CI = confidence interval; NS = p > .05.
OR = odds ratio compared to records without specified maltreatment type.
* $p < .05$; ** $p < .01$; *** $p < .001$.

RISK FACTORS

Most theories of child maltreatment recognize that the root causes of child abuse can be divided into four principal systems: 1) the child, 2) the family and 3) the community and 4) society. While children are certainly not responsible for the abuse inflicted upon them, there are certain characteristics that have been found to increase their risk for maltreatment (4, 27).

The child

Young child age is consistently associated with increased rates of CM. Younger children are more likely to be neglected or physically abused, while the risk for sexual abuse increases with age. It is unclear whether they more likely than older kids to be neglected or more susceptible because of their young age and inability to fend for themselves. Evidence also suggests that gender is predictive of maltreatment risk. Female children and adolescents are significantly more likely than males to suffer sexual abuse (4). Children with disabilities or mental retardation, for example, are significantly more likely to be abused, but the risk varied by abuse type. Children with confirmed disabilities had significantly lower rates of physical abuse and of moderate harm from maltreatment, but they had significantly higher rates of emotional neglect and of serious injury or harm.

The family

NIS-4 confirmed findings from other studies that associated increased physical abuse in poor, larger, unemployed families, with one parent and an unrelated caregiver present. Monetary subsidies for child care and other family economic supports have been found to be protective and can reduce CM (46). Family configuration, child gender, social isolation, lack of support, maternal youth, marital status, poverty, and parenting practices contribute to increased risk (47, 48). Children residing in households with unrelated adults were significantly more likely to die from inflicted injuries than were children residing with two biologic parents, and increased risk was also elevated with step, foster and adoptive parents (49, 50). Independent of these factors, a prior CPS report of maltreatment has been associated with almost six times the risk for death from later injury (51).

The community and society

Community and social factors also play a role in child maltreatment. Community poverty, often represented by zip code or census tract, has been linked with maltreatment, particularly neglect, in each of the national incidence studies (27), and has been associated with child neglect, a strong predictor of substantiated child maltreatment (52). Violence and unemployment are other community-level variables that have been found to be associated with child maltreatment. Perhaps the least understood and studied level of child maltreatment is that of societal factors. Ecological theories postulate that factors such as the narrow legal definitions of child maltreatment, the social acceptance of violence (as evidenced by video games, television, films, and music lyrics), and political or religious views that value noninterference in families above all may be associated with child maltreatment. Few studies address the role of society in increasing the propensity for SA, but some work has suggested we can identify particular organizations, professions or neighborhoods for targeted prevention (53).

Factors by maltreatment type

There are several risk factors for medical neglect, including poverty, insufficient societal support systems, maternal mental health issues, limited paternal involvement, child prematurity, disability, and behavioral problems, and intimate partner violence (54). Several overlap with risk factors for neglect in general, but medical neglect is unique in its potential etiologies, which include a lack of access to health care, distrust in healthcare professionals, conflict with caregivers' belief systems, low health literacy, misunderstanding other cultures, insufficient communication between pediatricians and families, and the difficulties of caring for children with special health care needs or who are chronically ill (20). Lack of health insurance is also a factor, with 5.5% of US children being uninsured in 2018, a steady increase from 4.6% in 2016 (55, 56). As with adults, chronic physical illness can compound a lack of resources, and retrospective studies in pediatric hospitals in Chicago and Sydney have shown that ~90% of referrals to child protective services are for children with chronic illnesses and complex medical needs.

Several factors have been associated with physical abuse. Unlike previous NIS cycles, NIS–4 found strong and pervasive race differences in the incidence of maltreatment with rates of maltreatment for Black children significantly higher than those for White and Hispanic children (27). This agrees with studies of NCANDS data (24). Among newborns, 2.1 per 100,000 in North Carolina were killed or left to die each year, usually by their mothers, many of whom were poor, had no prenatal care, or were adolescents (57). There were more boys than girls, and infant boys had the highest rate (18.5 per 100,000). Higher mortality from all causes of injuries has been noted in African American, Native American and Alaskan Native children (58). Palusci and Covington (59) used cases from 2005 to 2009 in the US National Child Death Review Case Reporting System to compare child and offender characteristics and to link that information with actions taken or recommended by review teams. Among 49,947 child deaths from 23 states during 2005-2009, there were 2,285 cases in which child maltreatment caused or contributed to fatality. More than one-half had neglect identified as the maltreatment, and 30% had abusive head trauma. Several child and offender characteristics were associated with specific maltreatment types identified in fatalities.

Females and certain race, origin, and age groups appear consistently to have elevated risk for SA (4, 60, 61) but these are not case characteristics that can be modified (e.g., we would not want to reduce the number of girls to reduce SA). Some factors, such as poverty and single parent households are very difficult to address, and in many poor families with a single parent head of the household, no SA occurs. We are then left with several factors such as alcohol use, domestic violence, less than high school education, and mental illness, which, if they could be reduced or prevented, could reduce the incidence (and therefore the lifetime prevalence) of SA (60,62). And while up to half of sexually or physically abused adolescents have been found to be "resilient" or resistant to the effects of these adverse experiences (63), further reductions could occur by increasing protective factors such as attachment security and social supports (61). Interestingly, a lack of SA education has been found to be a risk factor that could clearly could be addressed by currently available programs (64). Unfortunately, most epidemiological studies fail to provide the proportion of SA (or any type of CM) in the population that could be prevented by reducing a particular risk factor (the population attributable risk fraction) or the specific type of intervention that could be used. This would allow us to better quantify the amount of SA that could be prevented by risk factor modification.

Annual datafiles from NCANDS can be used to identify risk factors in child victims by looking at statistical associations of CPS reported case information with confirmed CM in reports. Using NCANDS data for 2018 (65), there are differences in the effects of risk factors across different CM types. When comparing records for confirmed reports with one type of CM (physical abuse, sexual abuse, neglect and psychological maltreatment) to those in which that type was not confirmed, we found that there are child (see Table 5) and family factors (see Table 6) are associated with significantly increased risk. Boys were more likely to be physically abused or neglected and girls were more likely to be sexually abused or psychologically maltreated. Similar relationships were noted for infants and older teens. Whites had more physical and sexual abuse and PM. Blacks were found to have more physical abuse, and Native Americans had more neglect and PM. Hispanic ethnicity was associated with increased rates for all types except physical abuse. Child emotional problems increased risk for all except neglect while behavior problems led to PA and neglect. Child learning problems and drug and alcohol exposure were associated with more neglect and PM.

Table 5. Child factors by child maltreatment type (NCANDS 2018)

	Factor present in victims with physical abuse, # (OR)	**Factor present in victims with sexual abuse, # (OR)**	**Factor present in victims with neglect, # (OR)**	**Factor present in victims with psychological maltreatment, # (OR)**
Total confirmed reports	125794	62795	547154	40400
Boys	66698 (1.25)***	11918 (0.22)***	276181 (1.36)***	19188 (0.96)***
Child age: <1 year	22317 (1.29)***	421 (0.04)***	85942 (1.29)***	2830 (0.41)***
1-4 years	26167 (0.73)***	5023 (0.23)***	154621 (1.85)***	9489 (0.89)***
5-9 years	33580 (0.97)***	15884 (0.89)***	149587 (1.05)***	12355 (1.19)***
10-14 years	28825 (1.05)***	25960 (2.75)***	110368 (0.64)***	11208 (1.37)***
15-19 years	14067 (1.19)***	15384 (3.49)***	45199 (0.53)***	4458 (1.14)***
Child race: White	79988 (1.07)***	44364 (1.37)***	354167 (0.91)***	27992 (1.19)***
Asian	1606 (NS)	824 (0.92)*	7640 (0.95)*	611 (NS)
Native American	19567 (0.68)***	1157 (0.54)***	17824 (1.35)***	3032 (2.76)***
Black	38642 (1.40)***	12655 (0.68)***	142427 (0.90)***	6999 (0.55)***
Hawaiian/Pacific Islander	634 (01.14)**	286 (NS)	2041 (0.44)	278 (1.41)***
Child Hispanic ethnicity	165088 (0.57)***	15491 (1.11)***	130539 (1.37)***	11211 (1.29)***
Child alcohol exposure	776 (0.47)***	247 (0.29)***	7003 (2.25)***	1302 (3.24)***
Child drug exposure	10288 (1.68)***	826 (0.19)***	27865 (NS)	2053 (0.94)**
Child emotional problems	3413 (1.34)***	2407 (1.51)***	9879 (0.73)***	1435 (2.06)***
Child hearing or vision impaired	735 (NS)	356 (0.77)***	3430 (1.56)***	337 (1.74)***
Child learning problems	1114 (0.89)***	520 (0.73)***	5008 (1.32)***	705 (2.74)***
Child physical disability	1209 (1.44)***	382 (0.71)***	3778 (1.19)***	129 (0.55)***
Child behavior problems	4629 (1.15)***	2390 (NS)	17362 (1.23)***	993 (0.98)**
Child medical problems	13832 (2.12)***	2549 (0.49)***	33268 (0.96)***	1923 (NS)

Note. Table derived from NCANDS Child File 234 (v1) (65). CI = confidence interval; NS = p > .05.
OR = odds ratio compared to records without specified maltreatment type.
*p < .05; **p < .01; ***p < .001.

Families with confirmed physical abuse during 2018 were more significantly likely to have emotional problems but, as defined in NCANDS, were less likely to have alcohol or drug problems, mental retardation, learning or physical problems. Compared to other confirmed maltreatment, physical abuse cases were also less likely to have been receiving public assistance or to have housing or financial problems. There was also less domestic violence (OR

= 0.72). Not surprisingly, physical abuse cases were more likely to come from medical sources (OR = 1.56) than were other types of CM. Military families had small increases in PA and SA. Financial needs were much more identified among confirmed cases of neglect, as were family drug, alcohol, medical and learning problems. PM cases also had family drug and alcohol problems as well as domestic violence and public assistance. It should be noted that domestic violence is often confirmed by states in NCANDS using PM as the type of CM identified.

Table 6. Family factors by child maltreatment type (NCANDS 2018)

	Factor present in victims with physical abuse, # (OR)	**Factor present in victims with sexual abuse, # (OR)**	**Factor present in victims with neglect, # (OR)**	**Factor present in victims with psychological maltreatment, # (OR)**
Family alcohol problems	5631 (0.48)***	1271 (0.22)***	45130 (2.52)***	4457 (1.73)***
Family drug problem	22286 (0.86)***	2785 (0.17)***	106123 (2.18)***	8303 (1.27)***
Family mental retardation	826 (0.91)*	401 (0.82)***	3914 (1.54)***	89 (0.64)***
Family emotional problems	6384 (1.37)***	1768 (0.65)***	20319 (1.08)***	1644 (1.56)***
Family hearing or vision impaired	339 (NS)	206 (NS)	1595 (1.48)***	52 (0.59)***
Family physical problems	826 (0.91)*	489 (NS)	4188 (1.31)***	135 (0.65)***
Family learning problems	687 (0.82)**	300 (0.75)***	3171 (1.43)***	295 (1.50)***
Family medical problems	1756 (NS)	732 (0.87)***	6374 (1.11)***	547 (1.61)***
Military family	350 (1.13)*	176 (1.21)*	1221 (NS)	99 (NS)
Family domestic violence	18421 (0.72)***	2889 (0.18)***	109288 (1.13)***	14563 (4.94)***
Family inadequate housing	5445 (0.61)***	1101 (0.32)***	38282 (3.57)***	1160 (0.56)***
Family financial problems	8444 (0.70)***	2534 (0.43)***	44080 (1.44)***	2477 (0.88)***
Receiving public assistance	16967 (0.87)***	5179 (0.47)***	85466 (1.60)***	7268 (1.50)***
Medical/Police Report Source	22597 (1.59)***	5493 (0.61)***	69405 (0.86)***	2205 (0.37)***

Note. Table derived from NCANDS Child File 234 (v1) (65). CI = confidence interval; NS = p > .05.
OR = odds ratio compared to records without specified maltreatment type.
*p < .05; **p < .01; ***p < .001.

PROTECTIVE FACTORS

Protective factors are conditions or attributes (skills, strengths, resources, supports or coping strategies) in individuals, families, communities or the larger society that help people deal more effectively with stressful events and mitigate or eliminate risk of child maltreatment in families and communities. Some moderate the effects of various risk factors such as intimate partner violence and depression (66) as a "counterweight" in that they buffer the impact of their effects such as toxic stress (67). Overall research has not specifically linked these factors with specific types on maltreatment, although it is conceivable that some are more protective than others in certain types.

There are many protective factor approaches in development and use by various agencies, programs, and practitioners who seek to prevent child abuse and neglect and promote child wellbeing. While some approaches are more grounded in research than others, there is no single "right way" to talk about protective factors. For example, Strengthening Families™ and Youth Thrive™ were developed by the Center for the Study of Social Policy. Essentials for childhood is an approach developed by the Centers for Disease Control and Prevention (CDC). The Administration on Children, Youth and Families, of the Administration for Children and Families, US Department of Health and Human Services is working on an approach that identifies protective factors specifically relevant across the populations served by ACYF (68). It is important to remember that administrative records provide information concerning the characteristics and risk factors observed among those children reported for maltreatment, but tell us little about how these children fit within the broader population of children who may have a similar risk profile yet were not reported. Likewise, the protective factors that promote resilience among children and families, despite profound adversities, remain incompletely studied.

Protective factors fall along the lines of both intrapersonal and sociological factors (66) with one of the most profound protective factors being individual resilience. Resilience can be defined as an intrapersonal characteristic such as perseverance or self-reliance that allows an individual to adapt in the face of adversity (69). Higher resiliency is associated with fewer depression symptoms, less Post Traumatic Stress Disorder symptoms, and lower rates of re-victimization (69). Other intrapersonal protective factors include higher level of self-regulation as well as individual child temperament, with easier temperaments being associated with higher levels of receiving nurturance (70). According to the "Strong and Thriving Families Resource Guide" (67), the 'youth thrive protective and promotive factors' include youth resilience, social connections, knowledge of adolescent development, concrete support in times of need as well as cognitive and social emotional competence in youth.

Protective factors also exist at the family level can be defined as sensitive and stimulating caregiving behaviors, cognitive stimulation and emotional support (70). In order to provide these positive experiences to children, families need to have their basic needs met, and have the sorts of social supports that encourage positive parenting techniques irrespective of stressful situations (69). According to the "Strong and Thriving Families Resource Guide" (67), the Strengthening Families protective factors include parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need and social emotional competence of children.

Attempts are being made to explicitly identify the protective factors most effective in reducing child abuse and neglect. Sprague-Jones and colleagues (71) generated new items informed by the literature on protective factors against child maltreatment and best practices in survey design to address feedback from the field and improve sensitivity to change. They conducted exploratory factor analyses to obtain a small, integrated set of items that tap the targeted protective factors, finding a five-factor solution. Four of the factors consisted of family functioning and resilience, nurturing and attachment, social supports, and concrete supports. A fifth factor emerged consisting of items intended to capture social supports. In addition to risk factor modification, supporting protective factors in families holds promise for preventing child abuse and neglect.

HEALTH EFFECTS

Other than documentation of fatalities, information regarding the physical injuries and health effects of child abuse has only recently been systematically collected on a national basis (18). Given that child abuse and neglect affect at least three to five percent of children per year, this translates into several patients per month for each pediatrician and a large proportion of children by the age of 18 years. While overall pediatric traumatic brain injury (TBI) has been estimated at 60-80 per 100,000 children, inflicted TBI has been found in 30 per 100,000 children under age two years (72), the age of most abusive head trauma cases. There are a variety of physical injuries that can occur in children who are abused, and the proportion of reports by physicians is increasing (73). The AAP has identified several physical examination findings that should be considered concerning for abuse, and a number of specific injuries have been called "sentinel" because of their association with later injury and death (74-76). These may not be recognized as it can be difficult to differentiate between inflicted and accidental injuries, and there are a number of "gray" cases with uncertain cause but which have injuries more common in accidents but psychosocial risk factors more like abuse cases (77-79).

A variety of long-term harms beyond acute physical injury have been linked to physical abuse. Maltreated children suffer from a variety of behavior problems and mental disorders in addition to physical injuries (20). Exposure to violence in general has been associated with stress symptoms, decreased appetite, difficulty sleeping, stomachaches and headaches (80), and the long-term biological effects are now being better understood (81). Advances in a wide range of biological, behavioral, and social sciences are expanding our understanding of how early environmental influences (the ecology) and genetic predispositions (the biologic program) affect learning capacities, adaptive behaviors, lifelong physical and mental health, and adult productivity (10). Research and practice have made it clear that being a victim of maltreatment has serious negative implications for a child's mental health. Although some children recover from adversity, traumatic experiences can result in significant disruption of a child's development. Symptoms of child traumatic stress and comorbid disruptions in the parent-child relationship can present to the pediatrician in a variety of ways (82). Physical abuse is usually (if not always) accompanied by psychological maltreatment with its attendant belittling, spurning and other emotional damage to the child's ego, emotional health and development.

The "Adverse Childhood Experiences" study has noted the powerful relationship between adverse childhood experiences and several conditions of adulthood, including risk of suicide, alcoholism, depression, illicit drug use, and other chronic diseases (7-9). A variety of physical and emotional ailments in adults have been identified in over 60 papers since 1998 by internist Vincent Felitti, pediatrician Robert Anda, and their colleagues, who studied the relationship of childhood adversity and a variety of lifelong physical and emotional outcomes (83). These ten adverse childhood experiences, or "ACEs" as they have come to be called, include exposure to emotional abuse, physical abuse, contact sexual abuse, alcohol/substance abuse, mental illness, criminal behavior, parental separation/divorce and domestic violence. Using a retrospective study design, they surveyed 17,337 adult HMO members (average age 57 years) and linked events during childhood in a dose–response fashion with cardiovascular disease, cancer, AIDS and other sexually transmitted diseases, unwanted often-high-risk pregnancies, chronic obstructive pulmonary disease, and a legacy of self-perpetuating child abuse. While it is hard to believe this now, many medical and child welfare professionals did not see the linkages

among child abuse and other common "social problems" (now called social determinants of health) with chronic disease and premature death in adulthood. While there have been questions about the validity of the study design, studies using ACEs have expanded to less affluent samples to fit within an accepted universal *ecobiodevelopmental* framework for understanding health promotion and disease prevention across the lifespan, supported by recent additional advances in neuroscience, molecular biology and the social sciences (84).

After adjusting for age, gender, and race, Widom and colleagues (85) found that child maltreatment itself predicted below normal hemoglobin, lower albumin levels, poor peak airflow, and vision problems in adulthood, all elements of chronic disease. Physical abuse predicted malnutrition and abnormal tests for albumin, blood urea nitrogen, and hemoglobin A1C, identifying early disease. Additional controls for childhood socioeconomic status, adult socioeconomic status, unhealthy behaviors, smoking, and mental health problems play varying roles in attenuating or intensifying these relationships. Child abuse affects long-term health status—increasing risk for diabetes, lung disease, malnutrition, and vision problems—and this supports the need for early health care prevention. While the exact pathways are still being explored, childhood abuse affects adolescent and adult health through changes in the stress response, genetics, epigenetic gene expression, and brain structure and function. It also puts people at risk for depression and post-traumatic stress disorders, difficulties in relationships, and negative beliefs and attitudes towards others (86).

Deborah Daro (87) projected that the national cost and future productivity loss of severely abused and neglected children is between $658 million and $1.3 billion each year in the US, assuming that their impairments would reduce future earnings by as little as 5% to 10%. Prevent Child Abuse America (88) used "conservative" estimates to calculate direct and indirect costs as $103.8 billion in 2007. Fang and colleagues (89) noted that the average abused child costs $210,012 in 2010 dollars, generalizing to $124 million annually in the U.S. Physical health care costs per child are significantly higher for children with contact with CPS (90). Mental health costs per child are always significantly higher for children with CPS contact and highest in children with foster care placement. The seemingly large costs for children pale in comparison with the economic and human burden of adult poor health and premature death (91).

Physical abuse

While there is considerable overlap, specific health effects and injuries are often related to physical or sexual abuse. Physicians have intermittently noted specific injuries as stemming from abuse and neglect through the years, with early identification of physical abuse as a condition in the medical literature (3). The most common physical injury from abuse affects the skin by bruising or burning. Any skin lesion beyond temporary reddening should be considered as potential physical abuse when: 1) the injury is inflicted and non-accidental, 2) the pattern of injury fits biomechanical models of abusive trauma, 3) the pattern corresponds to infliction with an instrument that would not occur through play or in the environment, 4) the history provided is not in keeping with the child's development or 5) the history does not explain the injury (74). *Location*, *pattern*, *size*, and *color* have been used to assess the specificity of skin lesions. This is particularly relevant for young children, and a series of bruises and other injuries have been found to be sentinel for predicting future injury or death (75, 92). For burns, determining whether the pattern is developmental consistent with the

child's abilities, the agent and mechanism offered by the caretaker addition to the degree of supervision, are key, and a tool has been developed to help assess risk for abuse when a child presents with scald burning (93,94).

After skin lesions, fractures are the second most common physical abuse injury (74). Specific patterns of fracture have been associated with physical abuse, with posterior rib fractures, rarely injured bones, and long bone fractures in non-ambulatory children being specific (95). While other causes of metabolic bone disease can be identified, specific radiographic patterns can help distinguish these from abusive injury (96). Skeletal surveys of all the bones are generally indicated for children younger than 2 years of age, but others are suggesting they are also helpful in older children and in certain situations to detect occult or healing bone injuries (98-100).

The leading cause of abusive mortality and morbidity is inflicted traumatic brain injury (101, 102). With mortality rates of 10%-50% and more than 90% of survivors having significant handicap, physical abuse to the head has been noted to have patterns of injuries that are distinct from accidental or medical causes. At least 1,400 cases of abusive head trauma occur annually in the United States at rates near 30 per 100,000, and there is growing sophistication in our ability to differentiate these fatalities due to abuse versus those from non-abusive causes.

There is also a growing body of knowledge of abdominal and chest trauma available to identify these often 'silent' injuries with potentially devastating consequences. Abdominal injuries, while contributing fewer than 10% of child abuse fatalities, are difficult to assess, given their occult nature, relative lack of bruising, and potential for significant delay in symptoms after injury. Abdominal CT imaging and/or liver function with pancreatic testing should be performed in all abusive head trauma victims to identify occult abdominal trauma; indeed, it has been shown that 25% or more of even fatal abdominal trauma cases can have few or no visible external bruises (103). Many inflicted deaths of infants have been mischaracterized, and there is growing support for comprehensive medical examiner investigations, with thorough pediatric autopsy procedures, scene re-enactments, and reviews of medical and investigation records by death review teams (104).

Corporal punishment

Children will often be found with injuries that are reported to have occurred from spanking, corporal punishment or physical discipline. Some researchers have examined the co-occurrence of physical punishment and more severe types of child maltreatment, and abusive parents have been found to be more likely to use physical punishment compared to non-abusive parents (105). Similarly, Canadian child protection services data indicates that physical punitive violence was involved in 75% of substantiated cases of physical abuse as well as 13% of emotional maltreatment, 2% of sexual abuse, 2% of neglect, and 1% of exposure domestic violence (106). In a representative sample from North and South Carolina, physical punishment was associated with a 2.7 fold increase in the likelihood of physical abuse (107). It may be that in some cases physical punishment as a disciplinary measure is a precursor in the progression and escalation towards child physical abuse; perhaps hitting as a disciplinary means evolves into more severe physical acts of maltreatment related to increasing anger in the person committing such acts (typically a parent) (108). The American Academy of Pediatrics has

reviewed this research, surveyed its members and has concluded that parents, other caregivers, and adults interacting with children and adolescents should not use corporal punishment (including hitting and spanking), either in anger or as a punishment for or consequence of misbehavior, nor should they use any disciplinary strategy, including verbal abuse, that causes shame or humiliation (109). When pediatricians offer guidance about child behavior and parenting practices, they may choose to offer information about effective discipline strategies to help parents teach their children acceptable behaviors and protect them from harm as well as describing the risks of harmful effects and the ineffectiveness of using corporal punishment to change longterm behavior. *No Hit Zones* are also being increasing used in children's hospitals and other places where families receive services (110).

Sexual abuse

The prime injury of sexual abuse is emotional. While most young children with proven sexual abuse have few physical injuries, behavioral and emotional problems, anogenital symptoms and sexually transmitted infections (STIs) have been identified and a history of sexual abuse has specifically been linked to sexual dysfunction and risk taking behaviors in adolescence and adulthood (111-114). Several large case series have been published, highlighting the normalcy of most examinations (115-116). Assessing sexual abuse requires detailed knowledge of anogenital anatomy and STIs in children, both of which have important differences from adults; specialized skills and examination techniques have had to be developed in this regard (118, 119). When confronted with concerns of potential sexual abuse, the pediatrician should obtain key elements of the history (such as type, frequency, and timing of contact) and physically assess the child for gross injuries or infection, particularly when trafficking is suspected (111, 112). There may be the need for forensic interviewing, STI and pregnancy testing and treatment, and collection of forensic evidence based on what has potentially occurred, when it occurred, the age and developmental ability of the child, and the resources available in the community (18, 111, 120, 121). Protocols have been developed, including the use of colposcopy, imaging, trauma informed care, telemedicine (122) and referral for formal comprehensive mental health assessment and treatment (111, 112, 123, 124).

Adolescents and sex trafficking

The issues surrounding sexual abuse are compounded during adolescence. Pediatricians should be knowledgeable about legal definitions and reporting requirements; they also should provide preventive counseling and screen adolescents for a history of assault, trafficking and emotional effects (106). Unwanted sexual contact and pregnancy places teenagers at increased risk for several health harms and has been associated with younger ages of sexual initiation and higher rates of depression, anxiety, substance abuse, and delinquency. Most rape and sexual assault in teenagers are perpetrated by an acquaintance or relative of the adolescent, with younger adolescents having assailants more likely from the extended family.

Human trafficking is a major global health and human rights problem, with victims reported in more than 100 countries (19). Traffickers target women and girls, and violence and psychological manipulation are common, with victims having increased risk of injury, sexual

assault, infectious diseases, substance misuse, pregnancy, untreated chronic medical conditions, malnutrition, post-traumatic stress disorder, major depression and other mental health disorders, homicide, and suicide. Adolescents have the greatest risk for commercial sex trafficking and exploitation.

CONCLUDING REMARKS AND FUTURE RESEARCH

The victimization of children and adolescents is wide-spread with lifelong harms. The personal and societal costs make a very strong case for prevention. More than 25 years ago, the US National Research Council of the Institute of Medicine published the report *Understanding child abuse and neglect* (125) that embraced a developmental and ecological perspective in examining the various dimensions of the problem of child maltreatment. The study panel offered a general conceptual, child-oriented framework to guide new approaches to child and family services as well as to set priorities. Since then, research has continued to expand. While the Office on Child Abuse and Neglect (formerly the National Center for Child Abuse and Neglect) within the US Department of Health and Human Services continues to support a modest research portfolio, other federal sponsors also invest in child maltreatment studies, including a national consortium on child neglect research organized by several institutes within the National Institutes of Health (13, 126).

Medical research studies have also had consistent increases in publication (127). The expansion of research in the neurosciences, including the development of new tools that are capable of imaging brain structures and functions, has advanced our understanding of the intricate and complex processes associated with the regulation of adverse stimuli (10, 81, 128). Additional biological studies, focused on other systems such as the immune function and interactions between genetic structures and the social environment, are shaping the ways in which researchers view complex interactions among threats and protective factors in forming the pathways to the consequences of child maltreatment. Research that is focused on selected childhood injuries, such as head trauma, has converged with studies of child maltreatment, especially in highlighting selected stages of development or child behaviors that may be especially vulnerable to particular forms of abuse or trauma among young children.

All of this will hopefully lead to enhanced child maltreatment prevention. By better understanding how CM occurs, whom it effects, when its harms occur in the developmental trajectory, and how it manifests during adolescence and adulthood, we can take steps to reduce it and mitigate its harms. We can do this through research which involves identifying children with increased risk, modifying risk factors, strengthening protective factors, designing and evaluating services for victimized children and their families, and studying the types of such services, their accessibility, costs, and ability to provide specialized care for child victims in the community and children in foster care. We can do this by realizing the importance of CM in our work, by integrating it into our practice, and by continually evaluating the accuracy and effectiveness of what we do (129). We can do this by providing services for everyone in a community structure that incorporates prevention, such as *Strong Communities* or *Prevention Zones* where the needs, risk and protective factors particular to the community can be addressed at the child, family and community levels (130).

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SECTION II: UNIVERSAL STRATEGIES

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Chapter 3

THE UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD AND THE PREVENTION OF CHILD MALTREATMENT IN THE UNITED STATES

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ABSTRACT

The United Nations Convention on the Rights of the Child was adopted in 1989, and represents the culmination of decades of advocacy for the recognition of children's basic human rights. The United States is the world's only country not to have adopted its tenets. It rejected doing so for two basic reason, concern over a loss of national sovereignty and a belief that the recognition of children's rights will diminish parents' rights. As it relates to the prevention of child maltreatment, the United States has ratified some of the Convention's supporting documents, particularly as they address the sexual abuse of children. Many provisions of US law exceed the requirements set out in the Convention.

INTRODUCTION

In 2005, in *Roper v Simmons*, the Supreme Court of the United States struck down as unconstitutional a law from the State of Missouri that allowed for the application of the death penalty to individuals under the age of 18 who commit murder. The death penalty, the Court reasoned, is always disproportionate to the crime when applied to juveniles (1). Before the *Roper* decision, in two cases decided in the late 1980s, the Court had established a rule that older teenagers could be executed for homicide crimes. In *Stanford v Kentucky*, the Court held that 16 or 17-year-olds could face the death sentence (2). Just a year later in *Thompson v.*

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Oklahoma, it ruled that 15-year-olds could not be put to death even for the commission of murder (3).

Some would argue that the death penalty imposed on children is the ultimate form of state sponsored child abuse. In *Roper*, the majority of the justices struck down the juvenile death penalty as being a form of cruel and unusual punishment and therefore barred by the Eighth Amendment to the Constitution of the United States. Justice Anthony Kennedy, writing for himself and four other justices, pointed out that, "Our determination that the death penalty is disproportionate punishment for offenders under 18 finds confirmation in the stark reality that the United States is the only country in the world that continues to give official sanction to the juvenile death penalty" (1). Kennedy then pointed out that Article 37 of the United Nations' Convention on the Rights of the Child ("CRC" or "the Convention"), by then adopted by all but two countries in the world, prohibits the imposition of the death penalty on children.

While it is not unusual for our highest court to consider international law in interpreting the vague generalities of our constitution—in *Roper* what constitutes "cruel and unusual punishment"—it is a controversial practice (4, 5) Justice Antonin Scalia dissented from the majority decision in *Roper*. Writing for himself and two other members of the Court, he railed against any consideration of international law when interpreting the US Constitution, particularly the CRC since Congress had not ratified the Convention. In his opinion, Scalia upbraided the five Justices in the majority for having the temerity to consider "the views of foreigners" or "alien law" when interpreting provisions of the Constitution of the United States (1). He began his rejoinder by noting that the US not ratified the CRC; additionally, when it did ratify the International Covenant on Civil and Political Rights in 1992, it did so with the reservation that the country maintained the right to impose capital punishment, something that document, too, inveighed against. Scalia argued that, "the basic premise of the court's argument—that American law should conform to the laws of the rest of the world—ought to be rejected out of hand" (1 p 624).

The CRC builds on the United Nations' broader commitment to "promote social progress and better standards of life in lager freedom" for all the people of the world (6 Preamble). The Convention recognizes that children need special care, attention and legal safeguards in order to grow and live their fullest lives and seeks to hold the governments of the world accountable for this elevated level of care. Given that the U.S. has never ratified the CRC— now the only country in the world that has not—what role does it play in child maltreatment prevention in the US?

After a brief discussion of the history of the CRC's development and adoption, and the process for ratification in the United States, this chapter provides an overview of what the Convention seeks to accomplish. With that foundation in place, the chapter turns its focus to the two Articles of the Convention focused primarily on child maltreatment, both of which have resulted in important supplementary documents that the US has ratified and adopted. First, the chapter examines Article 19, which addresses the physical, sexual and psychological abuse as well as neglect of children. To implement Article 19, the UN General Assembly adopted General Comment 13, which we will consider is some depth. Then we will consider Article 34, which focuses on sexual exploitation of children, particularly internationally. Article 34's provisions were elaborated upon by the General Assembly's adoption of the Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography, which, like General Comment 13, the US has adopted. In each instance, this text will address how US law incorporates these documents' provisions. Finally, the chapter will briefly consider some of the

major objections to the CRC. In doing so, several other articles of the Convention will be discussed in lesser detail.

BRIEF HISTORY

The adoption of the CRC by the United Nations (UN) on November 20, 1989, was the culmination of a sixty-five-year process of an expanding understanding of the needs and rights of children. That process began in the early 1900s, before the establishment of the United Nations. In 1924, the League of Nations, the precursor to today's UN, adopted the Geneva Declaration on the Rights of the Child, which addressed generally the child's need for development, to participate in society and for protection from economic exploitation. The international community founded the UN shortly after the conclusion of World War II, in October 1945, to work toward international peace and cooperation and to develop friendly relations among the nations of the world. The following year, the UN established the United Nations International Children's Emergency Fund (UNICEF), which focuses on the needs of the world's children. As articulated in its mission statement, UNICEF "strives to establish children's rights as enduring ethical principles and international standards of behavior towards children" (7 Mission Statement).

Three years after UNICEF's establishment, in 1948, the UN General Assembly adopted the Universal Declaration of Human Rights, several provisions of which protect children from various forms of harm and exploitation. Article 16, for instance, protects children from forced or underage marriage, while Article 25 recognizes that "motherhood and childhood are entitled to special care and assistance" and to "social protection" (8).

This sixty-year process of expanding recognition of the rights of children culminated in the General Assembly adoption the CRC on November 20, 1989. The Convention has been called "the world's most comprehensive framework for the protection of children's rights" (9). The CRC entered into force on September 2, 1990, after well more than the twenty countries necessary for it to take affect ratified its terms (6). Representatives from the United States were actively involved in drafting the CRC throughout the 1980s. Indeed, many of the CRC's provisions were derived from already existing legal doctrine in the United States (10). Despite overarching influence of the US in drafting the CRC, the US is the only one of the world's 196 countries that has not ratified the CRC. President Clinton did sign the Convention as a gesture of goodwill on February 16, 1995.

Since the General Assembly's adoption of the CRC, it has promulgated two supplemental documents relevant to this discussion. First, on May 25, 2000, the UN adopted the Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography, which was entered into force on January 18, 2002 (11). While the United States has not ratified the CRC, it did ratify this optional protocol on December 24, 2002.

The Optional Protocol (OP) was adopted because of concern about the increasing international trafficking in children, both for sale and for sexual exploitation. The states members were concerned about so-called "sex tourism," the phenomena of adults undertaking international travel in order to evade laws in their home countries that prohibit adults from engaging in sexual activities with children. They were also concerned about the involvement

of children in prostitution and the production of pornography. The Optional Protocol emphasizes the importance of public awareness and international cooperation to combat these heinous violations of children's rights. It details numerous requirements for states parties to undertake in an effort to reduce and eliminate the sexual exploitation of children as well as to address concerns about children being sold for labor, for illegal adoption and for organ donations.

Among its many provisions, the Optional Protocol defines terms and establishes a requirement that individual governments enact criminal laws aimed at implementing its provisions including prohibitions on the sale of children, child prostitution and child pornography. These forms of child maltreatment, the OP encourages, should be punished by appropriate penalties given their seriousness. Article 5 of the OP addresses extradition of individual perpetrators from one state party to another (e.g., from Cambodia to the United States), requiring that such offenders be extradited either where there are extradition treaties between the states parties or, where no such extradition treaty exists, establishes the OP as that treaty. The OP directs that states parties shall assist one another in investigating, prosecuting or seeking extradition of perpetrators. As part of the investigation of such cases, states parties agree to seize material or proceeds of such offenses, which seizures must be consistent with the law of the individual country. So, for example, if authorities in the United States are cooperating with authorities from another states party to the OP, those US authorities may seize evidence and proceeds consistent with US law, including the Fourth Amendment regarding search and seizure.

States parties must make efforts to protect the rights and interests of the exploited children, including when those children are witnesses to the crimes by which they are victimized. States commit to providing necessary services to child-victims of these forms of exploitation and abuse. The OP requires that professionals working on cases of international exploitation and trafficking of children be specially trained for this work.

In 2011, the Committee on the Rights of the Child promulgated General Comment 13: "The right of the child to freedom from all forms of violence" (GC 13) (12). The Committee took this action because of the persistence of violence perpetrated against children. GC 13 adds clarity and detail to the more general statement set out in Article 19. It also sought to incorporate findings from empirical research about violence perpetrated against children in the form of policy and technical guidance (13).

Ratification process

The Constitution of the United States assigns roles to the President and Congress in ratifying international treaties such as the CRC. It provides that the President "shall have Power, by and with the Advice and Consent of the Senate, to make Treaties, provided two-thirds of the Senators concur" (14). Thus, as suggested by the process used with the CRC, the executive branch of the federal government would negotiate the terms of a proposed treaty and would then submit it to Senate to seek its advice and consent. If ratified, the CRC, like other treaties, would become part of what the Constitution describes as "the supreme law of the land" (15).

By the beginning of 2015, all but three of the world's countries had adopted the CRC. In addition to the US, only Somalia and South Sudan were holdouts. By the end 2015, Somalia

and South Sudan had adopted the Convention, leaving the US as the only country in the world that has not ratified its provisions. The CRC celebrated its thirtieth anniversary in 2019.

What the CRC does

Building on this history, and specifically the Universal Declaration of Human Rights, which established the principle internationally that "childhood is entitled to special care and assistance," the CRC establishes aspirational goals for the care and protection of children around the world, recognizes children's basic humanity and declares that they are fundamentally entitled to dignity as human beings. The CRC addresses a broad array of issues impacting children and their development, ranging from economic, religious and political rights (e.g., freedom of association and assembly) to the right to be heard regarding issues impacting their care and welfare.

More specific to child maltreatment, the CRC requires that in all actions by public or private agencies, the child's best interests "shall be a primary consideration." It establishes the principle that children should be free from discrimination based upon race, sex, religion, national origin and the like. Further, it prohibits discrimination against children on the basis of the expression of political opinion by their parents or legal guardians. It seeks to guarantee children's rights across an array of circumstances while at the same time "respect[ing] the responsibilities, rights and duties of parents . . . members of the extended family or community . . . or other persons legally responsible for the child." It goes on to recognize the essential role adult caregivers play in guiding children in the exercise of their rights.

While recognizing the rights of children, the CRC reflects the principle that the family is the fundamental group in society, and it calls on the governments of the world to ensure that families have the resources they need in order to meet their children's needs. In relation to child maltreatment, because the family is the fundamental unit of society, children should not be removed from their families due to abuse or neglect except as is consistent with the law of the individual country and upon judicial review. The Convention requires that when removal from parents is necessary due to child maltreatment, both the child and his or her parents have the right to participate in the resultant judicial proceedings and to have their voice heard regarding the matter. When removal of a child due to maltreatment is necessary, children have the right to maintain family ties unless doing so would be contrary to their best interests. Particularly in any judicial or administrative proceeding, the Convention seeks to ensure that a "child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child" and provides for "the views of the child to be given due weight" in decision-making based upon his or her age and maturity.

With this background set out, this chapter will now turn its focus to two specific articles of the CRC most relevant to the prevention of child maltreatment.

Article 19

Article 19 focuses exclusively on child abuse and neglect, requiring that states parties take steps to prevent and respond to cases in which children are maltreated. It provides:

1. States Parties shall 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 or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.
2. Such protective measures should, as appropriate, 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 for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

To further elaborate on these requirements, on April 18, 2011, the UN Committee on the Rights of the Child (the Committee) issued General Comment No. 13 (GC 13), titled The Right of the Child to Freedom From All Forms of Violence" (12). The rationale offered by the Committee for issuing the Comment is that "the extent and intensity of violence exerted on children is alarming" and steps "to end violence must be massively strengthened and expanded in order to effectively end these practices."

In adopting GC 13, the Committee built on earlier commentary it had issued regarding the CRC, and, in particular, General Comment 8, issued in 2006, which addressed the child's right to be free from corporal punishment and other degrading or cruel forms of punishment. GC 13 is also built upon on a number of assumptions about children, their needs and the duties of their caregivers. Among these are that:

1. "No violence against children is justifiable; all violence against children is preventable;"
2. Children are rights-holders, entitled to dignity as well as physical and psychological integrity;
3. Primary prevention of violence against children "is of paramount importance;"
4. While families are essential to rearing children, most violence against children takes place within the family unit. Thus, families must be supported to prevent and when responding to violence against children.

GC 13 broadly defines violence against children to encompass physical abuse, neglect, sexual abuse, exploitation and psychological abuse. In order to address the needs of children, states parties are expected to provide necessary support to families so that children's basic needs may be met. Further, governments at every level, from national to local, have a duty to prevent and investigate instances of violence against children and to hold accountable those who perpetrate violence on children.

One important objective of the Committee in adopting General Comment No. 13 is to "overcome isolated, fragmented and reactive initiatives to address child caregiving and protection which have had limited impact on the prevention and elimination" of violence against children. Thus, the Committee made plain its view that primary prevention of child maltreatment is essential to the proper implementation of Article 19's mandate prohibiting all violence against children.

A basic difficulty acknowledged by the adoption of General Comment 13 is that while states parties have put in place many programs and legal frameworks to address the problem of violence against children, these are still inadequate because of gaps in both the law on the books and the law as implemented on the ground, that is, problems with enforcement. In the US, for example, so-called corporal punishment is still legal, though the practice is condemned both by GC 13 and by the earlier General Comment 8 (The Right of the Child to Protection from Corporal Punishment and Other Cruel or Degrading Forms of Punishment), which was adopted in 2006. Both criminal child abuse and civil child protection laws across the country routinely exclude from their application the physical punishment of children that does not, as defined in these laws, reach the level of child abuse. This has created the opportunity for some parents to attempt to justify truly horrendous acts of physical abuse as being nothing more than reasonable corporal punishment. As case in point, in 2014 the high profile professional football player Adrian Peterson asserted that he was merely applying corporal discipline to his four-year-old son when he beat him so savagely with a tree branch that the boy had numerous injuries on his legs, back and scrotum (16). Even after being charged with a felony and pleading guilty to misdemeanor assault, he forthrightly admitted that he continued to use implements such as belts to "discipline" his children (17). While the use of physical punishment, rooted as it is in Judeo-Christian religious philosophy (18), is still prevalent, there is a growing public discourse about its use, and wider recognition in the US that this form of "discipline" is harmful to children and ineffective as a parenting methodology (17, 19). Despite this, a number of states still permit the practice to be used by public and private school teachers (20), a practice that in 1977 the United States Supreme Court found did not violate children's constitutional or federal statutory rights (21). Courts, CPS agencies and scholars have weighed in in an effort to distinguish between "reasonable" corporal punishment inflicted upon a child and "child abuse" (22, 23).

Article 19 as elaborated by General Comment 13, however, makes clear that *any* form of violence against children is unacceptable, without regard to the rationale for its imposition. This blanket prohibition grows out of the recognition that children have the right to bodily integrity and respect for their basic human dignity rather than from an acknowledgement that perpetrating violence against children is not in their best interests. Thus, for example, even if some forms of violence against child might serve a useful purpose, it is nevertheless prohibited by the Convention. That is, the welfare of the child is irrelevant to the question. Thus, the General Comment (paragraph 24) prohibits corporal punishment despite the view of some that its administration may be in the child's best interests.

As is reflected in this position regarding corporal punishment, the General Comment makes clear that states parties must prohibit certain other violent cultural practices that may be harmful to children. These include, for example, female genital mutilation, scaring, burning or branding children and forced or early marriages. While the US has laws that prohibit some of these practices, those laws can be difficult to enforce. Regarding female genital mutilation, for example, in a high profile case from Michigan, United States v. Nagarwala, a doctor allegedly traveled between states to conduct the procedure at a clinic in suburban Detroit. Subsequently, she and several others were criminally charged with conducting the procedure and with related crimes. The federal court, however, dismissed the charges after finding the Congress had no authority to enact the statute under either international treaties or the Constitution of the United States (24). Similarly, in State v. Kargar, an Afghani immigrant was criminally charged with sexually assaulting his son after a neighbor child observed him kiss his son's penis and another neighbor saw a photograph him doing so in a family photo album. At trial, he presented a

cultural defense including expert testimony and other evidence detailing the cultural roots of the acts that lead to the charges. After he was convicted in the trial, he appealed. The Supreme Judicial Court of Maine ruled that the state's *de minims* statute, which provides relief from application of the criminal laws where there was little or no harm done, barred his prosecution (25). In so ruling, the state's high court recognized that the father's act of kissing his son's penis had its roots in cultural practice in his country of origin and, under these circumstances, any harm to the child was minimal.

Both Nagarwala and Kargar illustrate some of the difficulties in implementing laws intended to protect children. Kargar provided a form legal excuse for a practice that many in the US find offensive but that is longstanding in some cultures. The case suggests one concern that critics of the CRC advance: by adopting international treaties of this kind, the US may lose some modicum of its national sovereignty and the ability to define for itself acceptable and unacceptable behavior and to enforce its own laws. Critics fear that, in Scalia's words "foreign" influences may override or unduly impact the US's decision-making resulting in more outcomes like the Kargar case.

The Nagarwala case implicates a separate strand of difficulty in protecting children within to the US. Under our constitution, most criminal law is a state law matter rather than a question of federal law. In order to federalize criminal behavior, there must be an explicit authorization in the constitution. Unless individual states have adopted explicit laws prohibiting practices that are harmful to children, those children's victimization may go un-redressed.

A major method of addressing child maltreatment prevention under GC 13 is to encourage states parties to adopt a wide range of social policy and programming to support families. These range from financial assistance and programs to teach positive parenting to access to medical and childcare. GC 13 also seeks to protect children by requiting efforts to provide education. Another approach taken in the General Comment is a mandate that all professionals working with children—teachers, social workers, doctors, nurses, lawyers, judges among others—receive education regarding both the rights of children as outlined in Article 19 and how those mandates impact specific professions and professionals. Much of this will sound familiar to the reader.

Something that garners less attention is the role of children and youth in the mass media. GC 13 sets an expectation that states parties will implement laws, procedures and practices shielding young people from harmful media influences. This can be difficult and has had mixed results in the US. In 1968, the Supreme Court ruled that states can prohibit the sale of pornography to minors (26). While pornography is generally protected by the First Amendment, materials deemed "obscene" are not. States may define as "obscene" for purposes of sales to minors that which it could not so define for purposes of sale to adults. Therefore, it is not unconstitutional to criminally punish the sale of pornography to minors. Similarly, a state may define as obscene pornography that depicts actual children (27). However, materials that depict virtual children (i.e., animations) or materials that involve actual adults but that are pandered as involving children cannot be deemed obscene, and the government cannot, therefore, ban its sale or possession (28, 29). Prohibiting the sale of violent media to children can be difficult, as the State of California learned after it enacted a law that required parental permission before a minor could purchase violent video games. After it enacted such a law, a group of merchants filed a lawsuit challenging the law and seeking a restraining order to prevent it from taking effect on First Amendment free speech grounds. Every court that reviewed the case—the federal district court, the federal circuit court of appeals and the Supreme Court of

the United States—sided with the merchants and ruled that the law violated their Frist Amendment rights (30).

GC 13 contains provisions that address children not just as consumers of subjects of media but also as producers. It requires that states parties adopt policies that allow for the amplification of youthful voices in the media. Of interest here, National Public Radio, which is partially publicly funded, supports a project called YR Media, which develops media content produced by youth that is aimed at communicating information about young people, their lived experiences, culture influences and about matters of public policy (31).

GC 13 and Child Maltreatment Prevention

GC 13 includes a strong statement about the need for child maltreatment prevention as a critical element of the prevention of violence directed at children. It provides that:

> child protection must begin with proactive prevention of all forms of violence as well as explicitly prohibit all forms of violence. States have the obligation to adopt all measures necessary to ensure that adults responsible for the care, guidance and upbringing of children will respect and protect children's rights. Prevention includes public health and other measures to positively promote respectful child-rearing, free from violence, for all children, and to target the root causes of violence at the levels of the child, family, perpetrator, community, institution and society. Emphasis on general (primary) and targeted (secondary) prevention must remain paramount at all times in the development and implementation of child protection systems. Preventive measures offer the greatest return in the long term. However, commitment to prevention does not lessen States' obligations to respond effectively to violence when it occurs. (paragraph 46).

It follows this general statement of the need for and importance of prevention with an extensive list of programming states parties to the Convention should strive to implement in order to achieve the broad-based goal of preventing violence against children. Many of those aspirational program types—from prenatal care and home visiting to reporting mechanisms and professional education to identify risk factors—have been adopted in the United States and are discussed in other chapters throughout this book.

When children have been the victims of violence, GC 13 details the need for a continuum of child protection from investigation and intervention by public authorities to judicial involvement that, consistent with the needs of children, moves quickly while respecting the rights of all the parties to such a proceeding. Similarly, GC 13 recognizes a role for the criminal law in stopping child maltreatment. Penal laws "must be strictly applied in order to abolish the widespread practice of de jure or de facto impunity, in particular of state actors" (paragraph 55(c)). One rationale for the criminal punishment of a particular behavior is that through punishment both specific and general deterrence is accomplished. That is, criminal punishment is thought to deter the individual from repeating the prohibited behavior while also providing an example to other individuals of the consequences of engaging in the same behavior, thereby discouraging them from engaging in it.

Article 34

While Article 19 addresses child protection broadly, Article 34's focus is narrower, addressing the duty of governments to protect children from sexual maltreatment. It requires that states parties must "undertake to protect the child from all forms of sexual exploitation and sexual abuse," then goes on to provide that:

> For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:
>
> (a) The inducement or coercion of a child to engage in any unlawful sexual activity;
> (b) The exploitative use of children in prostitution or other unlawful sexual practices;
> (c) The exploitative use of children in pornographic performances and materials.

To elaborate on article 34 and related provisions of the CRC, the General Assembly adopted the Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography ("The Protocol). The Protocol entered into force on January 18, 2002, and the United States ratified it in December of that year. Congress then passed the Prosecutorial Remedies and Other Tools to End the Exploitation of Children Today Act of 2003 (the PROTECT Act), which the President signed into law on April 30, 2003. (32). Among other things, the PROTECT Act addresses the concerns set out in The Protocol, and restricts the production and distribution of child pornography, international child trafficking and "sex tourism."

The sexual abuse and exploitation of children has gone on throughout human history (33). The ease of international travel and technology have exacerbated the problem, expanding the mediums available to facilitate it and making it easier engage in across state and national boundaries. In July 1986, the United States Attorney General's Commission on Pornography published its final report, which detailed the Commission's grave concern about both the volume of child pornography and its impact on children and society (34). Both aspects of the problem have been exacerbated by the advent of the Internet and the expansion of electronic communications. Today, large numbers of children are exploited one way or another on-line and a tremendous amount of child pornographic material is available through this medium. This exploitation includes the exchange of photographs, videos and live streaming of sexual abuse (35). The sexual exploitation of children has been further exacerbated by the COVID-19 pandemic as children spend more time on-line and reporting the sexual exploitation of children has become more difficult (36).

Child sex trafficking

The PROTECT Act provides that a person who is convicted of knowingly transporting an individual who is a minor in either interstate or international commerce "with the intent that the individual engage in prostitution" or other sexual crime must be sentenced to prison for at least 10 years, and possibly for life (18 USC § 2423(a)).

Sex tourism

The PROTECT Act also provides for the imposition of criminal penalties upon any US citizen who travels in foreign commerce "with the motivating purpose of engaging in any illicit sexual conduct" (18 USC § 2423(b)). The relative ease of international travel has resulted in burgeoning market in international sexual tourism involving child-victims (37). Federal appellate court have upheld the law against various challenges, including that in enacting the law Congress exceeded its authority to regulate commerce with foreign nations, that the law violates due process and that it requires a person to engage in sexual relations with children "while" traveling (i.e., the US citizen need not simply be passing through the foreign country or there only for a brief period of time) (38, 39, 40, 41).

While PROTECT Act has been upheld in various situations involving international travel for the purpose of sexually abusing or exploiting children, this is not to suggest that the prosecution of these cases is by any means easy. Indeed, they present an array of practical problems that range from extraditing offenders back to the US to dealing with the complications of getting victims to the US to testify, which must be done in person in order to preserve the criminal defendant's constitutional right to confront witnesses (42).

Engaging in illicit sexual act in foreign countries

The PROTECT Act also prohibits a US citizen from engaging in illicit sexual acts in foreign countries, whether those acts are engaged in while the citizen is traveling or while he or she is living abroad (18 USC §2423(c)). In United States v Clark, the defendant, a US citizen, had been residing primarily in Cambodia between 1998 and 2003, though he made at least annual trips back to the US, owned property and had bank accounts in the US, and maintained a driver's license. After he was arrested while in the act of sexually assaulting two young boys, ages 10 and 13, he confessed to these acts as well as paying between 40 and 50 children to have sex with him over several years. He was extradited from Cambodia to the US where he was criminally charged under the PROTECT Act. Among arguments that he advanced against the statue was that it required that he literally be traveling in order to fall under its provisions. The Ninth Circuit Court of Appeals, however, held that although he resided primarily in Cambodia for several years, he was still subject to the provisions of the US federal law, in part because he regularly traveled between the US and Cambodia and had done so about two months before his arrest, stopping in Japan, Thailand and Malaysia along the way. Thus, it upheld his conviction.

Child pornography

The PROTECT Act defines "illicit sexual conduct" to include the "production of child pornography (18 USC 2423(f)(3)). Its application was challenged in United States v Park (38). In that case, Joseph Ricky Park, who had previously been convicted in the United States of sexual abuse of a child, was charged with the production of child pornography and sexual abuse of a child in Vietnam. Park supported himself as an English instructor while living and working in at least 15 different countries. He left many of those countries only after local authorities suspected him of engaging in sexually inappropriate behavior with children. In 2016, Park was

arrested and criminally charged. He challenged the constitutionally of the PROTECT Act's criminalization of his conduct in another country, arguing that its provisions exceeded Congress authority to regulate commerce with foreign nations. The United States Court of Appeals for the District of Columbia Circuit rejected Park's arguments, finding that the Congress's enactment of the PROTECT Act was legitimate under the treaty-making power of the federal government and that its provisions were rationally related to the demands of the Optional Protocol.

While sex trafficking and sex tourism have been relatively recent concerns for US law, domestic child pornography has been the focus of considerable attention over several decades. In the United States, the constitution protects the possession of pornography that is not considered obscene (19). As noted earlier in this chapter, however, the Supreme Court of the United States has ruled that pornography that involves children is obscene within the meaning of the law and therefore lacks the protection of the First Amendment (27). In New York v Ferber, a storeowner was convicted of selling films that depicted young boys masturbating. He appealed arguing that various First Amendment doctrines barred his conviction. A unanimous Supreme Court ruled that the government's interest in protecting children is of such critical importance that New York's law, which was carefully and narrowly written to protect children from exploitation, was constitutional. Thus, it concluded, there is no First Amendment right to sell child pornography, and Ferber's conviction was not unconstitutional. Similarly, while the constitution generally bars the state from convicting a citizen of a crime for the mere possession of obscene material (43), the state may prohibit and punish the mere possession of child pornography (44). Today, the production, distribution or possession of child pornography is banned across the nation. The invention of and ready access to the Internet, however, has led to a dramatic increase in the child pornographic material and has allowed it to be distributed clandestinely and with ease (45).

Each of these forms of child sexual exploitation are likely to present challenges to those seeking to protect children for decades, and the law's reactive efforts will always be insufficient to fully address the problem. The law seeks to prevent them primarily through the deterrence of harsh punishment. This is unlikely to result in any substantial decrease in this predatory behavior. Thus, members of the legal profession must work with professionals from other disciplines on prevention-focused efforts as discussed throughout this text in order to achieve any meaningful reduction in the sexual exploitation of children.

Objections to the CRC

Objections to the CRC seem to fall into two basic categories, national sovereignty and parents' rights. Some of the sovereignty concerns are set out in the beginning of this chapter. Here I will elaborate on the second objection.

Some critics of the CRC express concern that by ratifying this international treaty—and then enacting federal laws to implement it —guaranteeing children's rights will necessarily mean a diminution of parents' rights (10). They see "rights" as a zero sum game—if children have more, parents must necessarily have fewer. But in the context of preventing child maltreatment, this is not the case. Indeed an increased recognition of children's rights would in many ways increase the well-being of the entire family. These critics formulation also fails to consider how the notion of rights imposes duties on others. In a Hohfeldian sense, if a child has

a right to be cared for in a certain way, a duty is imposed upon some other to provide for the child in that way (46). Those duties would be imposed in the first instance upon the child's parents but also, secondarily, upon the state party—in the US, the federal government. This, however, t is already the case in the United States. American courts have recognized for nearly a century the right of the government as the ultimate guardian of the child to regulate certain parenting practices and to take action to protect and provide for a child when a parent cannot or will not (47). This is the legal doctrine of *parens patriae,* which forms the foundation for all child protection laws in the US.

Under this centuries old doctrine, the state has a duty to care for children subject in the first instance to the rights and duties of the child's parent to do so (48, 49). The CRC more than adequately balances the rights of parents to the care, custody and control of their children, with their duties to their children and the duty of the state (i.e., the community) to ultimately provide for those children whose parents cannot.

Among the concerns expressed by those who worry that adoption of the CRC would intrude on parental prerogatives in matters such as whether to vaccinate their children, the use of corporal punishment, whether children would have access to birth control over parental objection or without parental consent, and whether parents might choose homeschool for their children (10).

Article 7 of the CRC explicitly addresses these concerns. It establishes that a child has a right in the first instance be cared for by his or her parents and requires ratifying governments to implement the CRC "in accordance with their national laws." Thus, it is clear that the authors of the CRC intend for its provisions to be read and applied in a manner consistent with the law of any adopting state. In the U.S., this includes the right of the parent, absent a finding of unfitness, which is typically done through a proceeding alleging child maltreatment applying a predetermined process that protects the parents' due process rights. Reciprocal to the parents' rights as protected in Article 7, the CRC provides to the child a number of rights that are entirely consistent with these rights of parents. First, Article 5 provides that governments "shall respect the responsibilities, rights and duties of parents . . . or other persons legally responsible for the child, to provide . . . appropriate direction and guidance to the child" in the child's exercise of the rights in the CRC.

In the US, it has been nearly a century now since the Supreme Court first held that a parent had the right to direct his or her child's upbringing in Meyer v Nebraska (1923) (50). Since that seminal case, the Court has repeatedly made clear that parents have primary rights in relation to their children, which today is succinctly described as the right to "care, custody and control" of a child's upbringing. To be sure, the court has recognized that parents, in the exercise of their parental prerogatives vis-à-vis their children have a "high duty" to exercise their rights in a manner that will serve the welfare of the child (49). Thus, only in narrow, clearly defined circumstances or after there is a showing of parental unfitness in an adversarial legal proceeding, may the state engage in any consideration of what might serve a child's best interests (48).

If anything, in the US law, policy and practice regarding the protection of children from maltreatment may be overly deferential to parents' rights at the expense of children's safety and well-being (51, 52). One example of this is the tragic case of Joshua DeShaney (53). At the height of the family preservationist focus of the 1980s, child protective authorities in Illinois received repeated reports of abuse being perpetrated upon Joshua by his father. In the words of Supreme Court Justice Harry Blackmun, these authorities "took notes" but failed to take any

meaningful action to protect him from his father's violence. Ultimately, Joshua's father beat him so severely that he ended up permanently brain damaged. Joshua's mother brought a federal lawsuit against the Winnebago County Department of Social Services, alleging violations of Joshua's civil rights. The Supreme Court affirmed the trial court's order dismissing the case before trial because while the state stands in a *parens patriae* position, it is not required to act on its duty to abused and neglected children. This is but one of many examples of the sort of excessive deference to parents' exercise of their rights that are consistently seen in the child protection arena (54, 55, 56). Similarly, today homeschooling is virtually unregulated anywhere in the US, an extreme position that is rationalized as essential deference to parents' exercise of their rights to direct their children's educational upbringing, which, in some cases, allows child maltreatment to go undetected (52).

Article 9 recognizes that there may be cases of child maltreatment in which legal proceedings to protect a child from parental maltreatment may be necessary. The CRC allows a child to be removed from parental custody where doing so is in the child's best interests so long as that removal is accomplished only pursuant to law and is reviewable by a judicial officer. In the US, the state cannot override parental prerogatives based merely on the best interests of the child (48). Today in the US, the law plainly exceeds the minimum procedural requirements suggested by the CRC and is more deferential to parental rights. If the state or a private individual seeks to intervene into family life, they must allege and prove some specific act or acts of child maltreatment. Parents enjoy a panoply of procedural rights when allegations are made that they have abused or neglect their child. Frist, the parent is entitled to a hearing before a "neutral and detached" magistrate. He or she must receive written notice of what actions constitute the alleged maltreatment, which must to be filed with the court. The parent must be represented by a lawyer (including appointment of counsel in nearly every state at public expense if the parent cannot afford to hire his or her own lawyer). During a trial to determine whether the child was in fact abused or neglected, the parent is entitled to question witnesses against the parent, to review documents such as medical records and records held by state child protection authorities, and to bring witnesses on his or her own behalf. In many states, a parent is entitled to the appointment of expert witnesses at public expense to assist them in their defense (57). In some states, there is a right to have a jury of one's peers determine whether the parent maltreated their child.

Article 12 provides the child a right to express his or her views on all matters that affect the child if the child is capable of forming her or his own views. In the US, the federal Child Abuse Prevention and Treatment Act, which provides funding for state child protection systems, requires that children, through a guardian ad litem, must have a voice in child protection proceedings. In most states, the child is entitled to a court appointed attorney, whose role is to represent the child's expressed wishes. In other states, the attorney must represent the child's best interests as determined either by the lawyer or a guardian ad litem. Regardless of which role the child appointed representative plays, statutes or best practice guidelines provide that the advocate is to consider the child's expressed wishes and to weigh them in accordance with the child's developmental level and maturity (58). As these numerous procedural protections make clear, federal law in the US as well as the law in each of the states exceeds the requirements of the Convention.

CONCLUSION

The United States is the only country in the world that has not endorsed the United Nations Convention on the Rights of the Child, which seeks, in part, to protect the world's children from maltreatment. Courts and commentators in the US, concerned about the nation's sovereignty, are skeptical of the role of international treaties and international law in determining how the American law should be interpreted and applied. A growing recognition of children's rights is thought to diminish the rights of parents. These factors suggest that the US is unlikely to ratify the Convention anytime soon.

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Chapter 4

FEDERAL FUNDING AND THE PREVENTION OF CHILD MALTREATMENT

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ABSTRACT

Child maltreatment is a major social problem in the United States. The government, the Supreme Court has ruled, has a compelling interest in the welfare of children. To address these needs, federalism assigns to the individual states the responsibility of addressing child maltreatment how they will. To respond to and prevent incidences of child abuse and neglect in a more uniform way, Congress has enacted a number of laws that provide funding to the individual states if they respond to child maltreatment consistent with the federal funding statutes. These statutes seek to prevent child maltreatment either directly, as is the case with the Child Abuse Prevention and Treatment Act, or indirectly, through a number of statutes aimed at supporting and strengthening families.

INTRODUCTION

Child maltreatment is a major social problem in the United States (US). In fiscal year 2018, the last year for which statistics are currently available, children's protective services agencies in the United States received some 4.3 million reports of suspected child maltreatment involving approximately 7.8 million children. Some 3.5 million children were the subjects of either an investigation or an alternative response. After investigation, about 678,000 children were determined to be "victims," which means that that after investigation one or more forms of child abuse or neglect were either "substantiated" or "indicated." Additionally, an estimated 1770 incidences of child maltreatment resulted in a child fatality (1).

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While estimates of the economic costs of child abuse and neglect vary widely depending upon how they are assessed, it is clear that they are substantial. A study published in 2018 that examined federal data from the 2015 fiscal year, for example, estimated the per victim costs to range in the US from $210,00 to $831,000 and the population costs of substantiated cases (482,000 non-fatal and 1670 fatal) cases to be $428 billion. Costs range from the provision of social and economic supports to maltreating families, from increased health care costs to increased costs for necessary services when children must enter the child protection system (2). The impacts of child maltreatment are pervasive, affecting every aspect of society as well as government at the national, state and local levels. In addition to economic costs, child maltreatment has substantial human and social costs. For example, child maltreatment has long been linked to numerous poor outcomes later in life. Among these are poorer physical health, increased need for mental health services, decreased cognitive capacity, increased substance abuse, and increased juvenile delinquency and criminal justice system involvement in adulthood (3-5).

Preventing child maltreatment and its sequelae requires a multisectoral approach, including a comprehensive legal scheme aimed at supporting families, deterring child maltreatment and, at times, imposing criminal sanctions (5). American law has provided for a response to child maltreatment since the earliest days of the republic. Before the Civil War (1861-1865), local authorities assumed responsibility for responding to abuse and neglect perpetrated on children. Beginning in 1909 and continuing throughout the 20th Century, the role of the federal government in protecting children from maltreatment has expanded dramatically (6).

BASIC LAW

The Supreme Court of the United States has repeatedly held that the state has a compelling interest in the welfare of its child-citizens. In a series of cases dating to 1923, the Court has held that while parents have the right to make decisions regarding the parenting of their children, governmental officials may intervene into the family in order to protect children from harm and ensure that they receive a minimum level of care, guidance and education (7). This basic principle has been extended to the child abuse and neglect context in several cases addressing the balancing of the rights of children, their parents and state officials (8). Today the law recognizes that the state has civil authority to intervene into family life in order to protect children from abusive or neglectful harm inflicted by parents or others legally responsible for the child's safety and well-being.

The United States is a federal system of government consisting of a central, federal government and individual governments within each state or commonwealth and territories (e.g., Puerto Rico, Washington, DC). The Constitution enumerates certain powers that belong exclusively to the federal government and prohibits states from taking certain actions (e.g., entering into treaties with other countries). All powers not assigned to the federal government or denied to the states, the Constitution leaves to the individual states and their people. Absent an interstate component (e.g., an interstate human trafficking ring including children) or the use of telephones or computers to accomplish such a scheme, matters of family relations generally fall within lawmaking purview of state governments. For this reason, state laws govern the substance of child maltreatment and its prevention, and there may be wide variation from state-

to-state in what constitutes child maltreatment and how a state may seek to prevent harm done to children by abuse or neglect.

That is not to say that the federal government plays no role in addressing the scourge of child maltreatment. Indeed, today, despite our federal system, the federal government plays a predominant role in the prevention of child abuse and neglect. Rather than do so directly, however, it influences the field indirectly, through the spending power grated to Congress by the Article II, Section 8 of the Constitution. To accomplish its goals, the federal government creates incentive programs that provide substantial financial support to states for prevention programming, but only if they meet certain prerequisites established by statute or federal regulation. The executive branch agency responsible for implementing this federal funding program is the Department of Health and Human Services.

Broadly speaking, the federal government spends money to prevent child maltreatment in two ways. It spends directly on programing aimed at primary, secondary and tertiary prevention of various forms of child abuse or neglect, which is administered by the Department of Health and Human Services (DHHS). Although these funding statutes establish an elaborate framework that is intended to benefit children and families, the courts have held that they do not create an enforceable right to any individual. Rather, their purpose is to provide funding at a systemic level (9, 10). Despite the establishment of such programs, a state's child protection agency is not required to take any particular action on behalf of an individual child or family (11).

The federal government also spends money indirectly to support families. The majority of cases of child maltreatment fall into the category of "neglect." Child "neglect" may involve a range of causes—parental substance abuse, failure to provide adequate food, clothing, shelter and medical care, exposure to domestic violence in the home-- and harms or potential harms to children. Many of these social maladies are addressed through a variety of programming aimed at child and family well-being that are administered by various executive branch agencies ranging from DHHS to the Department of Agriculture.

DIRECT PREVENTION PROGRAMS

The federal government's two leading direct funding programs aimed at the primary and secondary prevention child maltreatment are the Child Abuse Prevention and Treatment Act 1974 (US) (CAPTA) and the Maternal, Infant and Early Childhood Home Visiting Program (Home Visiting). In addition to these programs, since 1980, Title IV-B of the Social Security Act provides federal funding to states agencies to support tertiary prevention and family preservation efforts. Most recently, in 2018 federal law was amended to permit the use of Title IV-E dollars—which have traditionally been available to support the foster care placement of children who could not be safely maintained in their homes—to prevent foster care placement.

CAPTA

Title II of CAPTA established what is known today as Community Based Grants for the Prevention of Child Abuse and Neglect (10). Title II funding provided to states and Indian

tribes "support community-based efforts . . . to prevent child abuse and neglect" and "to support the coordination of resources and activities aimed at strengthening families and prevention child abuse and neglect." Further, the Community Based Grants programs seeks "to foster an understanding, appreciation, and knowledge of diverse populations in order to be effective in preventing and treating child abuse and neglect."

The governor of each state receiving these funds must designate an agency—which may be a public agency (e.g., state department of health and human services, a quasi-public agency or a private non-profit agency—to receive and administer the funds. The state recipient must focus on programming that is "accessible, effective, culturally appropriate and [that] builds on existing strengths" in order to assist families, and provide early and comprehensive support for parents. Among other requirements, programs should focus on aiding parents, particularly young parents and parents with young children, in developing effective, non-abusive parenting skills. The individual states should provide programming for parents parenting special needs children and should specifically offer respite care to these families. The law encourages the development of a continuum of services aimed at the prevention of child maltreatment. The law also seeks to use federal funding to leverage other funding from state and local governments as well as private sector funders.

Title II dollars flow from the federal government to the designated state agency and then into local community programming. All but three states—Delaware, Illinois and Florida—have established Children's Trust Fund programs that focus on child maltreatment prevention. About one-half of the states use their Children's Trust Fund as a conduit to move federal child abuse prevention funding to local communities. For example, Missouri's Children's Trust Fund, a non-profit organization established by the state legislature in 1983, administers its Title II funding. It also receives a portion of its funding from state marriage license fees, from private donations though a check off on state tax returns and from the sale of specialized automobile license plates (13).

Title II requires that consumers of these community-based programs must be involved in policy and programming decisions. Thus both parents who are consumers of the funded prevention services and adult former victims of child abuse or neglect must be actively involved in the planning, delivery and evaluation of prevention programming at the community level.

In addition to Title II's prevention programming, CAPTA, as amended, requires that each state that receives funds must establish at least three citizen review panels (CRP). Each panel must consist of a membership that is "broadly representative of the community." The purpose of the CRPs is to "evaluate the extent to which State and local child protection system agencies are effectively discharging their child protection responsibilities." In order to carry out these functions, the federal law grants CRPs access to otherwise confidential information in the possession of the state agency. A number of states have established CRPs that focus specifically on the state's efforts to prevent child abuse and neglect. These panels typically meet at least quarterly and report to state authorities at least annually regarding prevention programming in the state (14).

Home visiting

The Home Visiting Program provides federal dollars to states in order to provide support services to pregnant women and their young children in communities deemed to be at risk for

a plethora of social maladies, including several that could elevate the risk of child abuse or neglect. The program's goals are "to improve coordination of services for at-risk communities" and "to identify and provide comprehensive services to improve outcomes for families who reside in at risk communities."

In order to receive support from the Home Visiting Program, states must conduct a needs assessment for the purpose of identifying eligible communities. These include communities with elevated levels of, among other social problems, poverty, domestic violence, substance abuse, unemployment and child maltreatment. The assessment must also evaluate the ability of existing programs in these communities to meet the needs of children and families through home visiting as well as gaps in the need for such programming. The resources available to meet substance abuse treatment and counseling needs must also be considered.

To retain the grant under the program, the individual state, tribe or other entity receiving the funding must demonstrate quantifiable and measurable improvements in the functioning of the individual families with which the program works. These improvements must in one or more of the following areas:

- Improved maternal and newborn health.
- Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits.
- Improvement in school readiness and achievement.
- Reduction in crime or domestic violence.
- Improvements in family economic self-sufficiency.
- Improvements in the coordination and referrals for other community resources and supports.

The program was allocated $400 million per year each year from 2018 – 2022. In fiscal year 2018, the program made grants totaling $351 million to 56 states, tribes or non-profit organizations. In 2019, the program served more than 154,000 parents and children, which included more than one million home visits (20).

Title IV-B

In addition to CAPTA and Home Visiting Program's focus on primary and secondary prevention-focused services, the federal government also provides funding to states and federally recognized Indian tribes to address tertiary prevention. It does so through Title IV-B of the Social Security Act, which was added to the federal law by the Adoption Assistance and Child Welfare Act of 1980 (15). Title IV-B focuses on the preservation of families that CPS has determined have experienced child abuse or neglect but for whom removal of the children into the foster care system is not mandated by law or required to ensure the children's safety. The intent of this program is to prevent further maltreatment and to preserve the abused or neglected child's family.

Among other things, Title IV-B seeks "to promote State flexibility in the development and expansion of coordinated child and family services program that utilize community-based agencies and ensures all children are raised in safe, loving families by-- . . . (2) preventing the

abuse, neglect or exploitation of children; [and] (3) supporting at-risk families through services which allow children, where appropriate, to remain safely with their families or return to their families in a timely manner. . . .” To the maximum extent possible, these services must be coordinated with the primary and secondary prevention services funded by CAPTA.

The federal government’s tertiary prevention efforts were further expanded by the adoption of the Family Fist Prevention Services Act 2018 (FFPAS), which allows states to utilize Title IV-E funds, which had previously been available to support children who had to be removed from their homes and placed into the foster care system. States can now use Title IV-E dollars to keep these “candidates for foster care” in their homes. That is, to the extent that the law, despite its title, focuses on prevention, that focus is on the prevention of moving children into the foster care system, and, at most, tertiary prevention of maltreatment. More specifically, the FFPSA allows Title IV-E funding to support in home parenting skills programming as well as services aimed at addressing parents’ mental health and substance abuse treatment needs. Unlike Title IV-B, which is a program with capped funding, Title IV-E is open-ended; it does not limit the amount of money available to the states. While this program is too new at the time of this writing to fully evaluate, there is reason to be concerned that it will focus too much on family preservation while paying insufficient attention to child safety and well-being (16). For example, the law permits state agencies to be partially reimbursed for expenditures on programs that research has demonstrated to be effective in keeping children safe while keeping children in their homes. But programs with highly questionable research support have been included among those the federal government will support (17). At a broad policy level, this includes, particularly, the use of differential response, which has been adopted by CAPTA as a primary approach to child protection despite a lack of empirical basis to support its effectiveness and concern that it may endanger children’s safety (18, 19).

INDIRECT PREVENTION PROGRAMS

An array of social problems experienced by parents—e.g., substance use disorders, developmental disabilities, mental illness— have been linked to child maltreatment. Poverty is among the strongest in this regard, though, of course, most poor parents neither abuse nor neglect their children. Poverty is, however, linked to the incidences of both child abuse and child neglect. It also correlates with the severity of maltreatment children experience. Leroy Pelton, one of the nation’s leading scholars of the linkage between poverty and child maltreatment has proposed two pathways by which poverty may lead some parents to maltreat their children. First, poverty leads parents to experience stress and anger, which may in turn increase maltreatment. Pelton’s second pathway is more direct. Poverty leads to material deprivation when parents cannot provide a minimally necessary level of care, resulting in child endangerment and harm (21).

Similarly, the World Health Organization has noted that “child maltreatment is more frequent among poorer communities and households” and concludes, therefore, that “Measures to reduce poverty and economic inequalities ought thus to have significant effects in reducing child maltreatment” (5). The US has an array of federal programs, administered by various governmental agencies, aimed at ameliorating poverty and its impacts on families and children.

These range from cash assistance to housing subsidies, from food assistance to medical insurance. What follows is a brief summary of a number of these programs and, to the extent currently available, information regarding their impact on child maltreatment.

Paid family leave

One primary approach to prevention, illustrated in part by home visiting programs, is to strengthen parent-child bonding and assist new parents in understanding and coping with the new challenges presented by parenting. Public policies that allow parents, and particularly mothers, to take extended leaves from work after giving birth or adopting a child provide a host of positive benefits that redound to the benefit of children. Among other things, such policies allow for better parent-child bonding and may reduce economic pressure on families (22).

In 1993, Congress passed and the President signed into law the Family Medical Leave Act (FMLA). The FMLA provides that certain private employers must allow employees to take unpaid time off after the birth or adoption of a child without losing their job. While this program is helpful for those families able to access the benefits, research suggests that it would be more helpful in preventing child maltreatment if it were accessible for more families (23).

For example, programs that provide new parent leave with even partial income levels have shown promise for reducing child maltreatment. Such programs have been shown to positively correlate with decreased incidences of child maltreatment, particularly cases of abusive head trauma (AHT), a leading cause of mortality and morbidity among infants and toddlers. Klevens and her colleagues examined the link between California's 2002 Paid Family Leave Act (PFLA), which guarantees new parents partially paid leave of absence at the time of birth, and the incidences of AHT. Examining data from the years 1999-2011, they found significantly fewer cases of hospital admission resulting from AHT after the enactment of the PFLA. While comparison states saw an increase of cases of AHT during the great recession that began with the collapse of the stock market in 2008, California's incidence of AHT did not increase (24). Because of positive benefits such as those identified in California, a number of states have adopted paid leave policies (e.g., Connecticut, New York, Oregon).

Although family leave programs, whether paid or unpaid, are required by law, they are privately funded and implemented. Research suggests that various publically funded family support programs play an important role in the lives of children who come into contact with the child protection system. Slack and her colleagues at the University of Wisconsin found that 82.4% of the abused and neglected children who entered Milwaukee's foster care system benefited from one or more of these programs before their removal from home while more than 30% of those children were the beneficiaries of at least three of the following programs (43).

Basic income

Because much child maltreatment is linked to impoverishment, federal programs aimed at ameliorating childhood poverty play an important role in preventing child abuse and neglect.

Child support

A parent has both a moral and a legal duty to provide financial support to his or her child until the child reaches the age of majority or is legally emancipated (25, 26). As such, every state has codified a parental duty of support (e.g., Ohio Revised Code Annotated § 3109.031, 2001) and the federal government has enacted the Child Support Recovery Act (18 USC § 228, 1992), which may be enforced through criminal as well as civil sanctions (24). A parent's failure to meet his or her obligation of support for their child is vitally important to the community because in the absence of such support, children may become dependent on the state, adding an unnecessary burden to the public fisc (25).

Temporary assistance for needy families

When parents cannot or will not support their children, state authorities must step in in an effort to ensure that children's minimal needs for food, clothing and shelter are met. Signed into law in 1996, the Temporary Assistance for Needy Families (TANF) program replaced Aid to Families with Dependent Children, which had been in effect since the New Deal in 1935. TANF provides a time-limited basic income (i.e., cash assistance) to families living in poverty. Whereas AFDC was an open-ended entitlement program, meaning states would be reimbursed the full costs of providing assistance to eligible families, TANF is a block grant program with a limited grant to the individual states. Among TANFs purposes are to: provide assistance to needy families so that children can be cared for in their own homes or the homes of relatives," reduce out of wedlock births and to encourage two parent families. States may impose work requirements or other contingencies on a TANF grant. Most TANF beneficiaries are children who live with their parents, but a significant number of these children live with relatives, some because they have experienced child maltreatment (15). According to the Congressional Research Service, in September of 2018, 2.3 million children living in 1.2 million families were supported, in part, by the TANF program (29). At the time TANF was adopted, experts predicted there would be an increase in child maltreatment as a result (27). This, those experts argued would result in part because the TANF program includes more aggressive sanctioning for things like failure to obtain employment or be involved in a job training programs than did the AFDC program. A study from Illinois published a decade after TANF's enactment found that while sanctioning was significantly related to increased CPS investigations, it was not associated with an increases in substantiation or indication rates (33). By the mid 2000s, confirmation rates for child maltreatments had begun to drops, so it seems those predictions do not appear to have borne out (28).

FOOD INSECURITY

The law requires that parents provide to their children the basic necessities of life, including an adequate diet. Failure to do so may be considered "nutritional neglect" (30). State child protection laws (e.g., Mich Comp Law Ann 722.622) routinely define a parent's failure to provide a child with proper nutrition as an actionable form of neglect. To address the needs of

children and families facing food insecurity, the federal government has established several programs, three of which will be discussed here.

SNAP

The Supplemental Nutritional Assistance Program is an entitlement program run by the United States Department of Agriculture. Formally called the food stamps program, SNAP is a means-tested program that provides monetary assistance to families to enable them to purchase eligible food items. It is the federal government's largest nutritional assistance program, providing food assistance to nearly 1 in 4 American children. In 2016, some $44 billion in assistance was provided to families with children through the SNAP program (31).

National School Lunch Program

The NSLP, which like SNAP is administered by the Department of Agriculture, is the second largest program for nutritional assistance in the country. A $13.8 billion program that provides free (for children living in families at or below 130% of the poverty rate) or low cost lunches (to those in families up to 185% of the poverty rate), it provides needed nutritional support to nearly 30 million American schoolchildren each day.

WIC

The Special Supplemental Nutritional Program for Women, Infants, and Children (WIC) program provides nutritional support to low income pregnant women and their children through age five. WIC provides nutritional supports for approximately seven million women, infants and young children annually. In addition to providing for nutritional needs—including breastfeeding supports—to women and children, the service works to identify other needs families have and makes referrals for additional health care and social services. Research demonstrates that participation in the WIC program has a range of benefits from increased birth weights to better diets and improved intellectual development (32). Participation in the WIC program—alone or in combination with participation in what is now called SNAP—is associated with a lowered risk of child maltreatment (34).

MEDICAL INSURANCE

State child protection laws generally include the failure to provide a child timely and necessary medical care as neglect (35). Arizona, for example, defines child "neglect" as "The inability or unwillingness of a parent . . . to provide that child with . . . medical care if that inability or unwillingness causes unreasonable risk of harm to the child's health or welfare, except if the inability of a parent . . . to provide services to meet the needs of a child with a disability or chronic illness is solely the result of the unavailability of reasonable services" (Ariz Rev Stat §

8-201(25)). To address the needs of impoverished children and their families for access to medical care, the federal government established a number of programs.

Medicaid

Medicaid is a federally funded, state administered individual entitlement program that provides medical coverage to adults and children. Because the program is administered by the states, the coverage and specific benefits available vary from jurisdiction to jurisdiction. States must cover pregnant women and children up to age 19 whose family income is at or below 138 percent of the federally recognized poverty line. Pursuant to the Affordable Care Act (ACA), individual states may choose to extend Medicaid funding to those children and families up 185 percent of the poverty level.

All enrollees must be provided a suite of services including hospitalization, lab and x-ray services, family planning and pregnancy-related services. Recipients who are under 21 must also be provided early and periodic screenings services such as routine physical exams, immunizations, and lead screening as needed to address their health care needs. States may elect to cover additional items, such as dental care and eyeglasses. The ACA also requires that minimum benefits include mental health and prescription drug coverage (15).

As of January 2020, Medicaid covered nearly 64 million Americans, 36.3 million of which were children (36, 39). The expansion of services that resulted from the enactment of the ACA appears to have had a positive impact on reducing the rates of child maltreatment in states that have chosen to extend benefits (37).

State Children's Health Insurance Program (CHIP)

The CHIP program provides medical insurance coverage to children whose families earn too much to qualify for Medicaid coverage. Established 1997, the program has been reauthorized several times since. It was last reauthorized in February 2018 by legislation that extends the program through fiscal year 2023. CHIP is a block grant program that encourages individual states to extend health coverage to children by paying the majority of the court for that extension. Funding for the program will increase from 21.5 billion in fiscal year 2018 to $25.9 billion in fiscal year 2023 (38). The CHIP program covered 9.6 million children in fiscal year 2018 (39).

Affordable Care Act

The 2010 Affordable Care Act amended Title V of the Social Security Act to establish the Maternal, Infant, and Early Childhood Home-Visiting Program, which provides federal funding to support one of the nation's most successful child maltreatment prevention programs. This program provides grants to states to support evidence-based home visiting programs (i.e., those that show statistically significant impacts on outcome measures such as increased screening for domestic violence and decreases in child maltreatment). The program was explicitly adopted

to prevent, in addition to other health risks, substance abuse—including prenatal drug exposure—and child maltreatment.

The law also established a program to evaluate the programs through which the funding for home visiting funds are funneled and the effectiveness and impact of the new federal support program. According to a 2017 report by the Bipartisan Policy Center, the evaluation determined that in fiscal year 2015, the program provided $400 million in federal funding in addition to the money states were spending on home visiting ($500- $750 million). The program funded services to 145,000 additional parents and children in communities with high rates of poverty, child maltreatment and premature birth (40).

HOUSING

In most states, it is considered child neglect for a parent to fail to provide a child minimally adequate housing when that failure is not the result of poverty alone. Florida law, for example, provides that "'neglect' occurs when a child is deprived of . . . necessary . . . shelter . . . when such deprivation . . . caused the child's physical, mental or emotional health to be significantly impaired" so long as that deprivation is not "caused primarily" by poverty unless services to address the need for shelter have been offered and rejected (Fla Stat Ann 39.01, 2020).

The federal government's Housing Choice Voucher Program—known colloquially as "Section 8" (so named because it is established by Section 8 of the United States Housing Act of 1937, 42 USC §§1437-1440)—helps very low-income families to afford housing. The program, which is administered by local housing agencies with funds provided by the federal Department of Housing and Urban Development, allows recipients to choose their own housing unit. The unit may be a house or an apartment, but must meet certain minimum standards as established by the local housing authority. Once approved, the program pays the property's owner directly. Eligible families must pay 30% of their income for rent and utilities (41).

Section 8 vouchers are paid on behalf of 1 million families with 2.2 million children. "The children whose families benefit from these vouchers are healthier and live more stable lives. Children in homeless families that receive housing vouchers change schools less often and are 42% less likely to be separated from their families and placed into foster care. Their families are also 20% less likely to be food insecure and 34% less likely to experience domestic violence" (42).

SUBSTANCE ABUSE AND MENTAL HEALTH

Parental substance use and mental health disorders play substantial roles in child maltreatment, individually and in combination with one another.

The abuse of alcohol and/or illicit drugs has long been linked to child maltreatment. Parents who abuse these substances are more likely to maltreat their children. CPS agencies report that between one- and two-thirds of substantiated cases of maltreatment involve parental substance abuse. These parents tend to be less attentive to their children's emotional needs and cues, discipline their children less effectively and more harshly, and fail to meet their children's material needs for food, clothing and shelter. At the same time, these parents' children tend to

have difficult temperaments and high levels of energy, and to fall in the low-normal range of intellectual, social and emotional functioning. Children born exposed to substances tend to have a number of direct and indirect problems in functioning. Eighty-percent of the states have reported that parental substance abuse is one of the two most prevalent problems faced CPS agencies (44-47). Similarly, when a parent experiences mental illness, his or her children are placed at increased risk of maltreatment (48).

The federal government, through the Substance Abuse and Mental Health Services Administration expends substantial amounts of money each year on numerous programs in an effort to prevent and treat substance use and mental health disorders, which are, unfortunately, frequently co-morbid in the child protection population. In fiscal year 2017, the Substance Abuse and Mental Health Services Administration budgeted $3.9 billion to address these issues (49). Given the well-documented linkages of these co-occurring disorders to child maltreatment, primary and tertiary prevention efforts aimed at their reduction should reduce the incidences of child maltreatment.

CONCLUSION

While substantive child protection law is the responsibility of the individual states, the federal government exerts enormous control over child maltreatment prevention through its spending power. It exercises that power both directly, through numerous funding programs designed to address prevention at the primary, secondary and tertiary level. Through indirect programs that address the underlying causes of much child maltreatment, federal programming also seeks to reduce the incidences of child maltreatment and to ameliorate its consequences.

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Chapter 5

PATHWAYS TO PREVENTION: *PREVENTION ZONES* AS A STRATEGY FOR MAKING PROGRESS IN CHILD MALTREATMENT PREVENTION

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ABSTRACT

Our collective body of knowledge about child maltreatment tells us that if we truly want to prevent child maltreatment and promote positive outcomes for most children, this goal is not likely to be achieved through the use of CPS processes and criminal prosecution alone. Delivering parent and caregiver support through communities, such as through home visits, in groups, and through comprehensive programs, is one of the seven strategies for ending violence against children internationally. We need to focus on the problem of child maltreatment more holistically, and that if the goal is to promote the best outcomes for children and families by preventing child maltreatment, focusing on prevention is vital. In this chapter, our goal is to begin to unpack that question and to offer some potential guidance to professionals and policymakers. We first explore some of the policy history of our current child maltreatment system in an attempt to understand why, historically, prevention has been unable to take root and flourish. Then, we turn to the present to analyze how the latest research can help inform us about what type of child maltreatment prevention works, and how well—even for the most serious cases of child abuse like Abusive Head Trauma. Finally, we strive to begin a discussion about where child

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maltreatment prevention can go from here by tying in some observations from the history of the system and from the collected knowledge base. We discuss a particularly promising strategy—*Prevention Zones*—that we think can make progress by avoiding or overcoming historical barriers without compromising the safety of even our most vulnerable children.

INTRODUCTION

Our collective body of knowledge about child maltreatment tells us that if we truly want to prevent child maltreatment and promote positive outcomes for most children, this goal is not likely to be achieved through the use of CPS processes and criminal prosecution alone (1). Afterall, CPS intervention was designed to prevent the continuation of abuse or neglect and to ameliorate immediate safety threats, not to continually promote a child's long-term development. The US Committee on the Assessment of Family Violence Interventions identified three initiatives that effectively address the complex interactions of risk and protective factors, multiple problems, and environmental effects has on family violence. These three initiatives are 1) service integration, 2) comprehensive services focused on separate problems sharing common risk factors, and 3) community-change interventions targeting social attitudes, behaviors, and networks (2). Delivering parent and caregiver support through communities, such as through home visits, in groups, and through comprehensive programs, is one of the seven strategies for ending violence against children internationally (3). US Advisory Board on Child Abuse and Neglect member Dr Richard Krugman called for significant structural change in how our government services function and a "quantum leap" in our ability to deliver services to abused and neglected children and their families in order for this occur (4).

In short, professionals and policy-makers alike agree that we need to focus on the problem of child maltreatment more holistically, and that if the goal is to promote the best outcomes for children and families by preventing child maltreatment, actually focusing on prevention is vital. So, if child maltreatment prevention is a theory that is supported and researchers continue to agree that it will work—why can't it seem to find the foothold necessary for it to thrive?

In this chapter, our goal is to begin to unpack that question and to offer some potential guidance to professionals and policymakers who also choose to explore it with us. First, we'll look to the past, exploring some of the policy history of our current child maltreatment system in an attempt to understand, why, historically, prevention has been unable to take root and flourish. Then, we turn to the present to analyze how the latest research can help inform us about what type of child maltreatment prevention works, and how well—even for the most serious cases of child abuse like abusive head trauma (AHT). Finally, we strive to begin a discussion about where child maltreatment prevention can go from here by tying in some observations from the history of the system and from the collected knowledge base. Of note, we discuss a particularly promising strategy—*Prevention Zones*—that we think has the opportunity to progress the prevention arena by avoiding or overcoming historical obstacles to which prior policies have succumbed, while not compromising the safety of even our most at-risk and vulnerable children.

THE PAST: LEARNING FROM OUR "FAILURES"

Understanding the history of how our system developed gives us potential clues for why most prevention programs have been unsuccessful in sustaining the necessary support, thereby allowing future prevention endeavors the opportunity to learn from these past "failures."

Before Henry Kempe's article (5) "The battered child syndrome" was published in the 1960s, the history of child maltreatment was dominated by a focus on child neglect and child delinquency as they both stemmed from poverty. For the first 100 years of US history, child abuse was largely ignored by most of the major movements related to child maltreatment programming and policy. Historically, however, child maltreatment was usually *perceived* as a social issue and legal issue that is addressed primarily by Child Protective Services (CPS) and the courts, with services for children firmly rooted in community supportive services as well as in criminal or social justice systems (6).

Beginning in colonial America, the goal of the child maltreatment system was not necessarily centered on the desire to ensure that children were safe and cared for. Instead, efforts were more aimed to ensure that these neglected and dependent children did not grow up to become adult criminals who would wreak havoc on the societies in which they lived (7). At this time in history, the term "children's rights" would have been a non-sequitur (8). Additionally, prevention of child maltreatment was not the goal *per se* of this early system either. If prevention can faithfully be applied to it at all, it is the prevention of criminality, not child maltreatment. Based on this focus, it is less surprising that there evolved no structured system aimed at preventing child maltreatment from occurring in the first place. During most of the 19th century, intervention by the state into the lives of children and families did occur, but, like in colonial America, only in instances of delinquency or dependency caused by poverty. Efforts in this era featured the House of Refuge Movement and state-funded Reformatories, both of which focused on removal and reform of poor children, often placing them in labor-intensive situations where they were treated similar to indentured servants (7,9). As the 19th century came to a close, this focus on neglect and delinquency as a means to prevent future criminality continued. By this time, state legislatures and courts had created a system of family law and intervention focused on saving poor children through removal and placement, irrelevant of the potential rights of the parent or children's' liberty interests (7).

Effort at prevention truly began at the turn of the 20th century when the federal government started to take interest in, and exerted influence over, child maltreatment programming that was happening at the state and local level. Child abuse was still not the focus of these burgeoning federal efforts, and leeway was still very much left to individual states and localities. The Great Depression led the federal government to realize that an uncoordinated state based response was no longer adequate to ensure the wellbeing of poor children, and the US Children's Bureau (CB) argued successfully that it was the responsibility of the federal government to aid states and localities in the funding, organization, and delivery of social services. As part of this campaign, the CB drafted and advocated for the adoption of what would come to be known as the "Aid to Dependent Children Act" (ADC, or, as it is better known and would become to be named in the future, the "Aid for Families with Dependent Children Act," or the AFDC). As originally intended, AFDC intended to provide funding to intervene in situations involving "neglected and dependent children in danger of becoming delinquent," but the program as passed looked *much* different than the program that was proposed.

As originally designed, the program was meant to operate with the highest social work standards, offering personal casework services to single mothers as well as cash stipends. Casework services were included in the original legislation not only because mother-headed families were thought to be problematic and in need of assistance, but also because the drafters of the legislation thought there was potential for services to help remove ADC recipients from the stigma of public assistance (10). Participation in the program was intended to be mandatory, and federal oversight was intended to ensure equal treatment to applicants, regardless of race or marital status.

However, faced with political pressures related to passing legislation, the lack of adequate resources, and given little to no authority to require that state programming was held to any reasonable standard of efficacy, many of the highlight-features of the ADFC that were originally designed to ameliorate problems exacerbating childhood dependency neglect—including casework services and stricter federal oversight—were removed. Thus, even though early federal energy in child maltreatment seemed to be trending toward laying the groundwork for an effective, holistic system to support services for families in need, this possibility was quickly dashed. Instead, the ADFC operated much like a private charity, providing minimal funding and support to states and localities, who continued to bear the weight of developing, organizing, and implementing programs and interventions as they saw fit.

While this world of traditional child welfare (e.g., social work) was never regulated, standardized, or funded, on the other hand, the world of child protection was all of those things from the start. When pediatricians identified the battered child syndrome, Americans expressed outrage. Congress passed the Child Abuse Prevention and Treatment Act (CAPTA) in 1974 with bipartisan support (11). Administration of services under the ADCF changed dramatically. CAPTA required that, in order to get federal funding for services, states must create agencies to manage all facets of receiving reports of, identifying, and providing services for abused children. Throughout the country, states rushed to establish child protective services (CPS) agencies.

Because there was no federal mandate to provide a basic level of standardized programming for child welfare agencies, and because at the time, perhaps it just seemed to make sense, in many states, these new child protection agencies replaced, or were co-mingled with, traditional child welfare agencies that had been providing material support for the poor since the New Deal (11). In New York City, for example, the New York Society for the Prevention of Cruelty to Children, which had been acting to protect children was replaced by a city agency in that role (6). In many jurisdictions, agency referrals from AFDC to CPS were made primarily when, in spite of the provision of financial aid and supportive social services, parents were still incapable or unwilling to meet their children's safety needs as a result of drug abuse, family violence, mental health issues, etc. The defining criteria for such referrals was the need for authoritative intervention to ensure the children's safety and well-being.

Fast forward to today. Over the years, piecemeal programming has attempted to revitalize community prevention (12). Yet, our current mixed system of universal and professional reporting and mandatory services has not decreased child maltreatment deaths (13, 14) and contradicts knowledge that higher levels of community involvement and organization are associated with lower levels of aggression and violence (15), and a more positive perception of community social control is associated with lower levels of physical assault (16).

THE PRESENT: WHAT DOES PREVENTION RESEARCH SAY?

Effective operationalizing child maltreatment prevention necessitates the continued development of effective prevention science programs and strategies to appropriately organize and execute implementation processes. As prevention science has progressed, our ability to better define and articulate important variables has allowed for a more nuanced approach to child maltreatment prevention.

First, academics and researchers distinguished prevention strategies or frameworks from child prevention program and models. Strategies and frameworks provide general guidance on the "who, when, where, and what of child maltreatment prevention" (17). Programs and models are components of a strategy or framework that allow for particular areas of that strategy or framework to be executed or implemented (17).

Next, the development of theories related to the levels of prevention interventions allows for more sophisticated program design and application. The original conceptualization of the levels of prevention was proposed by Caplan in 1964. He laid out three different levels: primary, secondary, and tertiary (18). *Primary* prevention refers to programs or services that occur prior to any occurrence of maltreatment and aimed at the larger population. *Secondary* prevention refers to programs developed to serve specific populations where there are known risk factors for abuse, but where there still has not been an occurrence of maltreatment. *Tertiary* prevention refers to programs and services that target individuals when there has already been an occurrence of maltreatment. Decades later, Gordon criticized Caplan's prevention levels concept, claiming that it only served to confuse and limit professionals and forced them to conform programs to a conceptual system that did not make sense (19). To remedy his perceived problem, he laid out another set of terminology, also with three levels, but that focused, he claimed, on populations rather than timing. Gordon's levels of prevention include *universal* prevention, which includes programs developed for the entire population; *selective* prevention, which includes programs developed for a targeted population with "evident characteristics" (age, sex, or culture), and; *indicated* prevention, which includes programs targeted to populations with a known risk factor for maltreatment (19).

A better understanding of the risk and protective factors related to all types of child maltreatment allows for more targeted program development and the greater potential that programs can be designed to be more effective. Risk factors for child maltreatment are characteristics located at the individual, family, and community level in an ecological model that increase the probability that child maltreatment will occur. At each level, research has identified risk factors that are unique to each level. Additionally, risk factors from each of these levels interact and influence each other, with the possibility that compounded risk factors, like a child who cries more often along with a parent who is more reactive to adverse stimuli, may have a multiplying effect on overall risk (20). Furthermore, research demonstrates that different types of child maltreatment each have different risk factors across all levels (21). Protective factors are conditions or attributes (skills, strengths, resources, supports or coping strategies) in individuals, families, communities or the larger society that help people deal more effectively with stressful events and mitigate or eliminate risk of child maltreatment in families and communities. Some moderate the effects of various risk factors such as intimate partner violence (IPV) and depression (22) as a "counterweight" in that they buffer the impact of their effects such as toxic stress (23). Protective factors also fall along the lines of both intrapersonal

and sociological factors (22) with one of the most profound protective factors being individual resilience.

At the intersection of family and community levels, this boils down to whether or not families have their concrete basic needs met, including food, shelter, housing, utilities, self-care and child care (22). With specific regards to one for of maltreatment, abusive head trauma (AHT), neighborhood effects have been consistently reported (24), with low neighborhood socioeconomic status (SES) being associated with higher levels of AHT and neglect. Indeed, in many countries, health and injury-related outcomes proportionately improve as people's social status increases (25). For that reason, moving out of poverty can have major impacts on children's risk of exposure to child abuse and neglect (26, 27), with a clear example of increased child support payments being linked to reduced risk for child maltreatment (26). In the opposite direction, reducing child welfare benefits has been associated with increased child welfare reports (27). At the macro level, public policies, such as those associated with Earned Income Tax Credit (EITC), have the possibility of reducing the stressors associated with financial insecurity to provide parents with more psychological "room" to engage in the types of nurturing and positive parenting behaviors that link to positive outcomes for children (28).

What's more, as our knowledge continues to increase, professionals and researchers have been able to better and more thoroughly identify and define patterns and characteristics present in both the most effective prevention strategies and programs. For strategies, Klika et al. (17) point out that a search of extant prevention strategies highlights at least six key recommendations related to approaching child maltreatment prevention: 1) focus must be oriented to not only removing risk factors, but also to promoting protective factors; 2) child maltreatment prevention is not generally about fixing bad parents, but instead, creating the circumstances in which parents can be good parents; 3) no one disciplinary field within the larger child maltreatment field can, alone, prevent child maltreatment; 4) understanding social norms as they relate to child maltreatment can serve as a lynchpin for change at the outer layers of social ecology; 5) any programming should be based on evidence, if if that is not available, there must be a solid logic model or theory of change, and; 6) child maltreatment prevention requires sustained commit tenets through policy and resource allocation (17). Similarly, researchers and academics have observed trends related to characteristics of effective child maltreatment prevention programming. Mikton & Burchart (29) summarized seven main types of interventions (home visiting, parent education, child sex abuse prevention, abusive head trauma prevention, multi-component interventions, media-based interventions, and support and mutual aid groups) and find that four (home-visiting, parent education, abusive head trauma prevention and multi-component interventions) showed promise in preventing actual child maltreatment. Meritt, Maquire-Jack and Negash (21) distilled potential best practices that underlying the most successful programs, including a strong theory of change and measurable outcomes; clear guidance for duration and dosage, strategies for reaching -specifically target populations; cultural sensitivity; and implementation and fidelity evaluations. (21).

For both prevention strategies and programs, the concept of community has traditionally been important for maltreatment prevention (30-33). In general, researchers continue to find that some of the most efficacious prevention programs and strategies are community-based or community focused. Programmatically, there is a large and growing body of research regarding the efficacy of home visiting (34, 35). The literature detailing the harms of corporal punishment is quite extensive, "No Hit Zones" have been offered as a means of reducing physical abuse in

the community, and the literature detailing the harms of corporal punishment is quite extensive (36).

Finally, the research designs used in prevention research have also evolved to include observational studies (e.g., case reports or other comparisons, with or without controls) that are analyzed prospectively or retrospectively without any intervention by the investigators) and experimental studies (in which the effects of an intervention are measured). Qualitative designs have been used to generate new knowledge or validate existing knowledge by using methods such as surveys or focus groups. As our knowledge improved in the 21st century, there was more use of rigorous prospective, controlled, and randomized clinical trials and systematic reviews, particularly for certain types of outcomes (37). A validity hierarchy has been proposed with randomized controlled trials and meta-analyses offering the highest level of evidence, and the American Academy of Pediatrics (AAP) proposed four levels of aggregate evidence quality (A-D) for classifying evidence for the development of clinical guidelines (38). Systems have been developed to assess the level of evidence for particular injuries or issues, with five levels and multiple sublevels having been used internationally (39, 40).

Yet, with all of this progress, it's important to remember that, at best, research can only guarantee that, at best, certain prevention strategies and programs show promise. The field has yet to concretely establish effectiveness with certainty (41). From the standpoint of program evaluation, research generally concludes that additional empirical evidence is necessary, especially if we wish to further develop promising approaches to be effective at preventing even the most severe types of abuse (41).

OUR 2019 SEMI-STRUCTURED REVIEW OF PREVENTING SERIOUS CHILD MALTREATMENT

Prevention strategies must show promise and strong theoretical foundations for being effective at preventing not only the types of maltreatment more generally associated with prevention efforts, like neglect and dependency, but also for addressing more severe types of maltreatment, like AHT. Additionally, as we noted earlier, despite all the progress that has been made related to child maltreatment prevention, only a small amount of child abuse prevention research to date has been performed with more sophisticated designs or that establishes certainty regarding theoretical effectiveness. And, as noted by the US Commission to Eliminate Child Abuse and Neglect Fatalities, even fewer studies establish clear and convincing evidence that they are effective at preventing more serious forms of maltreatment (42).

To more adequately understand the atmosphere of prevention as it relates to more serious forms of child abuse like AHT, the authors of this chapter embarked on a quasi-systematic review on prevention programs aimed at preventing AHT in 2019. We conducted a semi-structured review of prevention programs aimed at preventing this severe form of child maltreatment (43). Our database search resulted in 53 articles published from January 2000 through August 2019 that met inclusion requirements. This was fewer than three studies per year. By looking at the previous research reviews on AHT prevention as well as at the articles selected for inclusion from our database search, it appears that programs are clustered around three different categories based on the specific "type" of prevention utilized: 1) parent education; 2) community/public health interventions, and; 3) professional education. For our

review specifically, the majority of included articles (30) discussed various aspects of parent education programs, with the remaining articles discussing programs focused on community factors and services (14) and professional education and practice (9).

Our results failed to yield any obvious answers about the best programs for preventing the more serious types of child maltreatment in categories: I (parent education) and III (professional practice and education, but we were hopeful about the strong theoretical and correlation value we found in most of the studies falling in category II (community/public health interventions), suggesting that community-level interventions—like community-wide knowledge campaigns or socio-economically oriented efforts—could potentially prove to be both cost effective and effective at achieving preventing outcomes.

Within the research included in category II, we found studies looking at general knowledge about AHT (44), community factors such as the economic downturns, and the availability of resources, as well as analyses of cost savings of prevention as compared to medical and other costs. Some of these category II studies had samples coming from diverse populations. The effects of interventions in the U.S. such as an earned income tax credit and paid family leave were also examined (45, 46). Community-wide universal prevention through media campaigns was also assessed (47) as well as a universal public health intervention (48).

Our results support the idea that community-based or community-focused strategies show promise for preventing even the most severe forms of abuse. It appears that the current level of evidence is great enough to suggest *at least* a correlative relationship between economic hardship and an increase in incidence of severe child maltreatment. Conclusions also indicate that material benefit programs and education programs, particularly if offered during recessions, may help to counter an increase in rates of maltreatment. The promise embodied in these types of prevention programs is at least partially unsurprising. As we discussed above, the community has traditionally been an important focal point for maltreatment prevention (30-33).

Further, our research also suggests that money spent on these community-level strategies is likely money well-spent, leading to an overall reduction in the economic cost of severe abuse. However, to ensure that money is spent on the most effective programs leading to the most desired outcomes, more research needs to be conducted to isolate what the most effective material benefits could be and what types of programming, during what type of economic environment, would produce the best results.

In sum, both our review and other prevention research continues to support the idea that rates of more severe forms of child maltreatment, like AHT, are related to community strengths and economic resources (15, 45, 46, 49-51). Even though the relationships between variables and outcomes continues to be correlational in nature, we believe the strong theoretical foundations of these programs and the growing cache of evaluation research makes community-level programs worthy of a continued and reinvigorated focus.

THE FUTURE: IDEAS TO CONSIDER, INCLUDING THE *PREVENTION ZONES* STRATEGY

So where should researchers, practitioners, and policymakers go from here? Do we really think it is possible that even the most severe forms of child maltreatment, like AHT, can be

prevented? From the information we collected as a result of our quasi-systematic review, as well as the analysis of other research and of other systemic reviews, there is still an insufficient amount of empirical research to support the idea that prevention programming is 100% likely to be effective at preventing more serious types of child maltreatment while ensuring that at-risk children remain safe. However, even though our results failed to yield clear-cut, certain answers, they did reflect a small but relatively strong research-base for certain types of community-level prevention strategies. At the very least, our exploration into this area of child maltreatment yielded some potential areas of focus for future efforts at developing effective strategies and programming, which we will discuss below.

A promising strategy: *Prevention Zones*

In 1991, the federal government heeded the calls of professionals and academics for a more structured and holistic approach to child maltreatment prevention. Towards that goal, they initiated the US Advisory Board on Child Abuse and Neglect (30, 52). In 1993, the Advisory Board outlined a multi-disciplinary approach towards the prevention of child abuse and neglect in the community. According to Krugman (4) "caring is not enough" and despite well-intentioned efforts to make a difference or concern for the well-being of children, systematic and cross discipline approaches were needed.

The 1993 US Advisory Board on Child Abuse and Neglect's *Neighbors helping neighbors: A new national strategy for the protection of children* (30) is our preferred strategy or framework due to extensive research evidence to support its promise and logic model, and because it is targeted to communities where there are identified risks for child maltreatment. The report called for a new national strategy to prevent child abuse that was neighborhood-based and child and family centered, with the focus on strengthening communities. Programming based on this model were rigorously studied and evaluated.It included 34 recommendations for national child protection policy. These programs were to be: 1) comprehensive; 2) neighborhood-based; 3) child-centered; and 4) family-focused. Specific elements of the strategy included: 1) strengthening neighborhoods; 2) reorienting the delivery of human services; 3) improving the government's role in controlling child maltreatment; 4) reorienting societal values that contribute to child maltreatment; and 5) strengthening and broadening knowledge about child maltreatment. These elements had been or were to be implemented internationally (31).

The top priority recommendation of the Advisory Board was to develop programs that facilitated the development and safety of neighborhoods by establishing *prevention zones* to improve social and physical environments with high rates of child maltreatment (30). The report points out that threat to family and neighborhood integrity are concurrent with higher rates of abuse and neglect. Neighborhoods with higher rates of maltreatment are fragmented, and many residents in these neighborhoods don't know the name or identity of a single one of their neighbors (33). Similarly, controlling for income levels and ethnic composition, neighborhoods that residents regard as "scary, bad places to live" have higher rates of child maltreatment than do neighborhoods that residents regard in a more positive light (32).

Prevention Zones are described as comprehensive efforts to improve the social and physical environments in declining neighborhoods with high rates of child maltreatment. These model neighborhoods should be diverse in geography, population density, and ethnicity, and

should feature enhanced law enforcement, social services, and economic development efforts, coupled and coordinated to produce simultaneously basic safety and security, employment opportunities, and family psycho-social support (30).

Based on what we know about child maltreatment prevention and our observations related to why, historically, prevention has been unable to achieve a necessary level of sustained support, *Prevention Zones* appear to be uniquely situated to overcome hurdles and be effective at preventing all types of child maltreatment without putting our most at-risk children directly in harm's way. *Prevention Zones* is community focused, and, although more research is needed, the theoretical foundations of community focused and community-based prevention programming is widely supported by professionals and academics alike. The flexibility of application and potential programming provides the opportunity for this strategy to adequately meet all of the six characteristics Klika, Lee and Lee (17) identified as being central to developing effective prevention strategies. The flexibility of the strategy allows for a universal application that is more nuanced, or targeted, to meet the needs of specific populations. This idea of targeted universalism is not commonly applied to child maltreatment prevention programming, but through *Prevention Zones* and similar strategies, this type of policy and program development is well-poised to avoid the social and political pitfalls that have proven fatal historically.

Targeted universalism is a framework that was designed to address community cohesiveness by encouraging "belonging" and preventing "othering" (53). Although it was designed specifically to prevent racial bias or discrimination, its focus on identifying overarching community values, but requiring flexibility in how we ensure different populations achieve those values, allows for the flexibility prevention research calls for, as well as the ability to avoid the damaging effects of implicit biases of all types in the policy arena. Our country is embroiled in an era of political polarity, and human psychology primes us to see and evaluate policies using binary methods of thought. For prevention, we see this in a binary battle between universal or targeted strategies or programs. Universal solutions enjoy increased levels of legitimacy related to being fair for all those impacted, but they are often viewed as too costly and hard to immediately evaluate in order to justify the perceived high cost. On the other hand, targeted solutions might be more efficient, but are often viewed as being unfair, as one group receives services and benefits that are different than other groups, leading to resentment and lack of support in the policy arena.

Integrating healthcare to treat the environment and the patient

We theorize a collective, connective and socially engaging model that puts the lives of the family first, with the goal of preventing proximal violence such as child maltreatment while simultaneously enhancing parenting skills and community connections. Ultimately, the developmental trajectory of a child (within a community) is contingent upon safety, nurturance, parent skills, and social support integrated with health care. Ongoing relationships with medical providers provide the critical link for families transitioning from young adults to parents within the community. The endpoint of person in context development is the treatment of both the social ecological systems that contribute to the conditions that cause illness and abuse as well as the individuals who exist within those systems. In accordance with that philosophical and ethical standpoint, we argue that an important focus is healthcare institutions being actors

within the community and treating both individual and societal illnesses by enhancing parenting and integrating partnerships within communities.

The importance of coordinating multi-approach, multi-sector solutions

Effective child maltreatment prevention programs would need to involve coordination of multiple approaches, across multiple sectors, including strengths-based approaches focused on economic and social empowerment. As it stands currently, our system is almost completely reliant on CPS to handle all cases of child maltreatment. However, CPS intervention was designed to prevent continuation of abuse and immediate safety threats, not to promote a child's long-term developmental needs (54). CPS intervention was also never intended to handle dependency neglect and non-intentional neglect that stems from poverty.

In an assessment of family violence prevention and treatment programs, the US Committee on the Assessment of Family Violence Interventions identified three complementary initiatives that effectively address the complex interactions of risk and protective factors, multiple problems, and environmental effects on family violence. These were: (a) service integration, (b) comprehensive services focused on separate problems sharing common risk factors (cross-problem interventions), and (c) community-change interventions targeting social attitudes, behaviors, and networks (2). Any strategy for preventing child maltreatment should address both internal and external dimensions and focus simultaneously on strengthening at-risk families and improving at-risk neighborhoods (55). It appears that researchers now have a duty to expand our portfolios of prevention research for more severe types of child maltreatment by fostering clinical trials on multimodal interventions to counterbalance the overwhelming number of correlative studies (56).

ALIGNING POLICY WITH PURPOSE

Part of the struggle for strengths-based prevention programming is the inability to support its continuous development, strong implementation, and quality evaluation, all of which are necessary to sustain effective, efficient maltreatment prevention (17). Reviewing and reflecting on the history of the child maltreatment system in the US reveals that part of the problem—a huge part of the problem—is that the current system was not proactively designed to support the sub-structures—like funding streams—that would be necessary to sustain such a complex system.

It is important to examine how we might improve strengths-based community programming, but we must examine why even our most promising programs have failed. As this analysis has shown, the catalogue of strengths-based prevention programming includes many successful interventions. Research about the characteristics and methods of these successful programs provides us with an ever-increasing ability to craft new, ever more effective programs. Academics and policymakers across the field continue to be dumbfounded the lack of support for these programs, especially as research continues to show they are effective, necessary, and even cost-saving over time. From a policy perspective, we must consider what works and what doesn't work at a macro-level. Without this analysis, it's

unlikely that we can sustain or support implementation of these important programs, or that, in response, we are likely to achieve the goal of preventing all forms of child maltreatment.

The United States is at the eve of implementing a newly enacted piece of federal legislation —the Family First Prevention Act (FFPA)—that experts hope will help provide more flexible funding opportunities for prevention programming. But, it's not a fix; it's simply another swing of the pendulum. Implicit in the language of the bill, even the name, is the suggestion that the new goal of the entire child maltreatment field should be to keep kids out of foster care and to put "families first." What about child safety? It is unacceptable to ignore the potential effect that this legislation could have for CPS and the children whose safety relies on their services. Those who cannot learn from history are destined to repeat it, and here we are, repeating, once again, the mission-shifts heralded by previous legislation. We must advocate for a redesigned system that reflects what both history and research have told us is the best way to achieve maximum prevention of child maltreatment, while at the same time, ensuring that the most at-risk children are protected.

The power of definition

Currently, there is no one single definition of child abuse or child neglect. Each state has its own, and there are extreme variations among states. While there are some similarities, it is possible to develop a more standardized, robust definition that states could all adopt. The opportunity to define a problem, from a policy standpoint, is an opportunity imbued with an immense amount of power and influence. The first people to identify a problem often shape how others will perceive it (57). This is extremely evident in how the federal response to child maltreatment developed, starting with Kempe's "discovery" of child abuse in the 1960s.

As initially defined by Kempe, child maltreatment was a very tightly defined, self-contained problem: "A clinical condition in young children who receive serious physical abuse, generally from a parent or a foster parent" (5). Not only was the harm to children presented in a straight-forward, non-controversial manner, but the location of the blame was placed on an individual, usually the parent or caregiver of the child, who was thought to have serious psychological problems. CAPTA as it was initially conceived, was not supposed to address anything related to unintentional child neglect. On the floor of the US Senate, Walter Mondale went to great lengths to indicate this—yet somehow it got included (57). Worse is that CAPTA did not provide required standardized definitions; they left that up to the states to decide.

As mentioned above, somehow, child neglect made its way into the formal federal definition of child maltreatment, regardless of the fact that it was not initially welcome or planned for. As politics go, concessions were made, and neglect was included, even though the entire purpose and strategy of the bill was to tackle the entirely different phenomenon of abuse. Due, in part, to this very narrow, uncontroversial definition, legislation related to fixing child abuse was passed quickly and with ease (57).

It is hard to say that history would have changed had neglect not been included in CAPTA in 1974. Perhaps an entirely different system would have been developed and implemented—one that would work in concert with CPS—with the purposefully designed structural makeup necessary to deal with unintentional child neglect. Maybe that system would have been charged with researching, creating, and implementing programs that sought to alleviate risk factors inherent to family systems and communities. Maybe the hundreds of thousands of children who

are neglected each year would have decreased in number by now, leaving our CPS agencies to deal with the serious immediate risks to children, as was intended. Perhaps increased funding streams would have developed organically, and in ways to better fit the observed rates of child abuse and neglect, and we would actually be spending less to achieving better outcomes. It is hard to say with certainty, but it's absolutely not impossible to imagine.

Not only are the contents of a definition important, but the choice of how to record it or where it will "live" is also a powerful choice. The definition of child maltreatment in the US is primarily a legal definition, located within each state's set of laws. The legal definition of child abuse and neglect is what CPS relies on as a threshold for if, when, and how to be involved in the life of an at-risk child and their family. And, as the system is arranged, CPS is the gatekeeper to programs and services for all abused and neglected children. Not only that, but because the definition is a part of law, and one that is always linked to the state's criminal code, it's no wonder that there is a stigma around any program that even touches the words "child maltreatment." Violating that law is something you get "punished" for (under a state's "penal" code), which associates you with a crime, thus making your actions criminal, whether they are or not. Regardless, it is time to quit this piecemeal program design and implementation, and we've got to start with the simple, small things like creating common definitions that work across all disciplines and professions. Things and knowledge may change, and these definitions may need to change in the future, but at least we would all know from where we are starting.

Ensure adequate funding

Another thing to take away from the history of child maltreatment in the US is that when the federal government attaches funds to something, states generally take notice. One of the strengths of the programming that was created around CAPTA is that states were quick to act and strove to meet requirements that the federal legislation conditioned with federal monies. As the history of child maltreatment in the US illustrated, funding related to child welfare has never come with strings attached that were related to prevention program or system development or outcome evaluation. It is not a surprise that state-based child welfare programs seemed to be second-class concerns once CAPTA was implemented.

There have been plenty of calls to increase funding for prevention. The most recent piece of federal legislation, the Family First Prevention Act, will attempt to do just that. Maintaining adequate funding levels of ensure high-quality implementation remains a challenge, with the majority of funds provided to tertiary prevention rather than primary prevention (17). The history of US resistance toward welfare-oriented funding initiatives should make this unsurprising. Researchers and policymakers need to collaborate to on how to increase public support for welfare-type initiatives, most preferably on the grounds that it is an ethical social choice. In contrast, many advocates attempt to only use an economic argument to support increasing welfare funding, but that is a flawed argument on which to rely. By selling family preservation services on the grounds that they could save states the costs of out-of-home care, advocates essentially set these services up for failure; out-of-home care could always be prevented simply by closing the door to entry into care. The challenge is to sell family support and early intervention services to the public on the grounds that they can contribute to improved family and community functioning and enhanced child development. Such primary prevention alone should be a valued social goal (58).

Researchers and academics often discuss the need to shift the balance in funding, but this should be done with care (17). In lieu of the development of new funding sources earmarked specifically for prevention, removing necessary funding from the CPS, which functions much like the emergency room of child maltreatment, could have devastating consequences, especially if the programs that assume that funding are not faithfully vetted and evaluated for effectiveness. Probably the best path forward is to ensure that, when considering future funding opportunities, the field finds a way to advocate for dual funding of child welfare and primary/secondary prevention (addressed below) and to avoid placing child welfare dollars in competition with prevention dollars (17). Recent history is wrought with examples of policies that pit child protection and child welfare against one another. The most obvious proof of this is how it requires the two systems to compete for the same already inadequate, pool of funding. Based on the collective body of research, academics across all fields of research in child maltreatment remind us that it's imperative that the entire maltreatment community advocate for the dual objectives of family preservation AND child protection (58).

Ensure quality evaluation

It is time for the federal government—and for all of us—to get *really* serious about ensuring quality evaluation. This is true whether any large-scale systemic overhauls are possible or not. Many innovations in child welfare have not been linked to evidence. It seems to be the trend that the field is happy to embrace reforms simply on merit of their ability to reform, and administrators appear to be easily swayed by program branding in lieu of evidence of effectiveness (59).

This is especially true with regards to prevention programming. With all the calls for the need for a public health framework, policy makers and program designers need to be sure that they adopt all aspects of the public health framework, including the absolute necessity that programs are evaluated for effectiveness prior to and during implementation. It is hard to imagine rolling out a more traditional public health intervention without evidence of effectiveness. Think about the initiative to encourage hand washing—what if someone called for it to be replaced with a program that claimed NOT washing your hands was more effective? The ramifications of such a program could be devastating, and people could become sick or even die. It seems so ludicrous that it is almost unimaginable any such program would be adopted without sufficient evidence of its effectiveness. The ramifications of child maltreatment prevention programs failing due to lack of evidence or evaluation are not different. If they fail, children can and will die.

Currently, there are a few prominent groups that claim to judge the effectiveness of programs or to certify programs as being evidence-based. Policymakers and professionals must look critically at the criteria employed by these groups to ensure that they really do use adequate criteria to make the claims they are trying to make. There is the potential that certain methods of certification, like relying on the existence of two controlled trials to show evidences of positive effects of a program, may actually allow programs with little evidence of effectiveness to qualify as "model programs" or achieve "top-tier" ratings. Researches and policy-makers must ask themselves if it is legitimate to award such ratings to programs without other proven and necessary methods of evaluation, like comprehensive reviews of all the relevant evidence (including *gray* literature), careful assessments of study methodology and implementation,

disclosures of conflicts of interest, or consideration about result generalizability. It is possible that disregarding these basic principles of research synthesis could result in endorsements of programs that have little effect, have unintended consequences, or may even prove harmful (59).

Where we can go from here

This broader neighborhood, community, and cultural context is the place where community-based prevention is located. Even though the most frequently cited risk and protective factors for maltreatment reflect parents' individual functioning and capacity, community factors can influence parent-child interactions in myriad ways (60). How parents interact with children is a function of not only their own formative experiences and their own level of preparation or parenting, but also how well they are supported by the surrounding environment (61). Depending on their composition and quality, neighborhoods can either foster children's healthy development or place them at significant risk for physical, psychological, or developmental harm (60). When studied empirically using predictive analytics, the variables of community stability, number of adults per child, concentrated disadvantage and density have been associated with child maltreatment (51).

Recent trends in prevention models seek to understand the problem of maltreatment from an ecological point of view. These models consider the individual-family behavior as embedded within broader neighborhood, community, and cultural contexts. (29). Taking a broad view, the US Centers for Disease Control and Prevention (62) recommends forming community-level strategies to modify negative community influences and change cultural norms through laws that effect parenting. One such change—the provision of adequate paid family leave during infancy—was associated with a decrease in hospital admissions in children younger than two-years old (45).

All of this research suggests that any prevention initiative needs to include prenatal, perinatal, and postnatal education as well as community-level strategies to address the social and economic contexts that promote the triggers that potential child maltreatment. We believe this at least begins a discussion about where child maltreatment prevention can go from here by tying in observations from the history of the system and from our collective knowledge about the community. This particularly promising strategy—*Prevention Zones*—can make progress by avoiding or overcoming historical barriers without compromising the safety of even our most vulnerable children.

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Chapter 6

ECONOMIC SUPPORTS FOR FAMILIES

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ABSTRACT

A public health approach to the prevention of child abuse and neglect requires strategies and approaches that change the conditions and contexts in which children and families live. The US Centers for Disease Control and Prevention identify economic supports to families as a promising approach to preventing abuse and neglect. Specifically, providing families with additional financial support through programs like the Earned Income Tax Credit (EITC), assistance in paying for childcare, and family-friendly work policies such as paid family leave (PFL), have the potential to improve outcomes for children and families. In this chapter, we review the literature on the effects of EITC, childcare subsidies, and PFL on child and family outcomes. We conclude by highlighting the importance of a public health approach to child maltreatment and the need to build the research evidence around additional programs and policies to understand their ability to improve child and family outcomes.

INTRODUCTION

For those in the field of child abuse and neglect, new and seasoned, it is perplexing why these phenomena occur with such frequency. Even the general public views child abuse as a serious, preventable problem (1). So why, after so many years, are child abuse and neglect such public health issues in the United States and beyond? Like most societal problems, the answer to this question does not have a simple answer. Suffice to say, this is a complicated issue. What is clear, however, is that child maltreatment is often related to parental stress, which has a myriad of potential contributing factors.

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Ray Helfer, MD (1930-1992), one of the early leaders in the field of child abuse and neglect, discussed their etiology and suggested that parental factors, child factors, and situational factors all played an important role in its occurrence (2). Parents bring experiences, positive and negative, to their role as parents. For parents who had a traumatic upbringing, lack connection and support with other adults, or who otherwise have limited knowledge regarding child development, their role as a parent may be extra challenging and stressful. When children present with complex health needs or significant behavioral challenges (e.g., colic, attention deficit-hyperactivity disorder), the stress placed on caregivers is increased. Then, there is a precipitating crisis, or series of crises, which, combined with parent and child factors, leads to abuse or neglect. Helfer was careful to note that poverty is a prime example of a situational factor that increases strain and stress on a parent's capacity to care for their child that, in turn, increases the likelihood for abuse or neglect.

The science on the etiology of child maltreatment noted in the writings of Helfer still ring true today. Research shows that the perinatal period lasting into the first few years of life is essential for establishing parent-child attachment, which is a core feature of healthy child development. It is during this time however that risk for child abuse and neglect is highest. Data suggest that children in their first year of life are at the highest risk for child maltreatment (3**)**. A reactive response to child maltreatment—or waiting for child abuse to occur then funneling families into an overwhelmed child welfare system—does little, or nothing, to address the precipitating factors that led to the maltreatment. Instead, these services often exacerbate stress for families, creating the potential for future abuse risk. The prevention of abuse and neglect requires an altering of the conditions and contexts in which children and families live in a way that reduces sources of risk and increases sources of protection. Our prevention strategy must recognize that the perinatal period of development is both critical for establishing healthy child development but the highest risk period for abuse and neglect. Finding ways to strengthen household financial security, decrease family economic stress during these times and provide caregivers with flexibility to care for their children through family-friendly work policies is essential to the prevention of abuse and neglect.

Currently, the US lacks a coordinated, universal system of support for children and families that aims to prevent child abuse and neglect before they occur. That is not to suggest that prevention or other supportive services do not exist in communities. In fact, there are home visiting programs and family resource centers located in communities across the country; however, they do not receive the dedicated, sustained funding streams needed to bolster their programs. Creating a prevention system requires more than a menu of family-based services. It requires strategies, across the social ecology, that work to alter the conditions in which families live. As we will highlight in this chapter, a key feature of a prevention-focused system is an array of policies that support parents concretely, in their role as parents. This includes, but is not limited to, strengthening economic social support for families, assistance with childcare, and gainful, yet flexible, participation in the labor market. Emerging research, discussed in this chapter, has started linking economics and concrete supports for parents as a viable strategy in the prevention of child abuse and neglect.

In this chapter, we begin by defining a public health approach to prevention. We then discuss how such an approach differs from the current paradigm of addressing child abuse and neglect "after-the-fact." Next, we use the US Centers for Disease Control and Prevention's technical package on child abuse and neglect to highlight key policies aimed at strengthening household financial security, including Earned Income Tax Credits (EITC), childcare subsidies,

and creating a family-friendly work place (e.g., paid family leave) (4). Collectively, these policies have shown some evidence in reducing the risk for child abuse and neglect. In closing, we will highlight the importance of a public health approach to child maltreatment as we work towards universal policy implementation and, importantly, focus on the impact of COVID-19 on child abuse and neglect prevention.

PUBLIC HEALTH PREVENTION

Upon the professional and social recognition of child abuse and neglect as a public health problem in the 1960s (5), the field developed what we think about as "tertiary prevention" approaches; that is, treatment and intervention services that work to stop the abuse from reoccurring and to slow or halt the effects ensuing from the abuse. The child welfare system, treatment programs, and counseling/therapy exemplify common tertiary prevention strategies. There are also strategies that target individuals or communities that demonstrate a measurable amount of risk for child abuse or neglect (e.g., low-income, teen parent), but who otherwise are not engaging in abuse or neglect. These strategies are often referred to as secondary prevention. Many home visiting programs operate by identifying caregivers who, based upon a risk assessment, may be at higher than average risk for abuse or neglect. Further upstream along the prevention continuum are those strategies, often delivered universally, that seek to prevent child abuse and neglect before they ever occur. This approach is often referred to as primary prevention. Family resource centers and home visiting programs that are available to everyone in a community, not based upon risk, are viewed as primary prevention strategies.

The US allocates very few resources or time to the primary prevention of child abuse and neglect, instead spending large sums of money on child welfare services. A Child Trends estimate in FY2016 found the US spends approximately $30 billion annually on child welfare services (6). Conversely, in FY2020 Congress only allocated about $56 million to Community-Based Child Abuse Prevention (CBCAP) services, the largest dedicated federal source for primary prevention funding for child abuse and neglect (PL 116–69). Currently, the balance of funding for the issue of child abuse and neglect is in the wrong direction, and increased funding is needed for primary prevention to mitigate the costly, downstream services necessary to remediate the consequences of abuse and neglect.

Another significant element to primary prevention is promoting an evidence-based strategic framework. Over the past decade, the US CDC has advanced a strategic framework—Essentials for Childhood (EfC)—focusing on the prevention of child abuse, neglect, and other childhood trauma and adversity (7). The focus of this framework places balanced emphasis on the reduction of risk with the promotion of safe, stable, nurturing relationships and environments for all children. The EfC framework outlines four overarching goals, including the alignment of key stakeholders around a common vision, the use and integration of data into decision-making, the need to implement evidence-based programs and shift societal norms, and the implementation of policy strategies to support safe, stable, nurturing relationships and environments. While the EfC framework provides a broad roadmap of goals, it does not specify the concrete strategies and approaches for how this work could or should be done.

Table 1. Preventing child abuse and neglect (4)

Preventing Child Abuse and Neglect	
Strategy	**Approach**
Strengthen economic supports to families	• Strengthening household financial security • Family-friendly work policies
Change social norms to support parents and positive parenting	• Public engagement and education campaigns • Legislative approaches to reduce corporal punishment
Provide quality care and education early in life	• Preschool enrichment with family engagement • Improved quality of child care through licensing and accreditation
Enhance parenting skills to promote healthy child development	• Early childhood home visitation • Parenting skill and family relationship approaches
Intervene to lessen harms and prevent future risk	• Enhanced primary care • Behavioral parent training programs • Treatment to lessen harms of abuse and neglect exposure • Treatment to prevent problem behavior and later involvement in violence

To support the EfC framework, the CDC created a child abuse and prevention technical package that includes key strategies and approaches, based upon the best available scientific evidence (4) (see Table 1). For the purposes of this chapter, we focus on the first strategy, concrete supports for families, which the CDC suggests holds the most promise in the prevention of child abuse and neglect. Specific to this strategy, we will focus on policies that strengthen household financial security (i.e., earning income tax credits and childcare subsidies) and create family-friendly workplaces (i.e., paid family leave).

Earned Income Tax Credit

The Earned Income Tax Credit (EITC) is a tax policy that supports low- to middle- income working families by allowing them to pay lower taxes or receive a larger tax refund (8). The federal EITC is refundable, that is, a taxpayer is able to keep the additional refund, which increases a family's direct income (9). Some states offer an EITC that lowers state income tax liability, but not all are refundable. The requirements for receipt of the EITC are calculated through a formula based upon earnings and family composition (i.e., marital status, number of children). For example, in 2020, a working family with 1 child would receive a benefit of approximately $3,580 while a working family with 3 or more children would receive a benefit of approximately $6,660.

As noted by the Center for Budget and Policy Priorities (10), families use this additional money to purchase necessities, repair their homes or vehicles, or use the money to support career advancement through training and education. In 2018, nearly 5.6 million people in the United States were lifted from poverty as a result of EITC, including three million children (10). Unfortunately, nearly 20% of those who are eligible for EITC do not take advantage of the program, either because they are unaware or because they do not file an income tax return (11).

In addition to research evidence that EITC lifts families out of poverty and incentivizes labor force participation (10), EITC has been shown to have positive effects on maternal and child outcomes. Markowitz et al. (12) found that the EITC was associated with reductions in the rate of low birthweight infants. These effects were particularly pronounced in states with a refundable EITC option. Hoynes, Miller and Simon (13) also found significant reductions in low birthweight as a result of EITC and suggest that these reductions could be partially explained by reductions in maternal smoking and access to prenatal care. Using data from the Behavioral Risk Factor Surveillance System (BRFFS), Evans and Garthwaite (14) found an association between EITC and self-reported improvements in maternal mental and physical health indicators.

Evidence is also beginning to emerge about the protective effects of EITC on indicators of child abuse and neglect. Klevens et al. (15) examined the association between EITC and hospital admissions for abusive head trauma (AHT), an often-fatal form of child maltreatment. Using difference-in-difference analysis, the authors compared 14 states with EITC (combination of refundable and non-refundable) and 13 states without EITC between the years 1995-2013. The authors found that a refundable option of the EITC was associated with significant reductions in hospital admissions for abusive head trauma (AHT) for children under the age of two years. Specifically, the refundable option of the EITC was estimated to reduce cases of AHT by 3.1 cases per 100,000 children in the population. Interestingly, there was no association between non-refundable EITC and hospital admissions for AHT. These findings lend support to the idea that a modest increase in family income can have a substantial influence on reducing abuse and neglect.

Child care subsidies

Child care is a critical need for families, especially for the millions of people in the US that work low-wage jobs with demanding, unpredictable, and inflexible work schedules (16, 17). Notably, women, especially women of color, are more likely to have low-wage jobs— many of whom (about 20%) are mothers to young children (16, 17**)**. Child care is costly to families. The average annual cost of having one child in a child care center full time ranged from $4,600 in Mississippi to $15,000 in Massachusetts (18).

Child care subsidy policies aid in offsetting child care costs by providing vouchers, lower cost child care, or cash transfers to low-income families (4). These subsidies strengthen a family's household security by allowing access to affordable, reliable, and quality child care (4). One of the most significant child care assistance policies in the US is the Child Care Development Fund (CCDF), authorized under the Child Care and Development Block Grant Act (CCDBG) (19, 20). The CCDF allocates federal funding to states responsible for administering child care assistance programs to low-income families (19-21). Notably, states

have a great deal of discretion when implementing CCDF, such as setting eligibility requirements (i.e., education, income, and work hour requirements) for families to qualify for funding (20, 22). Allowing state-level flexibility in child care subsidy policy may increase the likelihood that families will receive benefits specific to their needs, however, much remains unknown about the ways state policy variations might differentially relate to abuse and neglect. The nature of low-wage jobs, including limited income and demanding work schedules, and the added difficulty of finding quality, cost-efficient, and consistent child care to keep their child safe, increases parental and financial stress, making children vulnerable to maltreatment (23, 24).

Research suggests that child care subsidies, including CCDF, may have a favorable effect on preventing child maltreatment. Meloy et al. (25) found that states with a broader implementation of CCDF (e.g., flexible eligibility requirements) had significantly fewer children who were removed from homes through child protective service intervention than states with more restricted implementation. Additional research suggests that parents facing child care concerns (e.g., quality of the available care, cost of care, and difficulty finding care during work hours) report higher levels of child neglect (25). Ha et al. (26) found that the instability and cost of child care are associated with higher levels of physical aggression and psychological aggression towards children.

Paid family leave

Unlike other industrialized countries, the US does not provide universal support to new parents in the form of paid family leave (27, 28) and many, if not most, families are placed in a precarious situation after the birth of their child due to this overwhelming lack of support. The guiding federal law for employee-sponsored leave is the Family and Medical Leave Act of 1993 (FMLA), which provides workers with employment protections when they need to take time-off due to personal medical reasons or to care for a family member (27, 29, 30). FMLA offers individuals up to 12-weeks annually of unpaid time-off, with a number of stipulations of eligibility for companies and employees. Specifically, coverage does not apply to small businesses (i.e., under 50 employees) or individuals employed for less than a year in their current position (i.e., 1,250 hours in prior 12-months) (31). These criteria make it difficult for families, especially low-income families, to benefit from FMLA, as many families cannot afford to take leave without pay (32). Moreover, only a little over half (59%) of the U.S. workforce is eligible for FMLA and many part-time and/or low-wage workers do not have access to leave benefits (i.e., sick leave or vacation time) at all (33).

Paid Family Leave (PFL) policies are an alternative to, or advancement of, FMLA, receiving bipartisan support at the federal and state levels. PFL supplements a parent's income and allows them time away from work to care for and bond with their newborn—in other words, parents are *paid* to take time off to care for their families (30). In the US, PFL has gained significant traction at the state level; at the writing of this chapter, eight US states and Washington D.C. have introduced and/or passed some form of legislation focused on paid family and medical leave programs (34). Similar to EITC and child care subsidy state policies, PFL policies vary from state to state. Many of PFL policies provide families with income replacement via employee payroll deductions for a specified amount of time (4 to 12 weeks), often incorporated through the state's temporary disability insurance (TDI) programs for

pregnancy (33). Currently, all these states allow PFL to be taken to care for a newborn or adopted child, a seriously ill family member, or one's own serious health condition.

Early research suggests that PFL benefits both families and society as a whole. Advantages include gender equity, healthy development of children, labor force attachment, and preventing hardship for families in their time of need, among others (33). Studies in California, the first state to pass PFL in 2002, found that mothers and fathers, independently, were taking leave at an increased rate (35) and often parents took leave at the same time (36). In terms of child health and well-being, studies show consistently positive effects. For example, Klevens et al. (37) found that California's PFL policy was associated with a significant decrease in abusive head trauma (AHT) admissions and a 6% decrease in avoidable infant hospitalizations (38). Additionally, Bullinger (39) notes California's PFL program improved overall health for children (via parental self-report) and improvements in maternal mental health. Further evidence suggests that PFL increases maternal employment in the short-term, although studies on long-term maternal employment have mixed findings (35, 40, 41). Importantly, the literature notes that PFL policies have a significant effect on low-income mothers. Winston et al. (30) found that PFL was critical to these mothers as it provided them with supplemental income, significant time to bond with their new child, time to secure child care, and time to recover physically from birth before returning to work. Yet, for some low-income mothers, the supplemental income from PFL was still insufficient, forcing them to make early returns to the labor force (30).

CONCLUSION

A public health approach to the prevention of child maltreatment works to address the conditions and contexts in which individuals and families live. One aspect of the public health strategy in the US is understanding policies that affect families at the state and federal levels. Policies that strengthen household financial security (e.g., EITC and child care subsidies) and create a family-friendly workplace (e.g., PFL) may help families remain in the labor force, increase wages, decrease family and interpersonal stress, and, therefore, decrease child maltreatment. In this chapter, we explored the ways in which concrete, economic, and family-supportive policies can lead to reductions in child maltreatment. Research shows that reducing the economic strain faced by working families through programs, such as EITC, or through policies that alleviate caregiving stress such as childcare subsidies or PFL, could serve to prevent child abuse and neglect.

Notably, at the time of writing this chapter, we find ourselves in the midst of a global pandemic, like no other in recent history. The physical and economic toll of COVID-19 has, and will for some time, exact a massive toll on the well-being of children, families, communities, societies, and our world as a whole. There is no better time than now to explore a rebuilding of our social support system that advances economic support to families, especially those with low incomes or those who have otherwise been marginalized in society. This includes a reevaluation of other income and resource support programs such as Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), minimum wage, and the Supplemental Nutrition Assistance Program (SNAP). Another economic support policy proposal gaining traction in the US, which would expand the aforementioned safety net

benefits, is Universal Basic Income (UBI). Bidadanure (42) described UBI as a universal, unconditional (i.e., no work requirements), consistently recurring (e.g., monthly) cash payment to *all* individuals (i.e., not based on household). The general idea behind UBI has been in political discourse for centuries, yet it is once again gaining popularity around the world (42, 43).

Continued research is needed to understand the effects of UBI and whether or not it is a viable policy to strengthen economic supports for families (44). There has been some success in experimenting with UBI worldwide (e.g., Canada, Finland, and Switzerland), offering examples as the US explores this idea further (42, 43). In addition to addressing income inequality, UBI may also be an approach to tackle gender and racial inequalities (42). Yet, researchers have also noted that UBI may be exceedingly costly to implement and may not provide as much funding to lower-income households compared to other existing benefit programs (44). Despite the mix of findings, UBI could be a policy that provides families, specifically low-income households, with additional funding for basic resources, which, in turn, could have a positive effect on child well-being. Similar to the family supportive policies explored in this chapter (i.e., EITC, child care subsidies, or PFL), UBI may be a method for reducing economic strain, helping families remain in the labor force, increase wages, and decrease stress, therefore decreasing child maltreatment.

The field of child maltreatment prevention has an opportunity to create a primary prevention system that addresses family needs as a standard form of practice. A true public health approach to the prevention of abuse and neglect will work to change or alter the conditions in which children and families live. This includes a robust set of policy strategies for parents, especially those with low incomes, to increase their financial stability and provide them flexibility in labor force participation and options for high quality childcare.

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Chapter 7

HOME VISITING TO PREVENT MALTREATMENT

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ABSTRACT

Home Visiting is a child maltreatment prevention strategy that supports pregnant moms and new parents to promote infant and child health, foster educational development and school readiness, and help prevent child abuse and neglect. Early childhood home visiting is a service delivery strategy that matches expectant parents and parents of young children with a designated support person—typically a trained nurse, social worker, early childhood specialist or paraprofessional. Services are voluntary and provided in the family's home or another location of the family's choice, often reaching socially or geographically isolated families. A two-generation approach, home visiting delivers both parent- and child-oriented services to help the whole family. This chapter briefly reviews the history of home visiting, its theory of change, workforce and funding issues and experience in New York State.

INTRODUCTION

The National Conference of State Legislatures defines home visiting as "a prevention strategy used to support pregnant moms and new parents to promote infant and child health, foster educational development and school readiness, and help prevent child abuse and neglect" (1). This broad definition scratches the surface, but to understand what is happening for families when the doorbell rings we must look deeper.

Early childhood home visiting is a service delivery strategy that matches expectant parents and parents of young children with a designated support person—typically a trained nurse, social worker, early childhood specialist or paraprofessional. Services are voluntary and

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provided in the family's home or another location of the family's choice, often reaching socially or geographically isolated families. A two-generation approach, home visiting delivers both parent- and child-oriented services to help the whole family. It views child and family development from a holistic perspective that encompasses: child health and well-being, child development and school readiness, positive parent-child relationships, parent health and well-being, family economic self-sufficiency, and family functioning (2).

Typically, families enter a program based on "word of mouth" referral or a referral originating from a community-based service provider such as a hospital, doctor or social service agency. A program staff member will go to the family's home and complete an intake assessment. When the family accepts the program services, a regular schedule of in-home visits is established and a goal plan is developed with the family. Often the program will work with the family to complete various assessments—child development, family function, interpersonal violence, and others as appropriate. Families stay in the program for varying periods of time based on their need and the design of the program.

HISTORY OF HOME VISITING

When you think of maternal, infant, and early childhood home visiting, you do not necessarily think of a practice that originated in Elizabethan England, but that is, in fact, the case. Formal home care began with services provided to paupers and crossed the pond in colonial times during an era when care at home, provided by family and community members, was deemed preferable to institutional care (3). The first US hospitals were New York City's Bellevue, established in 1730, and Philadelphia's Blockley, established in 1731-2.

In 1899, Mary Ellen Richmond wrote the first workers' guide to home visiting, *Friendly visiting among the poor: A handbook for charity workers,* which stressed the importance of a mutually respectful relationship (4). Richmond may be best known for identifying six sources of power for families/clients and their social worker: within the household, in the person of the client, in the neighborhood, in wider social networks, in civil agencies, and in private and public agencies. The 20th Century brought state and national attention (including federal funding) to the plight of abused and neglected children, the importance of early learning, and the impact of poverty on families (3). It also saw the creation of several evidence-based and evidence-generated home visiting programs. (Figure 1).

The Affordable Care Act (ACA) of 2010 included funding for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. Administered by the US Health Resources and Services Administration (HRSA), the program is funded through 2022 and focuses on the same population as *Home Visiting Evidence of Effectiveness* (HomVEE)—pregnant women and parents of young children up to kindergarten entry who live in at-risk communities. MIECHV provides funding to the states and territories for 19 approved home visiting programs, including Early Head Start, HFNY, NFP, PAT, and SafeCare in New York State. In 2019, MIECHV programs served over 5,500 participants in more than 3,000 households, with 34,526 home visits. Of these households, 55.4% were low-income and 15.9% had a reported history of child abuse or neglect. Positive program outputs included: 98.2% of enrolled caregivers received a depression screening either within three months of enrollment or

three months of delivery, and 91.8% were screened for intimate partner violence within six months of enrollment (5).

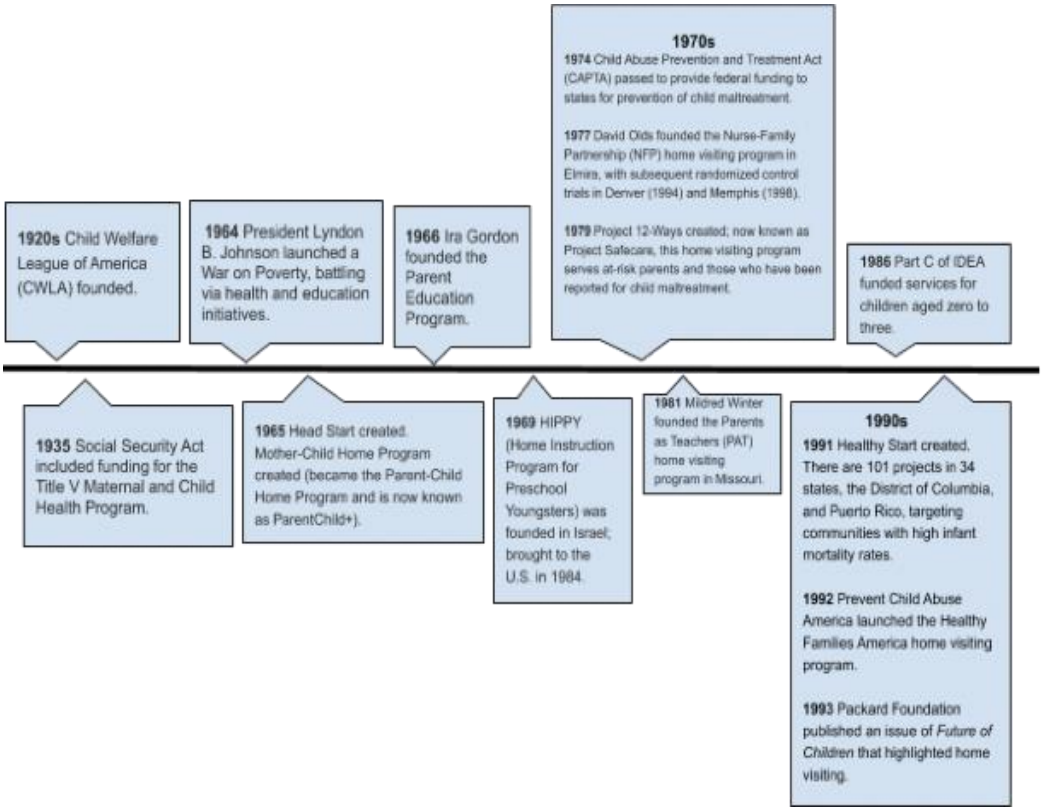

Figure 1. Home visiting advances in the 20th century. Courtesy Margaret Dickson.

HOME VISITING AS A CHILD ABUSE PREVENTION STRATEGY

Understanding home visiting as a prevention strategy requires at least two different angles of perspective. *Risk reduction* is one central theme of prevention efforts. By identifying risk factors and reducing or eliminating these factors, programs prevent maltreatment. This has spawned many innovative home visiting approaches specifically designed to address particular risks. For instance, substance abuse counselors have been paired with home visitors to support recovery and reduce the impact of substance abuse on parenting. Home visiting programs specifically designed to support teen parents have achieved significant success (6).

More and more, a *strengthening families* perspective is being applied to the work. In this prevention approach, programs identify family qualities that contribute to positive outcomes and focus attention on strengthening those factors. The *Protective Factors Framework*, developed by the Center on Social Policy, includes the following five protective factors: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children. Home

visiting programs often specifically aim to strengthen one or more of these factors through their focus on these protective factors (7).

Theory of change/levers of change

All home visiting programs, regardless of which broad approach they take, have an underlying theory of change—*improved family function will lead to better outcomes for children.* Various models of home visiting apply different levers of change to achieve this theory. While programs employ different levers, the central theory is common across programs.

Overview of Select Evidence-Based and Evidence-Informed Home Visiting Programs

Program	Program Description	Program Goals	Population Served	Service Delivery
Early Head Start (EHS)	Service provided through center-based, home-based or mixed models, with visits by trained home visitors. Focus on: prenatal outcomes, health family functioning & school readiness.	Promote healthy prenatal outcomes for pregnant women. Enhance the development of very young children. Promote healthy family functioning.	Serves families from pregnancy until child turns 3.	By trained professionals.
Family Connects	The Family Connects model is an evidence-based program that connects parents of newborns to the community resources they need through postpartum nurse home visits. FC also conducts rigorous research and evaluation of the model, as well as innovative research on early childhood well-being and parent-child relationships.	Improve child and family health and well-being. Create access to a continuum of community-based care to support health and success. Values: Equity; collaboration; excellence; integrity. The nurse may recommend longer-term programs, such as Early Head Start.	Home visits begin 2 to 3 weeks after birth, offering one to three home visits in total. The child may be enrolled until they are 6 months of age.	By trained & registered nurses.
Healthy Families New York (HFNY)	Home-based services to expectant families and new parents. Trained home visitors provide support, child development & parenting information to reduce family stress. Participants screened to identify risk factors & stressors.	Identify overburdened families needing support. Promote positive parent-child interaction. Ensure optimal prenatal care. Promote healthy growth & development. Enhance family functioning. Prevent child abuse & neglect. Promote parental self-sufficiency.	Enrolls expectant parents and parents with an infant less than 3 months old; serves until age 5.	By specially-trained family support professionals.
Maternal and Infant Community Health Collaborative (MICHC)	Community Health Workers (CHWs) assess individuals and families of needs, provide education and assistance, and connect individuals/families to supports within their community.	Improve maternal and infant health outcomes, while reducing racial, ethnic and economic disparities. Assess needs and barriers to accessing services. Connect to community resources. Maintain healthy behaviors and reduce or eliminate risky behaviors.	Medicaid-eligible/low-income women across the lifespan (and their families).	By trained Community Health Workers
Nurse-Family Partnership (NFP)	Intensive home visiting provided by an RN who uses clinical assessment skills to deliver a comprehensive, nationally-proven prevention model. Focus on: family & environmental health, maternal-child attachment, nurturing child-caregiver interactions, maternal life course development, referrals to health & human services.	Help women improve pregnancy outcomes. Help parents improve child's health & development. Help parents become economically self-sufficient.	Enrolls low-income, first-time mothers in pregnancy (first two trimesters) and serves until child turns 2.	By registered nurses.
Parents as Teachers (PAT)	Certified parent educators work with families through visits, child screenings, group connections, and connecting families to resources. The evidence-based model focuses on: parent-child interaction, development-centered parenting & family well-being. Organizations can replicate the model, use the curriculum independently, or blend the PAT approach into existing programming.	Increase parents' knowledge of early childhood development & improve parenting practices. Provide early detection of developmental delays & health issues. Prevent child abuse & neglect. Increase children's school readiness & success.	Serves families from pregnancy to kindergarten entry.	By trained professionals and parent educators.
ParentChild+	Through a research-proven model, PC+ prepares children for school success by increasing language & literacy skills, enhancing social-emotional development, and strengthening parent-child relationships. Parents become children's teachers & advocates: reading, playing, talking & learning together.	Prepare children challenged by poverty for success in school. Stimulate parent-child verbal interaction. Enable children to gain critical language and literacy skills.	Two-year program serves families with 2- and 3-year-olds (can enter as young as 16 months and stay until age 4).	By specially-trained paraprofessionals.
Power of Two	Power of Two is a non-profit organization operating in NYC that is scaling Attachment and Biobehavioral Catch-Up (ABC), a proven parenting program, in New York City. ABC gives children a foundation for success in school and life by fostering a strong and healthy attachment between parent and child.	With ABC, pre-school age children showed higher levels of executive functioning than their peers, are more likely than their peers to develop secure attachments to their parents, and have normalized stress hormone levels after only 10 coaching sessions in the home.	Serves families from 6 month - 2 years of age.	By parent coaches trained in ABC.

Figure 2. Overview of Select Evidence Based and Evidence-Informed Home Visiting Programs. Used with permission from the Schuyler Center. (URL: https://scaany.org/wp-content/uploads/2020/07/Overview-of-Select-Evidence-Based-and-Evidence-Informed-HV-Programs_06-2020_FINAL.pdf).

The continuum of home visiting practices is characterized in figure 2. In a public health, postpartum model designed to see a family once or twice and then refer on to another service, the lever of change is a connection to social and community support that creates better family function. For short course, treatment home visiting, the goal may be to address a barrier to effective parenting such as substance use or depression (with elimination of specific risk factors). In longer-term programs, the work may be about building positive parent/child interactions since increasing parental nurturance will reduce abuse.

The US Department of Health and Human Services launched HomVEE in 2009. This meta-analysis of home visiting research grouped findings about home visiting into categories of levers that connect to theory of change. Each of these categories linked to specific practices the program employs to accomplish the change with families. Each addresses a major risk factor for child maltreatment. The categories include (8):

- Child development and school readiness
- Family economic self sufficiency
- Maternal health
- Child health
- Positive parenting practices
- Linkages to community resources
- Child maltreatment reduction

As a result of the programs' lever of change, practitioners were to identify different issues and focus their resources with a family in different ways. While not all home visiting programs explicitly attempt to reduce child maltreatment, even those addressing risk factors and improvement of overall family function will play a primary prevention role.

Home visiting's success as a prevention tool

Home visiting's success as a child maltreatment prevention tool has been much discussed and a range of evaluation studies have been conducted to assess its actual impact (9). Here again the HomVEE meta-analysis is helpful in understanding the evidence (8). Looking specifically at studies that have examined reduction of child maltreatment, HomVEE found that six home visiting models showed "primary" results and four programs had "secondary" results in reducing maltreatment. Primary results are defined as *"an outcome measured through direct observation, direct assessment, or administrative data; or self-reported data collected using a standardized (normed) instrument."* For instance, for a primary result, the evaluator reviewed Child Protective Services (CPS) records and the family had no interaction with CPS in the past five months. Secondary results are defined as *"most self-reported data, excluding self-reports based on a standardized (normed) instrument."* For instance, a parent reports they have had no CPS contact in the last five months.

Results relating to child maltreatment can be lumped into three main categories: 1) reduction in interactions with CPS or the child welfare system; 2) reduction in medical treatment for injuries relating to child maltreatment; and 3) reduction in harsh parenting practices such as spanking. The evidence across these 30 studies makes it clear that home

visiting programs can be effective prevention tools (8). While this is a compelling record, there are as many studies that found no effect on these specific indicators. The evidence is strong; these programs work to reduce child maltreatment. Valid questions remain about what conditions allow them to be most effective with these specific evaluation criteria (10).

The picture changes significantly when examining the results of research in the remaining categories: child development and school readiness, family economic self-sufficiency, maternal health, child health, positive parenting practices, and linkages to community resources. For these categories, the studies with positive findings far outweigh the studies with no supportive findings. The picture here is clear and decisive. Home visiting programs reduce risk factors for child maltreatment and improve family functioning, such as poor maternal health status, especially mental health and emotional support, which are considered risk factors for child maltreatment (11).

For *maternal health*, there are 88 studies that identify positive impacts for home visiting. Among these factors were improved maternal depression; lower maternal ratings of stress; reduced substance misuse; increased prenatal visits completed; birth spacing; general health status; access to social/emotional support; reductions in hypertension; access to Women, Infant, and Children's (WIC) services; reduced labor and delivery complications; increased healthy activity levels; and engagement with a primary care doctor.

Eighty-five studies indicated improvements for *positive parenting practices*. These findings align with quality of dyadic interaction, attention to caregiving behaviors, attention to in-home learning environment, harsh or punitive child rearing techniques, positive child rearing practices, reduced screen time for children, and school attendance. Improved understanding of child management practices and close, nurturing relationships greatly reduce risk of child maltreatment.

Twenty-seven positive findings for *linkages to community resources* were identified. These relate to parents' access to a range of community-based services including mental health, early education, early intervention, and medical and social services. Also reported was improved access to housing, domestic violence services, food pantries, immigration services, and adult education. A critical factor in reducing risk for children is ensuring caregivers are well connected to a range of community services.

Economic stability reduces risk by lowering levels of stress related to poverty. HomVEE again points to 30 positive study findings on *economic self-sufficiency*, including number of hours worked per week, length of employment, high school completion, General Education Degree (GED) achieved, enrollment in vocational training, and households where caregiver had support of spouse/partner (another important risk reduction factor.)

One hundred and one studies found positive effects on *child development and school readiness*. Parents with a better understanding of child development are less likely to assign negative intent to their children's behavior and are also less inclined to harsh discipline approaches. Home visiting programs regularly assess individual children's development and involve parents in the assessment process, as well as share the results and include families in planning for ongoing developmental supports. The range of developmental domains have received attention in programs with specific increases in early identification of developmental problems and parental identification of challenging behaviors. Findings related to improved educational achievements include increased participation in gifted programs, reduced grade retention, and increased rates of high school graduation.

Children with lower health status also have increased risk for child maltreatment. Seventy-one studies found that *child health* was improved through home visiting programs. Findings here include improvements in low birth weight, gestational age at birth, neonatal intensive care stays, injury rates, immunization rates, breastfeeding rates, reduced emergency room visits, well baby visits completed, and higher rates of health insurance coverage.

Home visiting models offer home-based services to support expectant families and new parents with the changes and needs that often come with the birth of a new child. Working from family strengths helps parents and caregivers manage life's challenges, such as single parenthood, low income, child history of abuse, substance abuse, mental health issues, and/or domestic violence. This approach can help to reduce child maltreatment and harsh parenting practices, increase prenatal care, improve parent-child interactions and school readiness, promote healthy child development, improve positive parenting skills of caregivers, promote family self-sufficiency/decreasing dependency on social services, improve primary health care access, and improve child immunization rates (8).

Workforce training and development

Home visitors' workforce and life experiences, as well as their educational backgrounds, vary. This work with families requires knowledge, skills, and attributes—core competencies—to provide a model-specific framework, a shared language, and a set of expectations for home visiting. Many states use home visitor core competencies to ensure service quality across local agencies and models help promote consistency across the workforce. Each model has training specific to the role of the home visitor that relates to their mission and model of practice. While many of the topics and competencies are shared, there are variables and distinctions for the populations they serve.

The Institute for the Advancement of Family Support Professionals developed a *National Family Support Competency Framework for Direct Service Professionals* (e.g., home visitors, parent educators, family support workers, nurse home visitors) that is recognized nationally to advance the delivery of high quality, efficient services that improve the health, social and educational outcomes for new and expecting parents, young children, and their families (12). While competency focus may vary depending on the state or program(s), these core values are seen throughout:

- The parent-child relationship is fundamental.
- The parent is the child's first and most important teacher and role model.
- Families are assessed using a strength-based approach.
- Relationships are the cornerstone through which services are delivered.
- Home visiting services are:
    - Voluntary
    - Family-centered and family-driven
    - Culturally-informed
    - Trauma-informed
    - Best practice, research-informed, and evidence-based

Competency-based professional development practices help to provide a starting point of workforce development and an ongoing trajectory for goal setting and skill building. Home visitors are also trained to use curricula with families to improve outcomes. The curricula delivered during home visits is a critical component to improve family functioning, support family-staff bonding, teach parents about child development, and encourage positive parent-child interaction. The prenatal period is a particularly important one for preparing parents for their baby's arrival, building needed skills, and connecting to resources (13).

While there are many different curricula to choose from, using evidence- or research-based materials is considered best practice. Many programs use a variety of these to meet the needs of the families they serve and the challenges they face. There are targeted resources and materials for families who may have or had experiences with domestic violence, substance abuse, mental health concerns, and/or developmental delays. There are also curricula that focus on engaging prenatal families, teen parents, the importance of including fathers as an integral role in the child's growth and development, and grandparents who may also be involved in the caregiving (14).

NEW YORK STATE'S HOME VISITING CONTINUUM

Most states utilize multiple programs to serve a wide array of families with differing needs. Several evidence-based or evidence-generating programs began in or operate in New York State (NYS). These include *Early Head Start*, *Family Connects*, *Healthy Families New York*, *Nurse-Family Partnership*, *Parents as Teachers*, *ParentChild+*, *Power of Two*, *Safe Care*, and the NYS Department of Health (DOH) Community Health Worker Program, in addition to more region-specific, community-responsive programs (15, 16). Current programs serve a small fraction of children in the state (17).

Over a three-year span in New York State, there were 704,466 live births; approximately 313,972 of those young children live in families with income below 200% of the federal poverty level and are considered low-income families (17). The overall funded capacity of evidence-based and promising home visiting programs in NYS is 17,748 (18). Based on these numbers, NYS has the home visiting capacity to serve 6% of babies in low-income families and 3% of all children ages zero to three years. Ideally, multiple programs would operate in each county and refer to each other, so that when a family left one (possibly due to age of child) they could continue services with another. In 2015, the NYS Council on Children and Families created an interactive map of the State that showed where six evidence-based home visiting programs were in operation. The maps display the number of children aged 0-5 below 185% of the federal poverty line by cities/towns and home visiting catchment area, as well as by congressional and state legislative districts (URL:http://nysccf.maps.arcgis.com/apps/MapSeries/index.html?appid=888a5e7daa7448a3a4a6340152ad4daf).

Regional approaches, initiatives, and themes

In October 2018, Prevent Child Abuse New York (PCANY) launched the *NYS Home Visiting Coordination Initiative* (HVCI). The HVCI is committed to supporting a continuum of services

from the preconception period through the earliest years of a child's life by working in partnership across existing programs. The goals of the HVCI are to help NYS serve more families, find additional ways to best serve those families, refer families to the most helpful supports, and share resources. In 2019, with funding from the federal *Preschool Development Grant*, the work of the HVCI expanded to include 25 summits—at least two in each of the ten Regional Economic Development Council regions of NYS. Participants in the summits were a mix of home visiting programs, parents, state and local human services agencies, and community supports, such as child care. Participants cited a lack of understanding of what home visiting is, stigma, and implicit bias as reasons that families were hesitant to take part in services. Programs identified professional development needs and a desire to offer model-neutral training. This feedback greatly influenced the HVCI's recommendations around both outreach and curriculum/training in New York State. Other themes that emerged from the summit were:

- collaboration/coordination
- lack of funding
- universal home visiting
- social/economic issues
- program standards/requirements
- limited community resources
- inadequate data

Regions prioritized these themes and identified four considerations for State action:

- Develop a plan for statewide implementation of prenatal home visiting
- Institute a workforce development plan
- Implement coordinated intake and a referral data system to support collaboration
- Create a statewide public education campaign

FEDERAL AND STATE POLICY AND THE FUTURE OF HOME VISITING

On the national front, home visiting has taken on increased significance over the past decade. Under the guidance of the US Department of Health and Human Services and conducted by Mathematica Policy Research, the HomVEE initiative undertook a thorough and transparent review of the home visiting research literature in 2009. HomVEE continues to provide research and assessments on home visiting models that serve families with pregnant women and children from birth to kindergarten entry (8).

In New York State, the year 2000 saw the adoption of the Home Visiting Law (Chapter 141, Laws of New York, 2000); in 2006, *Healthy Families New York* (HFNY) became part of the NYS Budget General Fund. In the early 2000s, the Schuyler Center for Analysis and Advocacy (SCAA) convened a statewide home visiting workgroup comprised of state agency representatives, programs, and other key partners. In 2007-08, SCAA released the first in a series of policy briefs and other materials that, over the past 13 years, has shaped the policy and advocacy landscape in NYS (19). Between 2008-2019, programs were generally flat-funded,

although certain programs were able to secure some funding to expand access. In 2019, HFNY programs received a cost-of-living increase to help support the workforce, but in 2020, the State Budget cut funding for some *Parents as Teachers* and *ParentChild+* programs (19).

In 2000, New York City unveiled its plan to bring universal home visiting to all first-time parents. Families will receive up to six home visits, as well as "comprehensive health education and connection to resources which will include mental health screenings for anxiety and depression, infant feeding, infant safe sleep and referrals to services such as WIC and SNAP." By 2024, NYC will have invested $43M a year, with the goal of reaching 45,000 families across the City when fully implemented (20). NYS's Medicaid Redesign Team II approved a home visiting recommendation to provide "light touch" home visiting to families. Their recommendation notes the strong return on investment from home visiting programs based on the reduction in emergency room visits in the first year of life and the cost effectiveness of $3 saved for every $1 invested.

Now more than ever, primary child maltreatment prevention is crucial. While the COVID-19 pandemic has shined a light on gaps in all of our systems, it has also illuminated ways in which we can fill those holes. In response to the public health crisis, programs have risen to the challenge by continuing to serve families remotely through telephone and internet visits and by distributing food and household supplies. When the people stayed home, the home visitors kept helping. They offered support in isolation when stress within families was at its highest. They served as allies when women were sheltering in place with their abusers and they were eyes and ears when school-based mandated reporters could not see children because of building closures. They have diversified and evolved, continuing to serve families virtually and providing hands-on assistance when feasible—sometimes "visiting" with families more often than usual using internet or telephonic-based communication. Home visitors have done what they long acknowledged was necessary, and programs have supported that need for increased flexibility to meet families where they are. Moving forward, policy must reflect this "new normal" and both practice and funding should align with this approach.

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Chapter 8

NO HIT ZONES IN CONTEXT: CHANGING NORMS THROUGH PLANNED CHANGE

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ABSTRACT

No Hit Zones (NHZs) are a recently developed intervention program contributing to a larger movement that aims to end corporal punishment of children, a key risk factor for child physical abuse. Through the vehicle of environmental change, NHZs work to alter individual and social norms that support hitting children and move to a new normal where developmentally focused alternatives to hitting become the norm for relationships and interactions between parents/caregivers and children. Drawing on Lewin's technique of force field analysis, this discussion identifies various driving forces that are contributing to the end corporal punishment movement and from which NHZ implementation formulates its content. In addition, this discussion analyzes NHZs as 'planned change' efforts, identifying change processes and techniques that NHZs employ to bring about changes in norms and behavior.

INTRODUCTION

No Hit Zones (NHZs) offer an upstream solution to a problematic social norm. In the United States, it is socially acceptable for adult caregivers to hit children for a number of reasons: to

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stop the 'bad' / bothersome behavior, to punish the child for acting in a way the caregiver believes the child should know is wrong, or to discipline the child in a way the caregiver believes is effective. There are presumptions that a child's caregiver has *'a right'* to hit the child, the adult's *role* as 'caregiver' allows hitting as part of the parental script, adults use *what they experienced and learned* as children, and that the adults' religion or culture *demands* it. Corporal punishment by guardians (i.e., hitting their children) has been observed historically and cross-culturally for decades (1). Approximately 67% of parents and guardians in the U.S. use corporal punishment as a means of disciplining their children. However, meta-analyses of numerous spanking studies confirm that hitting results in lower self-esteem, poor parent-child relationships, aggressive behaviors, impulsivity, as well as an increased likelihood of developing mental health disorders and antisocial behaviors (2). For the purpose of this discussion, hitting is synonymous with spanking, pinching, slapping, and any other forms of physical punishment.

Just as hitting a child can be seen as a responsibility, a 'No Hit Zone' (NHZ) (3, 4) is an essential preventative solution. At a minimum, it creates a physical space where public "No Hit Zone" signage is displayed, announcing that it is normal and expected that: *No adult shall hit another adult; No adult shall hit a child; No child shall hit an adult; No child shall hit another child.* NHZs can be utilized anywhere, such as in hospitals, schools, churches, community centers, and government offices (3, 4). It is recommended that No Hit Zones be implemented across the spectrum of prevention, thereby including practice and policy settings. Additionally, to assist with implementation, the National No Hit Zone Committee of the National Initiative to End Corporal Punishment (NIECP) (www.NoHitZone.com) has developed an NHZ toolkit with sample policy, signage, training, and materials.

By designating a public space in which hitting is unacceptable, NHZs establish environments that seek to change the complex societal norms and processes that support the hitting of children described above. NHZs not only aim to raise awareness of the negative impacts of hitting children, they also work to directly prevent hitting behavior where it happens. They help create a new normal where the *right* to hit a child does not apply, where hitting children is not an acceptable part of a caregiver's role, where it is not right for caregivers to recreate what was done to them, and where there is no social support for hitting children. The multidimensional social reforms needed to execute this environmental transformation require a deliberate plan for change involving efforts that are equally polymorphous and calculated.

This chapter views "No Hit Zones" as: 1) part of the larger movement to end corporal punishment of children, a key risk factor for child physical abuse; and 2) a 'planned change' effort to alter social norms and behaviors within the movement. It is hoped that doing so will help those wishing to establish NHZs to understand their dynamics and to be more intentional in their efforts.

WE ARE NOT ALONE: NO HIT ZONES AND THE LARGER MOVEMENT TO END THE HITTING OF CHILDREN

The application of NHZs as a planned change effort began in 2005 when Dr. Lolita McDavid revitalized the child abuse prevention efforts used at the Rainbow Babies and Children's Hospital in Cleveland by turning the hospital into a "No Hit Zone.' The primary focus of NHZs

is part of the larger movement to end corporal punishment and, indeed, all violence against children. Its normative principles also provide links to and reinforce efforts to end many forms of violence that are part of children's lives: domestic abuse (*No adult shall hit another adult*); bullying (*No child shall hit another child*); elder abuse, and violence against parents and teachers (*No child shall hit an adult*).

Although the justification for and the legal and normative acceptance of hitting children has extended back through time, periods of social and legal change in the past two hundred years have addressed the need to protect children. Despite this, the actual practice of hitting has changed very little (5). Hitting children to control and/or punish a child may be seen as the ultimate mechanism of social control in child-adult relations. Part of the foundation of any oppressive relationship, especially one that applies to children, is the use of force that is legally sanctioned and buttressed by ideologies that justify it as necessary and "for the children's own good" (6). Supported by social norms and the law, hitting children is an example of the legitimate use of force. As Bitensky (7) observes with respect to social control in other contexts, "as historically oppressed peoples have liberated themselves from being legally categorized as the property of others, *such liberation typically has brought in its wake legal protection from physical chastisement"* (7) (Emphasis added).

The last forty to fifty years have seen the development of a 'movement' on a global (5) and national (8) scale attempting to change social norms and behaviors related to the hitting of children that are deeply embedded in the structures of and beliefs about adult-child relationships. With all countries of the world (except the United States) ratifying the United Nations Convention on the Rights of the Child (CRC) adopted in 1989, which deems physical punishment a violation of human rights and freedoms, there are calls from the UN Committee on the Rights of the Child to end legal support for corporal punishment of children. About this movement, Donnelly (1) writes:

> If there are noteworthy similarities with earlier reform movements, there are also significant (and perhaps decisive) differences. In the current campaign, child-care professionals have occupied the forefront of advocacy; they are far more numerous than their earlier amateur counterparts; and more significantly still, they have the power of established institutional positions. Moreover, while the current campaign repeats the arguments of past campaigns, it also echoes the rhetoric and the claims for recognition of other "oppressed groups" (notably those of the women's movement). "Children's rights" are akin to the "human rights" claimed by other groups (the United Nations Convention on the Rights of the Child makes the equation explicit) (1).

In addition to the CRC, there are other forces driving normative change toward ending the hitting of children. These driving forces include the following: legal reforms, academic research, public health approaches, policy statements, and a growing awareness of the importance of childhood experiences, both negative and positive. All these forces provide a supportive context for social change within which NHZs are emerging. The networking and dissemination of information about hitting amplifies their respective powers to change norms supporting the hitting of children.

Legal reforms

Since Sweden abolished legal support for corporal punishment of children in all contexts in 1979 and undertook educational efforts to support the change, 59 other countries have removed legal supports for hitting children in all contexts. An additional 28 countries have committed themselves to legal reform to achieve a complete ban on hitting children (9). On a macro-level, removing legal supports for corporal punishment has been shown to have impacts on both behavior (10) and attitudes (11) toward hitting children.

Academic research

Building from the work of Straus (12), Gershoff (2), and others in the field of academic research on the impacts of hitting children, there are now calls to change the focus of research from 'does corporal punishment work?' to 'how do we end corporal punishment?' Shifting research focus from control of children to children's safety and well-being, Afifi and Romano (13) observe:

> We now need to reframe the research we are conducting, the questions we are asking, and the discussions we are having to move this field forward and to ensure the safety and well-being of children. Our focus in research, policy, and practice needs to shift to address how traditional social norms related to spanking can be changed, to examine what intervention strategies are effective to help parents replace spanking with non-physical discipline, and to understand what role researchers, professional organizations, professionals working with families, policy makers, and public health officials might play to accomplish these goals.

Public health

There is also a recognized need to change norms related to the treatment and discipline of children in the public health sphere. In a technical package on preventing child abuse and neglect, the Centers for Disease Control and Prevention notes (14):

> "Changing social norms that accept or allow indifference to violence is very important to the prevention of child abuse and neglect. One social norm that is particularly relevant to preventing child abuse and neglect relates to how parents discipline their children. Another has to do with whether it is appropriate for parents to seek help in parenting."

A crucial aspect of an effective public health response to the use of corporal punishment is supporting and educating health professionals to be active bystanders when witnessing its use. According to a 2016 study, 20% of physicians self-reported "never" or "rarely" intervening when witnessing use of corporal punishment for children in hospital settings. Yet, research on NHZs demonstrate areas of promise for creating environments in health care settings which prevent physical punishment of children. A study conducted at a pediatric clinic serving approximately 25,000 patients annually found that of the 244 parents and guardians surveyed

about their use of corporal punishment with their children between the ages of 18 months and 5 years, 50.2% had reported use of spanking to discipline their children, and 29.3% of respondents had not been taught about No Hit Zones from their pediatrician. However, receiving information about NHZs from their pediatrician resulted in significant "change" of viewpoint among parents and caregivers regarding the use of corporal punishment. This demonstrates the effectiveness and value of intervention by pediatricians (15).

In addition, in 2016, the World Health Organization together with nine other international partners developed INSPIRE (16), a technical package focusing on seven key strategies for ending violence against children. These strategies include changing norms and values, creating safer environments, supporting parents and caregivers, and enhancing education and life skills with violence prevention curricula. Each of these is relevant to the successful implementation of NHZs (3).

Policy statements

Recently, many professional organizations have issued policy statements opposing the use of corporal punishment in child discipline, communicating about the negative impacts of corporal punishment, and enhancing parent and caregiver education on non-hitting alternatives. These national organizations include the American Academy of Pediatrics (2018), American Psychological Association (2019), National Association of Pediatric Nurse Practitioners (2006), American College of Emergency Physicians (2016), and the American Professional Society on the Abuse of Children (2016). These statements reflect the quality and wide dissemination of research on the negative impacts of hitting children and the need for positive alternatives, both of which are part of NHZ staff training efforts (4, 5).

Importance of childhood experiences

In the late 1990's, a seismic shift occurred in our understanding of the importance of childhood experience. As research linked the impact of trauma and neglect on children's brain development in 1997 (17) and the publication of the Adverse Childhood Experiences (ACEs) (18) research in 1998, mindsets began shifting from 'they'll get over it' to 'it stays with them for life.' Medical and mental health professionals came to understand that the perceived behavioral problems of children as well as risky behaviors and health conditions of adults were forms of coping with childhood experiences. The world of children took on a new salience as research demonstrated that being hit in childhood was related to adult mental health impairment and met the criteria for being included as an ACE (19). The formation of ACEs Connection (20) network and trauma informed networks (21) have helped individuals and practitioners from psychology, counseling, education, social work, child welfare, juvenile justice, medicine, religion, and faith communities to rethink both prevention and intervention from a new perspective and share information.

While ACEs and trauma-informed perspectives focus on negative childhood experiences, the effects of increased resiliency developed from positive childhood experiences (PCEs) (22) and developmental assets (23) has gained greater recognition. This work supports the alternatives to hitting modeling and training that NHZ implementation provides for staff,

parents, and caregivers. Additionally, the development and distribution of resources related to positive discipline (24) and painless parenting (25) reinforce the shift from maintaining "control" of children to healthy child development as a central frame for parent-child interactions.

These various threads of law, research, and changing perspectives on public health and public policy provide a backdrop for NHZs to contribute to the overall movement to end the hitting of children. NHZs work to break through the 'pluralistic ignorance' (where adults assume more support for hitting children than there is (26)) and embolden adults' instincts against hitting, showing support for not hitting norms, and positive adult-child interactions.

This current movement to end corporal punishment of children seems to be having some impact on spanking rates. Recent research (2020) suggests that this long-term, multifaceted approach to end the hitting of children is effective, with the prevalence of 35-year-old parents spanking dropping from 52% to 36% for men and from 48% to 35% for women between 1993 and 2017 (27).

NO HIT ZONES AND PLANNED CHANGE

NHZs provide a straightforward approach to reduce a complex risk factor for child physical abuse - the hitting of children. Yet, an NHZ is also a complete package for planned change related to hitting behavior, social norms related to hitting children, beliefs about the status of children and childhood in families, and the practice of 'discipline' in the lives of children. NHZs transform institutions and individuals that interact with children from a bystander to an intervener role with regards to hitting children.

In viewing NHZs from a planned change perspective, it is important to identify the NHZ targets of change as: 1) organizations and environments where NHZs are established; 2) parents interacting with children in the NHZ space; 3) family members and friends with whom the parents interact; 4) staff members of NHZ organizations who implement the NHZ; 5) family members and friends with whom the staff members interact; 6) communities where NHZs are established; and 7) children who interact with the NHZ. Each of these targets of change has the potential for becoming a change agent and actively advocating against hitting children.

According to Chin and Benne, planned changes are those "…in which attempts to bring about change are conscious, deliberate, and intended, at least on the part of one or more agents related to the change attempt" (28). Clearly, NHZs are a conscious, deliberate, and intended effort to change the way the children of the world are treated. As Lewin describes it (28), change involves three-steps: unfreezing, moving, and freezing at new normal. *Unfreezing* involves making those whose behavior we wish to change (parents/caregivers/staff) see that the change is necessary. This breaks the inertia of rest (old norms and behaviors), leaving those we wish to change with a need to seek alternatives to hitting. *Moving* involves learning about the negative impacts of the old behavior (hitting), finding alternatives, putting them into practice and evaluating their effects. *Freezing at a new normal* involves the target of change adopting the new strategies as one's own and as a preferred way (new normal) of interacting with children.

Quasi-stable equilibrium of hitting children

Before we can explore NHZs as a mechanism for changing social norms related to hitting of children, it is important to identify the constellation of forces that serve to maintain the *status quo*, what Kurt Lewin calls the "Quasi-stable equilibrium" (29). These are the norms, perspectives, and social understandings that have allowed and continue to support adults hitting children. In addition, it is important to describe the goals we are moving toward, and the new normal we want to create. This quasi-stable equilibrium or starting point identifies the restraining forces (preventing us from moving past hitting to not hitting) that the driving forces discussed above work against.

STARTING POINT FOR CHANGE: CHILD AS PROPERTY, THE ACCEPTED *STATUS QUO*

There are several characteristics that form a constellation of forces supporting traditional adult-child relationships and interactions. This is our starting point–or quasi-stable equilibrium:

- Child-adult relationships are built upon inequality, adult dominance, and children's submissiveness;
- Short-term control of children as a central theme;
- Law reflects and supports power relationships of adult dominance and children's submissiveness (research has little value to the law);
- Hitting children is supported by social expectations, religious beliefs, and law;
- Children do not have a voice in decisions that affect their lives;
- Children's human dignity may be degraded 'for their own good';
- Children have no right to bodily integrity, hitting them is seen as acceptable;
- Corporal punishment of children is not considered violence;
- Adults have the power to define children's 'authenticity';
- Hitting of children is a private, family matter promoting a bystander mentality.

This is the status quo as it has existed for generations. It is characterized by an 'inertia of rest.' That is, it will stay that way until something comes along to change its state to one of an 'inertia of motion.' Earlier, we discussed how the children's rights movement, legal reform, corporal punishment research, public health agencies, professional organizations, adverse and positive childhood experiences research, and positive discipline approaches have challenged many of the dimensions of the *status quo* and are providing alternative perspectives which support NHZs and which NHZs help support in a reciprocal relationship.

The new normal: Changes that end the hitting of children

In order to focus our strategies of change, it is important to identify the constellation of forces that will characterize the new normal we are trying to achieve. This constellation consists of the following:

- Child-adult relationships are built on the principles of mutual respect and values;
- Research and knowledge about impacts of hitting children inform laws;
- Children's voices matter;
- Long-term child development becomes a central theme;
- Children have a right to physical integrity, hitting is not acceptable;
- Children have a right not to have their human dignity degraded;
- Corporal punishment is considered a form of violence;
- Harm to children extends beyond the physical to subjective experience of harmful acts;
- Hitting of children is a community concern (upstander mentality).

In planned change terms, the NHZ is a strategy for *unfreezing* the social norms and *status quo* for children and outlines the substance of the changes that must occur. What needs to be done now is to maintain and strengthen the inertia of motion the NHZ activates. Essentially, things at rest tend to stay at rest (stationary inertia) and things in motion tend to stay in motion (inertia of motion) unless acted upon by an outside force. This is the task of change agents seeking to construct this new normal for children into a day-to-day reality.

Strategies for bringing about change

NHZs have been identified as "promising" intervention and a "feasible way" to address a key risk factor for child abuse, social norms surrounding corporal punishment. They are a practical way to educate medical staff on how to intervene during incidents of parent-to-child hitting while promoting a safe and healthy environment (2, 30).

Gershoff et al. (30) identified four reasons why intervention in medical settings is essential. First, medical professionals greatly influence parents' attitudes about the use of physical discipline. Parents often rate medical professionals as highly trustworthy regarding advice on discipline. Secondly, staff surveyed from "two medical centers found that 50% of physicians, 25% of nurses, 27% of other direct-care staff, and 17% of non-direct care staff had witnessed at least one incident of parent-to-child hitting in the previous year" (30). Thirdly, medical facilities are viewed a safe place for healing and therefore, witnessing unrestricted violence can add to the stress and anxiety of patients waiting to be helped. Lastly, medical staff intervening in such situations is progressively seen as a professional and ethical obligation.

Furthermore, after receiving NHZ training, staff who saw parent-to-child hitting reported intervening more often than before training (2). Additionally, after reading NHZ materials, parents stated that their attitude changed about discipline (36.4% spankers, compared to 20% among non-spankers), to now think: 1) spanking is harmful (36.4% vs. 21%); 2) there are better ways to discipline than spanking (50% vs 29%) and 3) medical staff should intervene when parents hit children (45.5% vs 25.7%) (30).

Chin and Benne (28) identify three general strategies for bringing about change in human systems: 1) power-coercive; 2) rational-empirical; and 3) normative re-educative. NHZs apply all three of these strategies at different points in the change process. For example, when an organization develops and implements an NHZ policy, it is exercising its *power to control* the environment in which people interact. In training staff about the negative impacts of hitting children, NHZs are employing a rational-empirical approach. By modeling non-hitting

alternatives, staff implementing an NHZ are utilizing a normative, re-educative approach to change.

Unfreezing hitting and power coercive strategies of change

In the context of an NHZ, the goal of preventing the hitting of children (or other negative behaviors likely to escalate into violence toward children) is met through using organizational power to set and give notice of behavioral rules in the space they control. The NHZ message seeks to deter the hitting before it happens. Much like 'No Smoking' efforts, employing organizational power through the use of visible NHZ signage by the organization (controller of the space) empowers and supports staff to intervene and enforce the no hitting policy when they observe problems. Immediate instances of power-coercive strategies of change rely on the legitimate use of political, economic, or moral power as rewards for behavior reflecting the goals of the change. Signage indicating the space (e.g., a hospital waiting room) is an NHZ and describing the four principles, communicates this message. Using staff to calmly intervene and explain to parents that "No hitting" is hospital policy to create a safe environment for all, establishes the legitimate power of the organization.

How do NHZs start the unfreezing process of hitting? First, an NHZ is unambiguous: No hitting. NHZs do not attempt to determine the fine line between hitting and abuse (a legal question). Second, NHZs connect all hitting – corporal punishment (adult on child), domestic violence (between adults), bullying (child on child) and elder abuse (child to adult). Though the focus is on children, NHZs do not make child hitting a special case. Third, NHZs focus on the behavior itself, not judgments about the behavior, its degrees, or justifications. Fourth, NHZs incentivize the intentional and conscious search for and application of alternatives, since NHZs eliminate the often non-thinking or conditioned response of hitting.

Movement and rational empirical change strategies

A rational and empirical approach to change assumes that people will move in the direction of change desired by the change agent (see 'new normal', above) if information is presented that shows the existing conditions do not benefit the person's best interests and the desired change does. Once unfreezing has occurred by establishing an NHZ, communicating evidence-based messages to the various targets of change about the short and long-term harms, ineffectiveness of, and alternatives to hitting is central to implementation efforts. This is achieved via trainings, signage, brochures, electronic messaging, and modeling alternative behavior. This approach integrates research and knowledge describing the problem, demonstrates how change can occur (evidence-based programming), and explains how the person, group, organization, or community will benefit from the change. Rational-empirical change strategy is a component of staff training. It works by translating the vast body of research findings about the many negative impacts and the absence of benefits of hitting children into clear and simple messages. It also includes information about positive parenting/interaction strategies (3).

Refreezing: Normative re-educative change strategies

Modeling and communicating positive child-adult interactions for parents and staff is crucial. Normative re-educative change strategies recognize the social and knowledge-based aspects of change. Change occurs not only through acquiring new information, but also by having individuals participate in social contexts that permit them to interact with others in the development of solutions to social problems. Elements of Normative re-educative change include: 1) targets of change are involved in dialogues, which helps them understand the problem of change as the change agent perceives it; 2) since a lack of knowledge can be part of the problem, attitudes, values, and norms reinforced in social contexts can determine whether information is received and processed; and 3) mutual and collaborative relationships between those proposing change and those being asked to change with regard to defining the problem and solutions are important whether it is at the personal, organizational, or community levels (28).

NHZs demonstrate and make clear that hitting children need not be the norm. They demonstrate how respected institutions and organization value children and parents and the long-term development of both. They support staff and parents in learning designed to foster 'rethinking' hitting in an environment where hitting is not an option. They give staff trained in NHZ implementation opportunities to practice alternatives, model for others and practice for themselves non-hitting alternatives. They provide children with opportunities for positive experiences in their relationships with adults.

CONCLUSION

In the larger movement to end violence against children, No Hit Zones provide an opportunity to increase awareness of the short- and long-term harms of hitting children, as well as the opportunity to alter behavior and change social norms at multiple levels. Drawing from the diverse contributions within the movement, NHZs utilize various change strategies to integrate both micro- (individuals) and macro- (communities and organizations) normative change related to the hitting of children. By creating environments in which hitting is not acceptable, NHZs motivate others to understand why this counter hitting norm is in place and explore alternatives to this behavior. By educating all those involved with children about the negative and ineffective nature of hitting, NHZs provide support for parents, caregivers, and organizational staff to substitute evidence-based behavior for rituals. Finally, through training, modeling, and practice, NHZs provide opportunities for the solidification and personal acceptance of the new norms in non-hitting behavior. By making support for non-hitting visible through larger population-based campaigns, NHZs have the potential to make "non-hitting" a cultural practice.

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Chapter 9

USING TECHNOLOGY IN CHILD WELFARE AND CHILD ABUSE PREVENTION

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ABSTRACT

Technology is often thought of as the application of scientific knowledge to practical aims including changing and manipulating the human environment, such as through the use of automobiles, kitchen appliances, or safety devices like "child-proof" bottles and seatbelts. However, a recent digital revolution generates vast quantities of social, psychological, and organizational data that can be used to address society's most difficult problems, and technology makes it possible to use these artifacts to manipulate both human and digital environments. In particular, innovations have made it possible to manage and analyze digital assets in real time to reduce and prevent child abuse and neglect. A grand challenge for prevention is to build the capacity to deploy these powerful digital resources to discover and apply social solutions to benefit society. This chapter describes technology available for child welfare and is intended to raise policymaker and practitioner awareness of the capabilities, affordances, and limitations of such technology and where they may take us for child abuse prevention.

ABBREVIATIONS

AI	Artificial Intelligence
ALS	alternate light source
CCWIS	Comprehensive Child Welfare Information System

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CM	child maltreatment
CPS	child protective services
CRC	Convention on the Rights of the Child
GIS	geographical information systems
ICT	Information and communication technology
IoT	Internet of Things
IPV	Intimate partner violence
NCANDS	National Child Abuse and Neglect Data System
PA	predictive analytics
PCIT	parent-child interaction therapy
PRM	predictive risk modelling
TF-CBT	trauma-focused cognitive behavioral therapy

INTRODUCTION

Technology is the application of scientific knowledge to practical aims including changing and manipulating the human environment, such as through the use of automobiles, kitchen appliances, or safety devices like "child-proof" bottles and seatbelts. This term may also be applied to computers and digital and electronic media. The Digital Revolution produces vast social, psychological, and organizational data that may, like physical manifestations of scientific knowledge, help address society's difficult problems. Data from computerized social service, education, and health records, open data portals, social media posts, web searches, and mobile sensors can identify social problems and advance strategies to prevent child abuse and neglect, with recent innovations making it possible to manage and analyze digital assets in real time. Despite technological progress, child welfare systems have been slow to incorporate data analytics to inform policy and practice, in part because knowledge gaps limit effective collaboration with other disciplines in accelerating data-driven social innovation. A grand challenge is to build the capacity to deploy these digital resources to discover and apply socially-beneficial solutions (1).

Child welfare and child maltreatment prevention face high caseloads, crises, workforce shortages and limited financial support. Information and communication technology (ICT) have the capacity to increase worker efficiency and extend services; however, mistrust in use and poor implementation create public financial burdens, contradict worker efficiency and agency goals, and thwart service implementation. For countries confronting the global child welfare crisis, a lack of information-organizing technology may be a stumbling block to family preservation, reunification, and prevention. A significant barrier is the inadequacy or the inability to access data in electronic form (2). Another major shortfall is the lack of empirical research about use, effectiveness and replicability of ICT in this field.

The following case highlights this issue: In 2018, the New York Foundling, a charity offering child welfare, adoption, prevention and mental health services, was stuck in "cut-and-paste" hell. Clinicians and administrative staff spent hours transferring text among databases to meet legal requirements. The charity's Chief Information Officer blamed data entry drudgery for an annual staff turnover of 42 percent. Since then, the New York Foundling has automated "grunt work" using Robotic Process Automation (RPA)—programs hand-crafted to perform

monotonous tasks. These programs record and mimic a user's keystrokes, eliminating hours of work. After implementing RPA, staff turnover fell to 17 percent, with remaining employees believing RPA will free resources to take on complex tasks such as transcription or sorting images. The charity hopes that "software robots" will learn how to automate the automation of repetitive work, freeing workers to directly help families and prevent child maltreatment (3). This problem and solution, like many impactful technologies, appear simple but lead to significant impact. Like other technologies, RPA suffers common challenges.

Technology concerns include but are not limited to ethics, confidentiality, security, financial liability, worker perceptions, feasibility, and ease of use. If these hurdles can be surmounted, technology may expand prevention services to larger populations otherwise unreachable with standard, worker-based models (4). Cloud/web-based information systems and case management tools, mobile technologies (including applications), interagency data-sharing and data-integration efforts, social media platforms, the incorporation of technology into foster parent recruitment and retention efforts, and data/information mining to aid in the application of predictive analytics may all inform and enhance child welfare practice. In addition, emerging technologies may be beneficial, including data visualization software, document management systems, the Internet of Things (IoT), location-based services/geofencing, business rules engines, blockchain and intelligent automation, conversational platforms, and virtual reality.

Technology also presents an array of new terms to be learned by busy clinicians and administrators. Definitions of common terms in the field are presented in table 1, with most described technologies requiring agency transformation of systems, policies and procedures, program design and implementation, casework practice and protocols, and staff training/workforce development plans. As new technologies develop, it is hoped that child welfare, law enforcement, medical and social work professionals will experience the benefits (as well as the challenges) related to the use of these technologies directly or indirectly with their clients (5).

This chapter non-exhaustively describes the state of the art in technology for child abuse prevention and child welfare. It is intended to raise policymaker and practitioner awareness of the capabilities, affordances, and limitations of such technologies as of 2020. Technology has the potential to impact child abuse and neglect, beginning with prevention, by changing human interactions and reducing or eliminating the potential for abuse, through improving reporting and identification of high-risk social situations and training professionals, to enhancing and expanding service provision to treat harm and change behavior after maltreatment has occurred. We first focus on Big Data, artificial intelligence, predictive analytics and data linkage and then consider emergent capabilities for technology within child welfare, including telemedicine and teleservices, connectivity and mobile technologies. We explore how these capabilities enable the use of the Cloud and the Internet of Things (IoT), followed by a discussion of technical, policy and human-factor related challenges. We close with considering future directions for technology in child abuse prevention and child welfare.

Table 1. Definitions and descriptions of terms used in technology

Term	Abbreviation	Definition/description
Analytics		Human and machine learned models relating data to specific, often insightful, outputs.
Artificial Intelligence	AI	Broad term used to describe the set of technologies that enable machines to sense, comprehend, act and learn. The history of Artificial Intelligence is traced back to the 1940s when scientists and mathematicians began discussing how a mechanical device could be used to imitate the human process of mathematical deduction.
Big Data		Digital byproducts of human activity (e.g., carrying out government functions, delivering services, administering programs, conducting business transactions, communicating through social media, using digital devices).
Blockchain		A list of records, called blocks, that are linked using cryptography. Each block contains a cryptographic hash of the previous block, a timestamp, and transaction data. By design, it is resistant to modification of the data through the use of an open, distributed ledger recording transactions in a verifiable and permanent way.
Cloud		A network of remote servers connected to the Internet to store, manage, and process data, rather than requiring a local server or a personal computer. Cloud computing supports platform creation and application enablement, as well as Cloud-run software.
Cognitive computing		Platforms combining Artificial Intelligence with other aspects of the cognitive cycle, including like perception, reasoning and decision optimization. Cognitive computing encompasses disciplines such as machine learning, natural language processing and computer vision among others.
Computation		Electronic systems for processing data. The state-of-the-art includes multiple core (parallel) processors.
Connectivity		Ubiquitous communication across devices, often at a large geographic and numeric scale.
Connected Homes and Smart homes		A home is smart or connected when it can help with the day-to-day of life by automating tech for security, convenience, comfort, and entertainment. Appliances and devices that can communicate on a home network include some appliances, lighting, heating, air conditioning, shades, security system, sound systems, TVs, etc.
Cyberbullying		Bullying that takes place over digital devices like cell phones, computers, and tablets, also known as cyberharassment or online bullying. It has become increasingly common, especially among teenagers as the digital sphere has expanded and technology has advanced.
Data Analytics		The end-to-end process by which data is cleaned, inspected and modeled. The data analytics process encompasses qualitative and quantitative techniques used to discover insights into behaviors, trends and patterns.
Deep technologies		Technology based on substantial scientific advances and high-tech engineering innovation requiring lengthy research and development time and that may take a long time to reach commercial application, often requiring large investments to achieve commercial success. A “deep” technology was impossible yesterday, is barely feasible today, and will quickly become so pervasive and impactful that it is difficult to remember life without. Fundamental capabilities comprise sensing, connectivity, computation, inference, actuation, and control.
e-Health		The organization and delivery of health services and information using the Internet and related technologies or the transfer of health resources and health care by electronic means.
Geofencing		Location-based service in which an app or other software uses GPS, RFID, Wi-Fi or cellular data to trigger a pre-programmed action when a mobile device or RFID tag enters or exits a virtual boundary set up around a geographical location, known as a ‘geofence’.
Global positioning system	GPS	U.S.-owned utility that provides users with positioning, navigation, and timing services across the surface of the Earth. This system consists of three segments: the space segment, the control segment, and the user segment.

Term	Abbreviation	Definition/description
Information and communication technology	ICT	Although there is no single, universal definition of ICT, the term is generally accepted to mean all devices, networking components, applications and systems that combined allow people and organizations (eg, businesses, nonprofit agencies, governments and criminal enterprises) to interact in the digital world.
Internet		A global computer network providing a variety of information and communication facilities, consisting of interconnected networks using standardized communication protocols.
Internet of Things	IoT	A phrase that refers to the objects and products that are interconnected and identifiable through digital networks. Internet of Things devices and services connect to one another intelligently and at large scale, and can sense, infer, and act. Any connected electronics in a home, office, or vehicle are part of this technology revolution.
Mobile technology		Equipment that goes where the user goes, such as portable two-way communications devices, computing devices and the networking technology that connects them, typified by internet-enabled devices like smartphones, tablets and watches.
Predictive analytics	PA	The process of applying statistical algorithms to data to make informed guesses about future events. It combines mathematical models (or "predictive algorithms") with historical data to calculate the likelihood (or degree to which) something will happen.
Predictive risk modelling	PRM	The process of combining data sources to learn risk factors and relate these to outcomes with high accuracy.
Radio frequency identification	RFID	Uses electromagnetic fields to automatically identify and track tags attached to objects. An RFID tag consists of a tiny radio transponder: a radio receiver and transmitter. When triggered by an electromagnetic interrogation pulse from a nearby RFID reader device, the tag transmits digital data, usually an identifying inventory number, back to the reader.
Sensors and Sensing technology		Pervasive, low cost, and accurate technology that uses sensors to acquire information by detecting the physical, chemical, or biological property quantities and convert them into readable signal. These sensors offer real-time monitoring, including detection and reporting, as needed by a process.
Tablet		A portable computer that uses a touchscreen as its primary input device. Most tablets are slightly smaller and weigh less than the average laptop.
Virtual reality	VR	Simulated experience created to allow the user through sight and sound to have experiences that can be similar to or completely different from the real world through interactive software and hardware to provide 3-D immersive environments. Virtual reality applications create experiences that can make users suspend their disbelief about the reality of an environment and how they interact with it. Looking real can be achieved by wearing a head-mounted display that displays a recreated life-size, 3D virtual environment without the boundaries imposed by a TV or computer screen. Feeling real can be achieved through handheld input devices such as motion trackers that base interactivity on the user's movements.
Wi-Fi	WiFi	A family of wireless network protocols based on the IEEE 802.11 family of standards, which are commonly used for local area networking of devices and Internet access. Compatible devices can network through wireless access points to each other as well as to wired devices and the Internet.

BIG DATA AND THE DATA REVOLUTION

Child abuse prevention and child welfare are large and growing fields with substantial economic and social considerations (6). As the need for enhanced services grows, so too grow supporting technical capabilities and government investment (6). Workers, for example, demand automation to reduce administrative burden (3) and the public increasingly asks to see

and engage with data (1). The same capabilities meeting these needs may enhance both abuse prevention and remediation. One way in which technology may help enhance child welfare is to provide information where data were previously unavailable, e.g., for mitigating abuse-related child fatalities (7). The "quantified self," smart environments, connected vehicles (8), and digital breadcrumbs serve to inform practitioners and algorithms alike such that informed decisions may be made, and outcomes evaluated empirically. Technology–and particularly data capture, electronic care records, and their interchange–provides an opportunity to match decisions to measurable outcomes across care mechanisms and geographies (9). These data provide assurance that case decisions and interventions are both evidence-based and effective. *Cognitive computing*, for example, is a powerful approach for better-identifying families at risk for child maltreatment fatality, as well as elucidating the spectrum of issues faced by various child welfare systems (7). Cognitive computing is a mode of thinking about existing technology capabilities and their integration with the aim of emulating human thought (e.g., combining pattern-based machine learning with domain knowledge and a scalable computing platform) though its use as a term of art has been driven in large part by corporate interests.

Monitoring the relationship between interventions and outcomes helps to determine effective care, and capturing data is easier than ever. A consumer-facing digital revolution has led to the widespread creation of digital artifacts useful to social work, ranging from social media to pervasive mobile and wearable devices (10), and connected homes, factories, and cars (11, 12, 13). Within child welfare, such artifacts have the potential to enhance agencies' ability to improve diagnostics and allow for an enhanced focus on prevention and early intervention rather than response (6). These data also support digital intervention, augmenting firewalls and filters with new approaches to content monitoring–such as natural language processing text inspection (14)–allowing for the detection and automated mitigation of cyberbullying (15). In aggregate, digital artifacts may comprise *big data*.

Big data refers to digital byproducts of human activity (e.g., carrying out government functions, delivering services, administering programs, conducting business transactions, communicating through social media, using digital devices). "Big" signifies volume as well as the velocity and variety of data elements and sources and the special analytic processes required to turn raw information into useful insight. Handling Big Data is complicated because it is variable and prone to misinterpretation if not curated and subject to review. These may include unstructured text, images, and recordings in addition to more commonly used structured data. For these reasons, traditional data management, processing, storage, and analysis may be inadequate for maximizing data value (1).

Every year there are more than 3.6 million referrals made to child protection agencies across the US. The practice of screening calls is left to each jurisdiction to follow local policies, leading to large variation in the way in which referrals are treated across the country. While access to linked administrative data is available, it is difficult to make systematic use of historical information about all the children and adults on a single referral call. Risk models that use routinely-collected administrative data help call workers better identify cases likely to result in adverse outcomes and which cases would benefit from prevention rather than investigation. However, the use of predictive analytics is contentious: some communities, such as those in poverty or from particular racial and ethnic groups, might be disadvantaged by the reliance on government administrative data. On the other hand, these analytics tools can augment or replace human judgments, which themselves are biased and imperfect (16). Enabling such systems requires national- and global-scale child welfare data collection

systems, like the National Child Abuse and Neglect Data System (NCANDS) which collects child abuse report, victim, offender and family information, and is representative of Big Data's growing role in abuse prevention and response.

Extending today's data-generating capabilities, deep technologies (problem-solving technology that was impossible yesterday, is hard to build today, and tomorrow has the potential to become so pervasive that it's invisible–and so important, it will be hard to imagine life without) (17) enabling sensing, connectivity, inference, and feedback/actuation make possible new modes of data capture, analysis, and operationalization. Sensing benefits from pervasive, low cost, and precise sensors in mobile and other devices; connectivity is now ubiquitous, and allows sensor data to be shared and heightens interpersonal communication; data storage, processing algorithms, and enhanced computation allow for automated analytics taking advantage of diverse and large-scale data sources, and feedback and actuation provide a means to share information and/or to care plans with buy-in from doctors, social workers, patients, and their families. As a result of the proliferation of technology and technical competence, information and communication technology's use is expanding and costs are falling (4), with state-run data systems capturing important information and integrating with external data sources to enable analytics and to reduce administrative burden while improving decision speed, traceability and auditability (1, 18).

BIG DATA AND ARTIFICIAL INTELLIGENCE

The generation of big data from individuals' and agencies' devices and services creates opportunities for its use in artificial intelligence applications designed to augment and eventually supplant human knowledge work.

Big data

Preventing child maltreatment increasingly demands evidence-based policy and practice (1). Big Data allows for the development of *measurable* strategies for change (9) and child abuse prevention and child welfare benefit from ready access to more data than ever. Data may be entered manually or passively produced, for example, captured by a device as a byproduct of one's actions (19). It may be stored within or shared from data warehouses, the Internet, and mobile devices (9). Social media is another data source when assessing child welfare (20). Often, data from multiple sources are combined to support complex analytics (e.g., combining communication metadata with mobile phone sensors to identify likely abuse) (21). For example, large data sets have been beneficial to law enforcement, which has used them to mitigate identified or anticipated harm to individuals or communities, including children (22). The Big Data revolution has fundamentally changed how data are captured, evaluated and understood to produce actionable intelligence (9).

Once a child is in a home environment, software facilitates attention to risk factors in early home visitation for child maltreatment prevention (23). Similar algorithms have utilized sensor and administrative data as the input for actuarial models for risk supporting decision-making (24).

Artificial intelligence

Artificial intelligence (AI) encompasses machine, deep, and reinforcement learning. AI may be general (emulating human thought) or task-specific. AI uses data to create supervisory AI models enabling systems that are descriptive (what am I seeing?), diagnostic (what happened?), predictive (what will happen?), and prescriptive (what should I do?) (9, 24). Big data and AI have the potential to offer insight into child welfare, including case assessment and global-level trend analysis. Today, governments are the biggest producers of data (2), with national databases collating information related to child maltreatment reports and deaths (25). Moreover, Big Data may evolve how nonprofit and the government service sectors operate (26). AI has found success in task-specific implementations, including as a tool to inform child welfare practice through predictive analytics (PA) (5). PA learns patterns in data to identify the future likelihood of events taking place (27) and supports risk assessment for future maltreatment, helps anticipate the likelihood of protective outcomes (28), enables automated child welfare case referral, and directs resources to the highest-risk children (16). AI has also been piloted as a means of identifying fit in "placement studies" for children in foster care, to reduce the number of families with whom a child is placed (29). Other AI algorithms automate knowledge extraction, for example, to identify the efficacy of services in improving child safety outcomes, checking whether risk factors for abuse exist, testing children and homes for fit, or even highlighting relevant literature to review, thereby limiting search time (7). AI and automation systems may help process administrative data, enabled by document management systems that makes online access feasible (5) and support RPA to reduce hours spent on repetitive work (3).

AI also has the potential to improve the diagnosis of child maltreatment. For example, the errors in diagnosis of abusive head trauma (AHT) in radiological studies can put children at risk of re-injury and death, but deep learning can be utilized to detect AHT from computer tomography (CT) scans (9, 30) . However, while AI is responsible for stunning advances, a challenge remains in converting AI-derived predictions or recommendations into effective action. The most pressing problem is to change the behavior of millions of families and professionals (31, 32). For health care, the promise of AI in the near term is the opportunity to assuage the frustration of health care providers who have been clicking away on electronic records with modest benefit beyond increased data transportability, legibility and reimbursement. AI will be the "payback" for the investment in both the implementation of electronic health records and the cumbersomeness of their use by facilitating tasks that every clinician, patient, and family would want, but that are impossible without electronic assistance—such as monitoring a patient for emergent sepsis and providing timelier therapy for a condition in which diagnostic delay correlates with increased risk of death (33).

Data linkage

Linking data across sources has the potential to create richer "profiles" for risk assessment and supervision, underpinned by "unbiased" information captured by technology – rather than humans (7). Linking and integrating disparate data is challenging but may advance efforts to protect children (34). Blockchain is a solution for preserving data integrity, using distributed—

and often public—ledgers, along with consensus technology, to validate that the information reflects that which was generated in the first place (5, 35).

The value of data linkage is increasing in crime prevention, for example (21). Another example of data linkage is birth match. Data have been used to identify risk factors for maltreatment, with a birth match algorithm (36) using existing systems to ingest birth certificate and child welfare data including whether siblings were previously removed from a household or whether a parent's rights have previously been terminated in order to determine whether a new infant may be at risk of abuse (though its critics note that automated systems lack transparency and explainability) (24). Procedures to identify and serve high-risk infants in three jurisdictions (New York City, Maryland, and Michigan) were found to offer a timely, low-cost, intervention squarely-based on current legal premises to increase the protection of newborns and very young children who were born to a parent with a prior termination of parental rights or with a child currently in out-of-home care (36). Proponents of the system suggest it may be made more effective if provided with data from automated surveillance systems capturing more than just historical family data (34).

It is increasingly common to link statewide birth cohorts with CPS reports to study child maltreatment incidence over a child's life course. One study compared the reported incidence between two states derived from population-based administrative data linkage using linked births and CPS records (37). Health informatics projects combining countrywide birth populations with child welfare records have emerged as a valuable approach to conducting longitudinal research of child maltreatment. Linked administrative data sources provide data on all deaths and risk factors for children in the population (i.e., children who died and those who did not) inexpensively. However, administrative data does not provide the same level of detailed information about a death as does child death review, serious case review (SCR), or a coroners' report. Targeted use of detailed investigations into the circumstances of child death could be guided by and enhance findings from administrative data, and the priority should be greater use and wider linkage of these data to inform strategies to prevent child deaths (25).

Predictive analytics

The implementation of electronic information systems in welfare agencies has led to the accumulation of information about service users and their activities. Predictive analytics (PA) refers to the process of applying statistical algorithms to data to make informed guesses about future events. While the analysis of such data is not new, recent developments have meant that datasets from separate agencies can be combined and analyzed on a larger scale with the promise of new insights that can inform how services are organized and delivered. Algorithms may be developed to utilize new data in order to calculate the likelihood of adverse events for both groups of people and individuals. Based on such analysis, research has suggested ways to reduce child abuse, including educational and economic support measures (38).

Predictive risk modeling (PRM), a subset of PA, has been used to mitigate the risk of maltreatment by combining public data sources to learn predictive factors and relate these to outcomes with high accuracy for young children (39). PRM is considered to be effective at targeting resources where they are the most needed, and for early identification of risk, as a decision point in triaging potential intake, and in determining neighborhood-level service needs (40). PRM may identify the need for intervention earlier and allow for behavior correction

rather than incident response (1), though models may be ineffective at predicting certain outcomes (41). Such approaches have been used in health and social work and have attracted international interest. In one New Zealand study, PRM has been applied when families enter the public assistance benefits system through which the government provides financial support to generate a score estimating the likelihood of future child maltreatment for individual children. Families with children who have high scores are then offered supportive services to reduce the likelihood of child maltreatment (39). While PRM can spotlight a child in trouble and suggest intervention, technology advocates say doing so is government's moral obligation (7, 42).

There are potential downsides to PRM (40, 41). It may help professionals make decisions more accurately, objectively, and quickly, though there is concern that some methods may result in discriminatory practices for vulnerable children and families (27). There are ethical considerations for determining its appropriate role in child welfare (27). To make the most impact on child protection practice and outcomes, it must embrace established criteria of validity, equity, reliability, and usefulness (28). PA may be faster and potentially more objective than humans, with enhanced accuracy and equity of decisions, though it is suggested that such algorithms support decision-making through the augmentation—rather than replacement—of professional judgment (5, 27).

Quality data may result in earlier, more positive interventions, whereas low-quality data could result in false positives and wasted resources or false negatives, missing preventable maltreatment. At the same time, vulnerable populations may be at risk of becoming “invisible” to algorithms through their non-inclusion in training datasets (9). What is driving this particular image, what heterogeneities are being homogenized, and what slippages occur in this process? What is foregrounded and what is invisible in these data? How does the result influence perceptions of child abuse and policy responses to it? For example, when considering child maltreatment reports, families who are subject to more surveillance by potential reporters tend to be over-represented, particularly those involved in public welfare systems or the justice system or those in contact with non-governmental organizations. This means over-reporting of those who are poor, ethnic minorities, single parents and women. International research suggests that ethnicity and poverty often affect notification patterns, and report rates have been found to be higher for black children, but this has been attributed to other risk factors for reporting and not race (40).

MOBILE TECHNOLOGIES

Mobile technology is familiar and emergent in child abuse prevention and child welfare. As of 2017, 95% of U.S. adults owned a cellphone, most of which were smartphones (43). Care providers use mobile phones and tablets to access databases (e.g., client history, resource availability, informational handouts) anytime and any place (5). Easing access to networked data makes it easier for workers to access information in the field and for clients to configure their homes (e.g., lights and switches, networks, appliances) to improve safety and assist with home health care.

Mobile-enabled capabilities include video visitation, paperless investigations, ready-reference, integration with government and other data sources, and appointment scheduling (5).

Mobile applications already help to improve visitation impact while enhancing worker satisfaction, increase the clarity of documentation, and enhance productivity (5, 44). Tablet devices have been used during home visits to provide parents with an opportunity to engage with psychoeducation and target skill-modeling applications to improve engagement with care plans and enhance parenting skills (42). These devices are also a valuable source of information to be used in forensics—whether by providing text messages, images, audio recordings, or location and motion data. Work modernizing child welfare services with mobile devices has been successful, and there are opportunities to grow the technology's reach and impact.

However, challenges in ease-of-use and unrealistic expectations may lead to potential disillusionment (44). Access to social services is important for the safety of children and ultimately for reunification of families involved in the child welfare system, but the process of linking families to services varies by caseworker and can be cumbersome and time-consuming. One study revealed four barriers: 1) caseworker apprehension regarding new technology, 2) variation in communication styles, 3) lack of technological infrastructure, and 4) competing workplace demands. Although Internet-based interventions are designed to inexpensively and effectively coordinate services, emerging interventions may require in-person assistance for success (45).

Technology advances allow for access to remotely-delivered interventions designed to promote early parenting practices that protect against child maltreatment. Leveraging mobile phone availability to support more frequent parent-child intervention has been shown to improve parenting, while texting has demonstrated increased engagement between families and intervention staff, enhancing long-term involvement with care programs (46). One study examined engagement and outcomes among mothers with heightened risk for child abuse who were enrolled in a randomized, controlled, intent-to-treat trial of an Internet adaptation of an evidence-based infant parenting intervention. They found engagement patterns were similar in both higher and lower risk groups. Moreover, an intervention dose by condition effect was found for increased positive parent behavior and reduced child abuse potential (47). Another study assessed whether a cellular phone-supported version of the parent-child interaction therapy improved long-term parenting practices, maternal depression, and children's aggression. They found parenting improved in higher and lower risk groups between baseline and 12-month follow-ups, with children being more cooperative and less aggressive than children in the control group (46).

Mobile devices enable data entry too, having been used successfully to review and revise family service plans in families' own homes as well as to deliver services with families during home visits (48). Home visiting programs support positive parenting in populations at-risk of child maltreatment, but their impact is often limited by poor retention and engagement. SafeCare®, a home visiting program shown to prevent child neglect and physical abuse, takes a technology-based hybrid approach to program delivery, where a provider brings a tablet computer to each session, and the parent interacts with the software to receive psychoeducation and modeling of target skills (42, 49). Interactive software may facilitate attention to risk factors and use of evidence-based approaches, and eight 20-min computer-delivered modules for use by mothers during the course of early home visiting resulted in their improved satisfaction, working alliance, retention, and reduced child maltreatment and child maltreatment risk factors (23). In another study, using mobile equipment in the field with families did not make a difference according to a worker survey (44).

CLOUD AND WEB-PLATFORMS

Mobile devices are elements in a larger system of networked devices. These devices generate data artifacts that must be managed, processed, and served to other systems or users. Web platforms (computers that store, process, and serve data to end-user devices) and the Cloud (a diffuse network of interconnected computers) provide a "backend" for these data to which end users including patients or care providers may connect. Web platforms tend to capture and serve smaller volumes of data and may have regional or other scope constraints. The Cloud is fast becoming a repository for data at a larger scale, facilitating low-cost storage, aggregation, and processing. The Cloud provides the industry with the infrastructure necessary for massive-scale computing projects and supports web application development and deployment (6). Both web platforms and Cloud interfaces may be the foundation for other applications and development aimed at expanding data access and usability (ie. through the creation of interface software or visual dashboards may continue to yield child welfare and operational improvements) (1). Challenges to the growing deployment of such systems include caseworker apprehension, though involving potential stakeholders during design may improve the likelihood of successful adoption (45).

Web-based platforms have been used for child abuse prevention and child welfare. Some providers find that web platforms offer enhanced efficiency (49), while others ease resource matching, help link families to available support services quickly and efficiently (45), or provide abuse reporting tools (5). Cloud-based information systems and case management tools that have been demonstrated include systems horizontally integrating agencies to enable data sharing (5). Indiana, for example, implemented a Cloud-based mobile child welfare information and case management system resulting in practice improvements (5).

Current web-based information systems and case management tools include the Statewide Automated Child Welfare Information System and CCWIS tools, the National Electronic Interstate Compact Enterprise, and child maltreatment online reporting systems for receiving child abuse and neglect reports. In June 2016, the US Administration for Children and Families issued The Comprehensive Child Welfare Information System (CCWIS) rule, replacing the Statewide Automated Child Welfare Information System (SACWIS) rule. Through the new CCWIS rule, the federal government provides 50 percent fund matching for agencies to transition to modern case management systems facilitating interoperability and extensability. CCWIS sparked transformation in child welfare because it encourages the use of innovative modern technology configured uniquely for each state's needs. It also emphasizes data quality and exchange with other programs and systems. The Families First Prevention Services Act (FFPSA) followed two years later, creating a new focus for agencies by making prevention a federally-fundable set of activities, supporting evidence-based practices as the preferred method of intervening with families and prioritizing family placements over congregate care. CCWIS and FFPSA present an opportunity for child welfare innovation and may spur new approaches to child welfare practices and technologies that improve outcomes for families and children (6).

ADVANCES IN E-HEALTH, TELEMEDICINE, AND GIS

e-Health includes the organization and delivery of health services and information using the Internet and related technologies and the transfer of health resources and health care by electronic means. It encompasses three areas: the delivery of health information for health professionals and health consumers, improving public health services (e.g., through the education and training of health workers, and health systems management) (50).

e-Health comprises powerful and emergent technologies. Telemedicine replaces direct contact between a practitioner and a patient with electronic communications, with training and practice as important elements to telemedicine's efficacy (51). Telemedicine is a system, not a technology, and primarily supports synchronous, real-time, and full-duplex communication and video between a patient and a care provider (51). Putting talented practitioners "on-line" allows care providers to reach patients in their own homes and has the potential to expand skilled workers' reach across geographies. This allows demand aggregation and load-leveling for practitioners (51). Such systems may reduce or remove barriers to access for social work and counseling services, increasing participation (18), or may complement traditional home visits and interventional techniques (43). Telemedicine systems are widely available, reliable, and easy-to-use (52). Telemedicine has grown increasingly important as a result of the Covid-19 pandemic, during which access to medical care has been limited and complex home situations may result in increased incidence of abuse (51). It has also been used to enable biological families to visit their children in foster care when environmental factors prevent in-person visits (53).

Another e-health application is teleradiology, "the electronic transmission of radiological images from one location to another for the purposes of interpretation and/or consultation." (52, p. S46). Due to large file sizes, compression is necessary to attain an acceptable transfer speed. Traditionally, compression has been associated with loss of image quality that may result in reduced diagnostic accuracy—particularly significant in child abuse, given the subtlety of findings. Lossless compression today eliminates this constraint (54). Other multimedia-enhanced healthcare augments education (e.g., through online classes and workshops) to support doctors and workers across expansive geographies (55) to improve their skills by simultaneously allowing digital artifacts to be reviewed in conjunction with an expert, for example, to learn how to differentiate images of fractures resulting from injuries from those resulting from abuse (54). In this manner, fewer certified experts may be required to review suspected child abuse cases, and travel needs may be reduced (54). Remote peer review of digital images is also supported (51), including in forensic applications (55).

Children may demonstrate trauma symptoms requiring clinical intervention. Obtaining behavioral health services for youth and families involved with child welfare can be challenging as need surpasses capacity and service coordination between the child welfare and behavioral health systems is inadequate (18). Technology may improve how child welfare agencies implement trauma-informed systems reform (1). Barriers exist in access to evidence-based, trauma-focused treatment among youth from economically disadvantaged backgrounds, those living in rural areas, and belonging to a racial and ethnic minority group, despite the high prevalence rates of trauma exposure among these underserved groups. In one study, trauma-focused cognitive-behavioral therapy (TF-CBT) delivered to underserved trauma-exposed

youth via one-on one videoconferencing provided preliminary evidence of the ability to successfully deliver TF-CBT via a telehealth delivery format (56).

Literature on the efficacy of telepsychiatry for assessing and treating children and adolescents with mental health problems is nascent, though there is evidence that telepsychiatry is diagnostically valid and offers high patient and provider satisfaction (52). Telepsychiatry may prove to demonstrate similar outcomes and reliability to face-to-face psychiatric care, and it has been argued that for children and adolescents, telepsychiatry consultation might be superior to face-to-face consultation because children may be more willing to provide detail to a care provider through a novel and impersonal communication method (57). It is, however, important to remember that there are limitations to its use (58).

Telemedicine has been used for remote coaching to minimize risk of child maltreatment (47). Internet-based telemedicine has also been used to deliver parent-child interaction therapy (PCIT). PCIT is an empirically-supported behavioral parent training program for reducing disruptive behavior in young children and for reducing future rates of child physical abuse. PCIT has traditionally been taught in university-based training programs in a mentored cotherapy model. By contrast, PCIT training in field settings typically consists of workshop training with a period of telephone consultation. Given concerns with the level of practitioner competency and fidelity yielded by the model, training programs have begun to examine Internet-based telemedicine to deliver live, mentored PCIT training at remote locations to better approximate the university-based training model in addition to using electronic communication to provide direct PCIT services (52). Outside of welfare screenings, telehealth has been used to screen children for developmental delays (44). One in three Internet users globally is a child (19), so with appropriate safeguards in place, this has the potential to become a powerful engagement approach with a broad reach.

Another recent technology capability is the use of location data and geographic information systems (GIS). GIS allow data to be attributed to relative and absolute positions on the Earth's surface. GIS improves decision-making by simplifying the analysis of relationships among people, families, communities, and environments. This allows for visualization of placement of children, proximity to family, and community resources. This may enhance educational stability, transitioning out of foster care, and resource allocation for welfare programs (59). Location-based services, such as those supported by mobile phones, may be used to ensure that care workers complete home visits or help to locate missing children (5). Geofences may also be configured to alert parents or caregivers if children enter or exit predefined boundaries (e.g., entering an area with known risk factors or leaving one's home) (60). GIS and location-based services may integrate with vehicle-tracking platforms (13, 61), including those used by care providers and transport companies (5) to monitor for compliance with directives, or to enhance motor vehicle accident forensics (e.g., by recording a vehicle occupant's seatbelt use). These systems work in conjunction with other connected devices and services (e.g., connected vehicles) to generate richer data and "control surfaces." Connected vehicles are vehicles that access, directly or indirectly, the Internet, providing occupants with an enhanced experience and sharing data with trusted third parties (e.g., insurers or law enforcement). Generated data allows vehicles to be optimized, for example to improve their safety or efficiency or to coordinate vehicle motion such that an ambulance could travel to a hospital unimpeded. In one study, mobile technology, digital maps, and geofencing helped a government more effectively protect child welfare. It also provided solutions for parents to monitor their children's activities (60).

THE INTERNET OF THINGS

The Internet of Things (IoT) is an evolution of the Internet incorporating devices, applications, data management platforms, and people into systems that previously were single-purpose. The Internet of Things comprises devices and services that connect to one another intelligently and that can sense, infer, and act(uate). Sensing captures data from devices, their users, and their environments, while inference processes information to distill it into actionable insight. Connectivity moves data, insight, and intents where they are most useful—whether in another device, or the Cloud—and actuation closes the feedback loop to ensure the insight is acted upon by a digital system or a human. Internet of Things devices include wearables, mobile devices, smart home devices, medical equipment, intelligent infrastructure, and connected vehicles. In child welfare and abuse prevention, IoT devices and services provide data and algorithms to practitioners, as well as offer engagement points for care workers, patients, and their families.

Connected and Smart Homes provide families with comfort and convenience but also serve an important role in child welfare and abuse prevention. Devices include smart speakers, thermostats, power meters, humidifiers, and light bulbs. Sensors detect incidents, generate information about behavioral trends, and can provide forensic information to families and prosecutors. Actuators provide a means of intervention or feedback to patients and their families. Additionally, devices such as smart speakers with conversational assistants (5) provide an opportunity to capture valuable information from children, to deliver care plan information to users, to monitor plan compliance, or to serve as portals for home visits or teletherapy. By bringing IoT devices into homes, families provide caregivers access to valuable information and opportunities for frequent engagement. Smart environments may be used by caseworkers to ensure healthcare compliance (e.g., through monitoring that patients follow prescribed care regimens) (62).

Wearable devices are connected or proximate to an individual and provide a means of capturing rich sensor data and serving as points of engagement. These devices include fitness trackers, smart watches, rings, glasses, smart clothing, and smart diapers (63). By virtue of their constant and pervasive connection to humans, wearable devices may generate insights never before possible, due to caseworkers' inability to provide constant accurate monitoring of patients, though whether remote patient monitoring should be considered equivalent to in-person observation remains an open question (58). Wearables have been used to monitor medically-fragile children (5) and to supervise workers in order to ensure correct care is provided (5). Future wearables may aid in child welfare, for example through the creation of a shake detection system in the form of an app run on a parent's smart watch. It may also be possible to develop wearable devices with a "help" button for empowering children to report abuse.

Social Media is a technology application reliant upon the ubiquity of mobile devices and pervasive connectivity. It allows users to share their lives and follow others in textual or multimedia formats. Social media provides youth with a voice and an attentive audience (5). This makes social media a good entry point for workers to engage with youth and helpers (e.g., as for pairing children with mentors or microtargeting advertising at potential foster families) (5, 64). Networking specifically opens youth to new types of relationships, enabling both strangers and caseworkers to more easily become friends (65). Information posted to social

media may also be useful in informing risk predictions (1), and search histories may identify likely abuse.

CHALLENGES

Technology for the sake of technology is meaningless. Practitioners must build usable systems and target the *right* problems in order to maximize impact (31), turning data and predictive results into care decisions for effective action. Even when appropriate problems have been identified, getting the right data to solve that problem–and engaging with legacy systems–is complex (6), and a host of other challenges await these technologies. In child abuse prevention and child welfare, these are institutional, personnel, and technological in nature. A partial list follows.

Overreliance on data and AI

Lack of data is an impediment to child welfare. Addressing a lack of standards for data management and interchange will facilitate enhanced predictive models and clinician tools. It has been said that "data is [sic] the new gold," (66-68) and this holds true in child abuse prevention and child welfare. Data, and the analytics they inform, not only help to make care decisions, but help organizations defend these decisions (1). Many practitioners fail to understand that AI requires high-volume, accurately labeled, unbiased data to perform well – lest it fall prey to "garbage in, garbage out" syndrome. Getting data into a comprehensible format may be a challenge, particularly for qualitative data (29), which may have non-standardized methods of recording, like qualitative metrics with poor equivalency to diagnosis codes (69).

Workers must also understand the limitations of AI algorithms themselves. Excessive trust in AI will become a problem, and it is possible for hyperconnectivity to generate "excessive" information and for workers and clients to feel as though it is impossible to escape observation. In addition to being overwhelming, having too much data means "false" trends or correlations may be learned as AI finds links among unlikely data (6). AI will improve over time, but healthcare providers may trust it to be more capable than it is today (70). For example, AI works poorly on unseen scenarios common within medicine (70). Without understanding how AI makes its decisions, it is easy to over-rely on data or misinterpret results (1). A partnership between clinicians and AI is the ideal solution. While AI matures, AI should check answers—like a calculator—rather than pick questions (70). In this sense, AI might best be used as a decision support system (71).

We have seen that data aggregation has the potential to inform models useful for child abuse prevention and mitigation. Despite the value in interagency sharing, there are technology and structural impediments to interoperability. There is a lack of data management, analysis, and handling infrastructure, and poor interoperability and standardization makes system migration—or integration with other agencies—difficult (1). State and other agencies may utilize legacy software in which data are siloed and unable to be shared across services or repurposed (6). This software may itself run on archaic infrastructure (18). This can prevent

caregivers from getting a comprehensive view of the child's status and needs (6). At the same time, many technology systems are designed for compliance and regulation, rather than to meet users' needs (64). Further, such systems were originally designed to ingest data rather than to share it with automated software. Some agencies intentionally implement silos to limit data sharing (32, 34), creating an agency-centered rather than client-centered focus (32). Within an organization, caseworkers may not know how to access critical information (72). Working across agencies, integration of data across diverse systems can be time consuming and inaccurate, despite a need to move quickly (16). This makes it difficult to implement solutions such as AI analytics (6). As a result, troves of information remain trapped in legacy silos, unacted upon (1).

Modifying legacy systems to enhance data sharing and portability is time-consuming and potentially costly (18). At the same time, the aggregation of data across sources—whether devices or databases—serves to grow the scale of and latent insight within information. There is opportunity in interagency data sharing and data integration (5, 7), including cross-vertical collaboration (1). With efforts made to enhance data interchange and interoperability, including data sharing agreements, partnerships, and collaboration with third-party data repositories, the ability to draw conclusions from digital artifacts grows. Partnerships may accelerate data sharing, enabling a shared vision for child welfare and care options (72). Incorporating non-traditional clinical data may also provide benefits (e.g., incorporating social factors into electronic records).

While there are data aggregators such as the Child Welfare Information Gateway (64), more standardization and data interchange agreements are necessary (32), like those being coordinated by the Office of the National Coordinator for Health Information Technology (69). Social Interventions Research and Evaluation Network is leading efforts to develop standards related to social determinants of health (69). The goal is to create electronic health records that are inclusive of diverse data types to increase the accessibility of such data (69). Data interoperability will allow caseworkers to comprehensively understand a child's needs and match these with available services across agencies and the creation of modular APIs will facilitate data sharing and flexible service composition (6).

AI models *might* outperform humans, but, without being explainable, transparent, and unbiased, their output may not be useful (24). AI must be designed for fairness, otherwise any potential benefits may be negated (27). Training in ethics is necessary for computer and data scientists to build systems that holistically help the world, rather than simply targeting numeric performance metrics (29). These models must be evaluated to ensure validity, equity, reliability, and usefulness of models (28). Finally, output must be communicated clearly such that social workers and others understand the implications of the model's output as well as necessary next steps (24). Even designed thoughtfully, AI can be opaque, inscrutable, and unexplainable (16). This problem is especially significant for neural networks and "black box" models (28). Without a clear understanding of *how* models work, careworkers may rely upon decisions made on tenuous causal relationships (10).

Technology may overcome some of these roadblocks (1). Advances in technology like Cognitive Computing revolve around the collection, sharing, and analysis of data at scale and may help facilitate data interchange, thereby simplifying the gathering, analysis, and utilization of information necessary to inform decisions in an increasingly-complex care network (7).

Child rights

In an era of increasing dependence on data science, the voices of the world's children—and those who advocate on their behalf—have been largely absent. While all nations except the US have ratified the United Nations Convention on the Rights of the Child (CRC), this legal framework has yet to adapt to the digital age. A recent paper estimates one in three global Internet users is a child, yet there has been little discussion of how to adapt traditional, offline ethical standards for research involving data collection from children, to a Big Data, online environment. There is potential for severe, long-lasting and differential impacts on children, and child rights need to be integrated into the agendas of global debates about ethics and data science. It has been suggested that to move forward, we should focus on the actors within the data chain (including data generators, collectors, analysts and end users) and have a stronger appreciation of the links between child rights, ethics and data science disciplines. Enhanced discourse is needed between stakeholders in the data chain and those responsible for upholding the rights of children globally (19, 41, 73).

Ethical issues and protecting human subjects

There are ethical issues applying to data collection and access. One study compared and contrasted the research strategies and dilemmas confronted by researchers using quantitative methods to collect and analyze big data compared to those used by researchers conducting an interpretivist ethnography grounded in the method of participant observation. The shared context of participant vulnerability produced overlapping concerns. With shifts in quantitative conflict research to examine the micro-dynamics of violence, quandaries of confidentiality and the ethics of exposure have become increasingly salient (74). Traditional data governance and ethical frameworks may be ill-suited to big data related to child welfare (19). There is a need to consider ethics and data rights as part of the technological development process, with an aim of assuring stronger data protections while balancing risks and opportunities in Big Data analytics. This is particularly relevant as we begin to link psychosocial data to the human genome. The study of gene-environment interactions has benefited from the growth of data tools that allow linking genomic data to health, educational, and other information stored in large integrated datasets. These advances have created new ethical challenges for scientists as they collect, store, or engage in secondary use of potentially identifiable information and biospecimens. To address challenges arising from the expanding contexts in which potentially identifiable information and biospecimens are collected and linked, the US Office of Human Research Protections has revised federal regulations to create new format, content, and transparency requirements for informed consent. These regulations have implications for how prevention scientists and oversight boards may acquire participant consent for the collection, storage, and future use of their data by other investigators for scientific purposes significantly different from the original study (73).

Confidentiality

A preponderance of systems, patients and caseworkers create digital artifacts at an unprecedented rate. However, individuals rarely know what data their systems collect—never mind how this information will be used and by whom. Smart systems must be thoughtfully implemented to ensure privacy, security, and confidentiality (1) and to allow individuals to make *informed* decisions related to the tradeoffs among these areas (10). Issues associated with privacy, control and dependence arise, suggesting that social and ethical concerns related to the way government and business strategically exploit digitized technologies that support everyday activities should be considered and discussed (10). Challenges relate to spoofing, tampering, leaking information, denial of service, performing unauthorized actions (51), and data may be leaked from devices including toys (19). Social media is of special note as it presents risks related to confidentiality, ethics, security, and privacy (5) while media-savvy children lack understanding of the nuances of their digital fingerprints (19). While children curate their own digital identities, their aggregate data inform algorithms used to make economic, healthcare, and other decisions that may have consequence later in life (10, 19), and it may not be possible for children to opt-out of the decisions their parents make on their behalf (19). It is recommended that agencies develop policy to clearly define acceptable use of social media in order to establish deterministic norms (20).

For some data, confidentiality is desirable, even if laws conflict. For example, while a foster care record is confidential, a child's social media is not. The public may know more about that child than they know about themselves (75). There are also ethical questions about the *secondary* use of data (1, 39). It may be possible, for example, to deanonymize information in the future (19, 73), or to repurpose "historic" data for previously-unimaginable applications (1). In the absence of robust "right to be forgotten" protections, data may persist after an account is deleted (19)—not just online, but also in devices with which children engage, such as vehicles (76). Relevant "Terms and Conditions" vary by geography, complicating things (19).

Professional and family acceptance

The use of technology in healthcare changes the way healthcare workers, patients, and their families interact. Remote engagement—for example, allowing a supervisor to observe or monitor a trainee—may change training efficiency. Or, technology might remove the human touch to create awkward interactions (55).

Lack of data or analytics is not the hard part; changing the behavior of case workers and clients is (31). Even proven technologies are slowly incorporated into policy and practice (1). "Social workers and foster parents are not first adopters, or second adopters, or even third adopters by nature. Child welfare is a change-averse system." (53) Technology must be thoughtfully introduced to ensure its adoption (77), and worker attitudes must shift to accept high-tech systems (72). Even then, reskilling may be necessary (1).

OTHER TECHNOLOGIES AND FUTURE DIRECTIONS

A decade ago, child welfare and maltreatment prevention began to explore how technology may advance research and practice. Articles demonstrated the use of technology in areas ranging from professional data sharing and training in evidence-based practices to family engagement assessment, to intervention augmentation and delivery. Recently, a proliferation of technology has altered our personal and professional lives. We are moving beyond descriptive and proof-of-concept research to a generation of technology for evaluating and delivering enhanced and delivered child maltreatment interventions and prevention, and addressing barriers to the implementation of evidence-based practice. Technology-based approaches allows researchers to move beyond standard self-report measures to the efficient inclusion of more rigorous measures less influenced by external bias and which provide better benchmarks for assessment-based studies and prevention research (43). The technologies discussed in this chapter are by no means exhaustive, and the field of child abuse prevention is adopting new capabilities at an accelerating rate. We now discuss technologies that we believe may have an increasing role in prevention and child welfare in the coming years and then conclude with thoughts and predictions about the future role of technology in child maltreatment prevention.

Social robots

Whether technology can help (or hurt) children is a two-way street. Children in fact may abuse technology, such as with social robots. Observing how children abuse technology and how that behavior is reinforced can provide understanding of "child on child" abusive behavior in real-world settings. Social robots working in public space often stimulate children's curiosity, but some children show abusive behavior toward them. Robots have been trained to identify potential abusive behavior and maneuver so as to avoid hostile interactions (78). Such abuse can be "emotional"—through hostile words—or physical—through violent actions (78) that escalate over time (79). One study observed cases where children persistently obstructed the robot's activity. Some abused the robot verbally or physically, kicking or punching the robot. Using a statistical model of children's abuse together with a simulation of pedestrian behavior, researchers enabled a robot to predict an abuse situation in order to escape, demonstrating a successful reduction of the occurrence of abuse in a shopping mall (78). In another study, the authors established a process model for robot abuse and used a qualitative analysis method specialized for time-series data to analyze interactions from nine children who committed robot abuse and to develop a multi-stage model with four stages: approach, mild abuse, physical abuse, and escalation. For each stage, they identified social guides that influence events that fuel the stage and conducted a quantitative analysis to examine their effect. The study found correlations of these four stages and children's behaviors: the presence of other children related a new child to approach the robot; mild abuse by another child related a child to do mild abuse; physical abuse by another child related a child to conduct physical abuse; and encouragement from others related a child to escalate the abuse (79). Understanding the stages of and motivations behind children's abusive behavior towards other children can be used to teach

other children how to avoid abuse as well as be extrapolated to young parents and adults' behavior toward children.

Cyberbullying

Cyberbullying is the use of electronic communication to bully a person, typically by sending intimidating or threatening messages. Use of social media and texting by adolescents carries the risks of bullying, exposure to inappropriate material and advertising, inappropriate posting, peer positive reinforcement of risky or unhealthy behaviors, and disruption of sleep and normal activities. While social media can positively contribute to development of adolescent identity and social development, balancing its pros and cons is challenging. Children are uniquely vulnerable to these exposures due to their immature critical thinking skills and impulse inhibition (80). Children may be reluctant to admit to being the victims of cyberbullying because they are embarrassed or shamed by their peer group and it has been associated with depression, anxiety and suicide. Anonymity and the lack of meaningful supervision in the electronic media (such as social media) are two factors that have exacerbated its reach and effects. Comments or posts involving sensitive topics that are personal to an individual are more likely to be internalized by a victim, often resulting in tragic outcomes. Social media allows the process to be damaging to the developing child's relationship with their peer group and others whom they trust while preventing resolution (or retribution) by hiding the identity of the offender. The American Academy of Pediatrics has recommended steps that parents, health care providers and communities can take to empower parents to help their children (80). Natural language processing text inspection (14) may soon allow for the detection and automated mitigation of cyberbullying (15), and one study detected when such communications involved sensitive topics. Looking at 4500 YouTube® comments, the authors found classifiers for individual texts and posts could be used to detect and prevent cyberbullying prior to being sent to potential victims (81).

Early identification of bruises

Bruises can be difficult to detect on victims of violence. While AI has the potential to better identify inflicted bruises through pattern recognition, another issue limiting detection relates to their healing and disappearance. Imaging techniques using alternate light sources (ALS) have been studied in an effort to increase their recognition by health and law enforcement professionals, and there is extensive literature over 30 years showing equivocal results for use in children. A recent randomized controlled trial measured the effectiveness of ALS within visible and long ultraviolet spectrums at improving bruise detection compared to white light while examining the effects of skin color, age, gender, localized fat, and injury mechanism on bruise detection. After controlling for other covariates, 415 and 450 nm wavelengths using a yellow filter had greater odds of detecting evidence of bruising than did white light. Under either light source, being female and having more localized fat increased the odds of detecting bruises. While this study adds to our knowledge of use for adults, further research, development and evaluation of clinical practice guidelines for ALS in children are needed (82).

Virtual reality

Virtual, augmented, and mixed reality offer an opportunity to extend telemedicine and increase patient and provider engagement. *Virtual reality* (VR), which presents to a user a synthetic environment in real time, may be used to take telemedicine into virtual, three-dimensional "doctor's offices," while *augmented or mixed reality*, which blend real-world and synthetic images, may allow doctors and patients to co-locate within shared, interactive environments. For children suffering from panic attacks, "calming rooms" may be created, or engaging environments may "gameify" therapy sessions to encourage children to share more information with their care providers. For training, VR has already been used to train workers to identify risky scenarios and to provide enhanced training, (6) as well as to allow for remote risk factor assessment and training in simulated environments (5).

Detecting and removing child sexual abuse victimization images

Victims of child sexual abuse suffer from physical, psychological, and emotional trauma that is worsened when their sexual abuse and exploitation is captured on videos and photos. Although it is difficult to determine the number of victims affected by the production and distribution of such materials, the effects on identified child victims are profound (83). The detection and deletion of these images can prevent the cycle of abuse from being repeated each time the photo or video is shared or viewed. The enormous volume of illicit material demands automation to detect images and videos containing child sexual abuse, and law enforcement does not have enough resources to properly navigate through the masses of material in the Cloud. Due to tech-savvy offenders and technological advances, continuous efforts in keeping up with current developments are crucial in the implementation of detection algorithms. A recent review (83) suggests that detection applications yield the best results if multiple approaches are combined, such as Deep Learning algorithms fused with multi-modal image or video descriptors. The application of Deep Learning neural networks may yield good results, as the literature showed that deep learning-based methods outperformed all of the other methods in the current state-of-the-art, particularly for unseen material.

Women's safety

In addition to protecting victims from harmful messages, one group has developed wearable technology to physically protect women from attack using a number of automated responses and the Internet of Things. In one paper, an IoT-based women's safety device used a three-way safety module to provide self-defense, evidence imaging, and tracking. For self-defense, it produced a shock to the attacker through a nerve stimulator using a TASER device that injected chloroform with the help of gun-based or voice recognition/facial reaction. An application is used to capture and share images of the offender to send to the police or control room using the IoT. A sensor in the device measured the heartbeat of the victim, and the device checked the status of the victim and the camera to record and share. While the use of such wearable technology seems extreme, it demonstrates the potential use of combined defensive, imaging and weapons-based technology designed for individual protection (84). To the extent that

parents are protected, and children do not have to go through the adverse experience of IPV, these technology-based protections may eventually have a role for certain families and in certain situations.

CONCLUSION

This chapter has described how different types of technologies might be applied in the child maltreatment field to improve case identification, services and prevention. Although technology holds promise to help solve intractable social problems, the decision to deploy such policy innovations must consider ethical questions and tradeoffs. Ethical considerations lacking in current implementation should be considered in future applications (24). The potential bias resulting from linkage misspecification, partial cohort follow-up, and outcome misclassification has been largely unexplored, and the failure to account for out-of-state emigration may induce bias in longitudinal data linkage (85). While a number of technologies have been discussed, there are others in the pipeline that will contribute to the state of the art and advance the science of practice in child welfare. For example, ridesharing has been used to great effect in improving outcomes by allowing for visits among family members, leading to eventual reunification (5), and advances in data visualization help to place diverse information in a visual context to help inform decision-making (5).

While technology use has become commonplace in the office, use in the field for decision-making and service provision is much less developed and perhaps aspirational for prevention (55). New technology does not necessarily make for better investigation, actual services, or actually physically stopping abuse and neglect (except for possibly wearable technology), but it does create exciting new possibilities that creative minds can use to advance the field of prevention. The projects described here are examples of such creativity, review the past, and give a glimpse of the future. Children reported for having experienced alleged maltreatment can be classified by a PRM tool to be at high risk of foster care placement and emergency department and in-patient hospitalizations for injuries (86). Covid-19 has forced a reevaluation of the social contract between what communities, cities, and states are obligated to provide for their citizenries, and technology can be used to enhance our services (particularly for underserved or isolated populations) while eliminating the systemic and structural injustices that exist in our communities (87). As Deborah Jones commented, "In addition to cost and cost-effectiveness analyses, it is likely time for the field to move beyond asking 'if' technology helps but rather who it is most helpful for and how is such benefit achieved" (88).

However exciting they may seem, advances in technology and its applications do not come without some cost and some loss. Technological approaches may reduce human interaction and result in the loss of its tangible and intangible benefits. The field appears ripe for broad-based application of technology in at least three areas: web-based professional training, self-directed interventions and prevention programs, and social networking technology. But there remains significant work to be done in development, evaluation and adaptation before we can understand the true cost of developing, implementing and maintaining technological applications and their long-term value to families and children (20, 46, 55). Time and technology are moving forward, and our response to child abuse and neglect and its prevention

will require our actively integrating these new techniques and technologies into our work, or they will be thrust upon us in ways beyond our control.

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Chapter 10

THE MEDIA AND CHILD MALTREATMENT PREVENTION

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ABSTRACT

The media plays a complicated role in child maltreatment prevention. This chapter examines the role of the media in reporting about child maltreatment and advocating for its prevention. The mass media tends to focus on spot reporting regarding individual cases of child maltreatment, which can distort the public's understanding of child maltreatment and official responses to it. Even when media outlets report longer feature articles, there is the risk of distorting the causes and consequences of child maltreatment. This is due, in part, to journalistic ethics, which presuppose a "balanced" approach to reported topics that can lead to false equivalencies. Media, particularly in the form of public relations campaigns, play a role in prevention efforts. The chapter then will consider the impacts of both reporting and public relations campaigns on changes in child maltreatment prevention. Finally, it provides practical guidance for those wishing to interact with the media as a tool in their prevention work.

INTRODUCTION

On Sunday, November 16, 1997, the *Los Angeles Times* ran a lengthy feature article authored by Sonia Nazario, an urban affairs reporter for the paper. Titled *Orphans of addiction*, the article presented an in-depth description of the life of several young children whose parents were addicted to drugs. The story described numerous deprivations and risks to these young children. Accompanying the text were a number of photographs. One of the photos depicted a three-year-old girl's father brushing the child's (Tamika) teeth with the child's mother's

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(Theodora) toothbrush. The caption to the photo read as follows: "Johnny brushes Tamika's teeth with a toothbrush she is sharing this day with Theodora, who is HIV-positive. After noticing that her own gums were bleeding, Theodora asked him to clean Tamika's teeth first" (1, 2).

The story's publication caused public outrage at the children's circumstances and condemnation of the reporter and photographer, neither of whom took any action to protect the children who were the subjects of the story. In the 24 hours that followed the story's publication, reports to children's protective services (CPS) increased by 20% and eventually increased by 45%. CPS quickly removed Tamika from Theodora's custody. Theodora was first arrested and then placed into a premier drug rehabilitation program (2, 3).

In addition to the media's involvement in reporting on the child protection system, it can also be used in campaigns to prevent child maltreatment. Such campaigns may have multiple prongs—articles in the traditional press (e.g., print and on-line newspapers and magazines), television and radio news reporting, webcasts, and social media outlets such as Facebook, Instagram and Twitter. As just a listing of some of the possible outlets suggests, campaigns of this sort may be elaborate and sophisticated and may have specific and ambitious goals. For example, one such campaign in Colorado aimed at preventing child sexual abuse sought to target every zip code in the state. Its goal was that 5% of the adult population in each zip code would know how to respond when suspicion arose. To accomplish this, it set a goal of training 284,000 individuals in the state to recognize the signs of abuse and how to respond to that recognition. One of the tools used in the campaign was an online map that tracked the training by zip code (4).

This chapter briefly examines the complex relationship between the media—both reportage and public relations campaigns—and child maltreatment prevention at the level of practice, policy and legislation. It also provides child protection professionals practical guidance to understand the role of media in child maltreatment prevention and how to help focus media and public relations campaigns on prevention in addition to system failures.

MEDIA REPORTING ABOUT CHILD MALTREATMENT

At its best, feature reporting such as that illustrated by *Orphans of addiction* can utilize the story of a particular child, group of children, or family to illuminate the often-opaque world of child protection agencies for members of the public (5). For example, in her article, Ms Nazario laid out a number of statistics regarding the frequency and prevalence of parental drug addiction as a factor in cases of child maltreatment handled by the child protection agency and the economic costs of children growing up in families and neighborhoods that are impacted by drug addiction. As an example of the power of this sort of case-specific reporting placed in broader policy and practice context, in the aftermath of the article's publication, Los Angeles County ordered an audit of its child protection agency and reorganized its maltreatment reporting hotline (2).

The feature reporting that culminated in the writing and publication of *Orphans of addiction* illustrates one form of media engagement with issues of child maltreatment—one that attempts to convey the complexity of the causes and consequences of abuse and neglect. Another is illustrated by spot news reporting. Reporting on individual cases that does not place

into a broader context the story's subject matter may leave a distorted impression upon the reader about how child maltreatment happens, it causes and consequences, and how CPS generally operates. Two examples of this less comprehensive reporting will be briefly presented here. First, in 2015, there was considerable media coverage focused on the interaction of CPS with the parents of so-called "free range children." That is, in a number of instances that hit the newspapers, CPS or law enforcement became involved in cases where children were unattended to in circumstances in which some member of the community believed those children were unsafe. In one such case, a mother allowed her 9-year-old to ride the New York City subway alone (6). In another, a Maryland couple allowed their 10- and 6-year-old children to walk home alone from a local park, and neighbors called the police. CPS investigated, and these cases became something of a media sensation for a time (7). It was less clear from the articles—or less a point of focus—that CPS took no action in these cases. Because of the focus on the report to CPS, rather than the ultimate outcome of these cases, the spot reporting on these cases left the impression that CPS agencies are out of control and routinely overreact to innocuous parenting choices.

In a similarly high-profile case from Detroit, one that became known colloquially as the "Mike's hard lemonade case," a man—a professor of classical archeology at the University of Michigan—took his 7-year-old son, Leo, to a Detroit Tigers baseball game. During the game, the father bought the child what he thought was an ordinary lemonade, but which turned out to be an alcoholic beverage. A stadium employee notified police, who notified CPS. Before the game was over, Leo was in foster care, where he remained for several days before being returned to his family. The case resulted in a federal lawsuit and in the passage of "Leo's law," which toughened the legal standard and procedure for the removal of children from their parents in child protective proceedings in Michigan (8).

As illustrated by these two examples, much of the coverage in the mass media of child maltreatment is episodic, focusing on spot reporting of a particular event or case, rather than systematic (9). Even with more in-depth feature-length articles such as the *Orphans of addiction*, there is a risk of sensationalizing and distorting information about child maltreatment if broader issues of law, policy and practice are not considered. While media attention may increase public awareness, it also may leave a distorted impression of what constitutes maltreatment and how relevant social agencies respond to typical cases. This is an unfortunate side effect of the media's spot reporting on individual cases, which are almost by definition aberrational—typical cases are simply not very "newsworthy" (10). The best reporters see in these unusual, high profile stories the opportunity to educate readers about the broader function—and dysfunction—of our child protection system. The reporting on the "Mikes hard lemonade case" in particular left a distorted impression of CPS's policy (family preservation whenever possible) and its typical practices (maintaining children in parental custody). What was lost in the reporting on the case was that the child's removal from the home resulted primarily from the situational exercise of poor professional judgment in an individual case. Uninformed readers or listeners could easily be left thinking that this is how our child protection system routinely operates.

As this discussion illustrates, media attention can influence child protection and the prevention of child maltreatment at every level—practice in individual cases, agency policy, and the passage of new legislation (11, 12). Child advocates themselves will have a complicated relationship with the media as they try to use the media to educate the public about the causes, consequences and prevention of maltreatment while at the same time minimizing unwanted

scrutiny (9, 10). But, as commentators have observed, the mass media is rarely effective at presenting the complexity of social issues, and few social issues are as complex and nuanced as an in-depth understanding of child maltreatment (13). Indeed, some have observed that the media writ large (including television shows, movies, plays and the like) may contribute to the culture of child maltreatment (14).

MEDIA ETHICS

The publication of *Orphans of addiction* occasioned considerable debate about journalistic ethics in the context of child maltreatment. Generally, professional journalists should avoid becoming part of or take actions that might change the trajectory of a story they are reporting, and should avoid personal entanglements with sources (2, 3, 15). However, there seems to be little in the way of enforcement of these rules, so there is much variation in their application, with different journalists applying them differently or not at all in particular situations (2). Further, there is concern about the exploitation of sources. After all, journalists sometimes tell other peoples' stories for profit, which in some circumstances may be substantial. Journalists also may receive prestigious awards—e.g., Pulitzer prizes or fellowships—based on their work telling the stories of others, including maltreated children and their families. Journalistic ethics in the context of child maltreatment are more complicated because journalists are admonished to exercise "heightened sensitivity when dealing with juveniles, victims of sex crimes, and sources or subjects who are inexperienced and unable to give consent" (15).

At the threshold of this discussion, it is worth considering the ethics of professional journalists. The Society of Professional Journalists Code of Ethics provides that, "The highest and primary obligation of ethical journalism is to serve the public" (15). Journalists have an obligation to be accurate in their reporting, which means to avoid either the intentional distortion of facts, misrepresentation or oversimplification of relevant issues by providing sufficient context for their reporting that the reader or listener can understand the issues involved in the story. Professional journalists have a special obligation to act as "watchdogs" over the government and governmental operations and to hold those in power accountable. Additionally, among other ethical obligations, they should be thorough, fair and act with integrity (15).

As these specific ethical considerations suggest, journalists should seek to minimize harm to their subjects and those who serve as the sources for their stories, particularly children. Still, the most basic and fundamental job of the journalist it to "get the story." Perhaps more often than we would like to think, by contrast, public officials who are responsible for the operation of the child protection system may want to hide the story for political or other reasons. There has long been a strong sense among members of the media as well as advocates for children and families that public officials use confidentiality laws not to protect individual children or families but to cover ineptitude and wrongdoing, to insulate public officials from criticism (9, 10). As a result of the perception that child protection agencies across the country were using confidentiality rules to deflect scrutiny in cases of child abuse-related deaths, Congress amended the Child Abuse Prevention and Treatment Act to require that state child welfare agencies release information to the public regarding child fatalities and near-fatalities that are

caused by child maltreatment (42 USC § 5106a(b)(2)(B)(x)), thereby making it easier for reporters to access this information.

Whereas journalists' ethical codes encourage them to strive for objectivity and balance, public relations professionals "serve the public interest by acting as responsible advocates for those they represent." Their duty of loyalty is not to some objective truth but to a client; they "provide a voice in the marketplace of ideas, facts and viewpoints" for those on whose behalf they speak (16). They can therefore be objective but are generally biased in favor of their clients.

MEDIA AND CHILD PROTECTION POLICY

Through its reporting and advocacy, media can inform members of the public as well as policy makers about child protection policies and practices. In doing so, the media can raise awareness of social problems and spur change in these same practices and policies (17). The stories that began this chapter exemplify this phenomenon. Historically, Americans have tended to frame social problems such as child maltreatment as resulting from errant individual actions rather than the failures of larger social systems (e.g., the Catholic Church, the Boy Scouts) or society at large (e.g., poverty resulting from personal failings rather than structural economic forces). However, in her longitudinal content analysis of reporting by major newspapers' (i.e., *The New York Times* and *The Washington Post*) and television network news' (e.g., ABC, NBC, Fox) reporting about child sexual abuse, Weatherred found that these major national news outlets focused on societal-level causes but individual-level solutions. That is, the stories she analyzed between 2002 and 2012 focused on social causes for sexual abuse and individual (but not social) solutions (18).

The federal Centers for Disease Control and Prevention (CDC) has observed that journalists can help members of the public to understand that the causes of child maltreatment are multifaceted and complex. They describe that maltreatment is generally the result of individual and family stressors such as substance abuse, mental health issues and domestic violence in combination with public health issues such as a lack of access to mental health care, unemployment, the lack of good-paying jobs, and the need to improve access to substance abuse treatment (14). Journalists can disseminate this information to the public to improve their understanding as members of civil society, as well as to promote health and healthy behaviors in families and communities.

At the practice level, media exposure to the functioning of child protection agencies, particularly after a child maltreatment fatality, has been linked to informal changes in CPS's operations. Agency administrators and supervisors tend to increase scrutiny of front-line employees at these times, making their jobs more difficult (18, 19). Cooper explains this process:

> "media sources are usually very critical of agencies that are responsible for protecting children, often implying that they are not accountable. In attempts to correct this image, agency managers react with restrictions on the one thing that they have control over in the agency—the employees. Many of the changes and restrictions do little toward accountability, and merely undermine the authority and integrity of the employees who are directly responsible for the well-being of at-risk children. As a result, these employees,

> bogged down with new restrictions and increased culpability, become less able to perform their duties and more frustrated. . . .” (19).

As with informal practices, media scrutiny can result in changes in formal policy. Again, the *Orphans of addiction* example that began this chapter provides an illustration. In the wake of the LA Times story of Tamika and Theodora, Los Angeles’s child protection agency changed its policy regarding its reporting hotline, undertook an audit of its child protective services program and reallocated some of the agency’s funding. Child protection agencies are not the only institutions that can alter their policies in an effort after media exposure of child maltreatment. In the aftermath of the Jerry Sandusky child sexual abuse scandal at Pennsylvania State University, for example, a number of institutions—particularly universities—altered their policies regarding adult-child interactions (18).

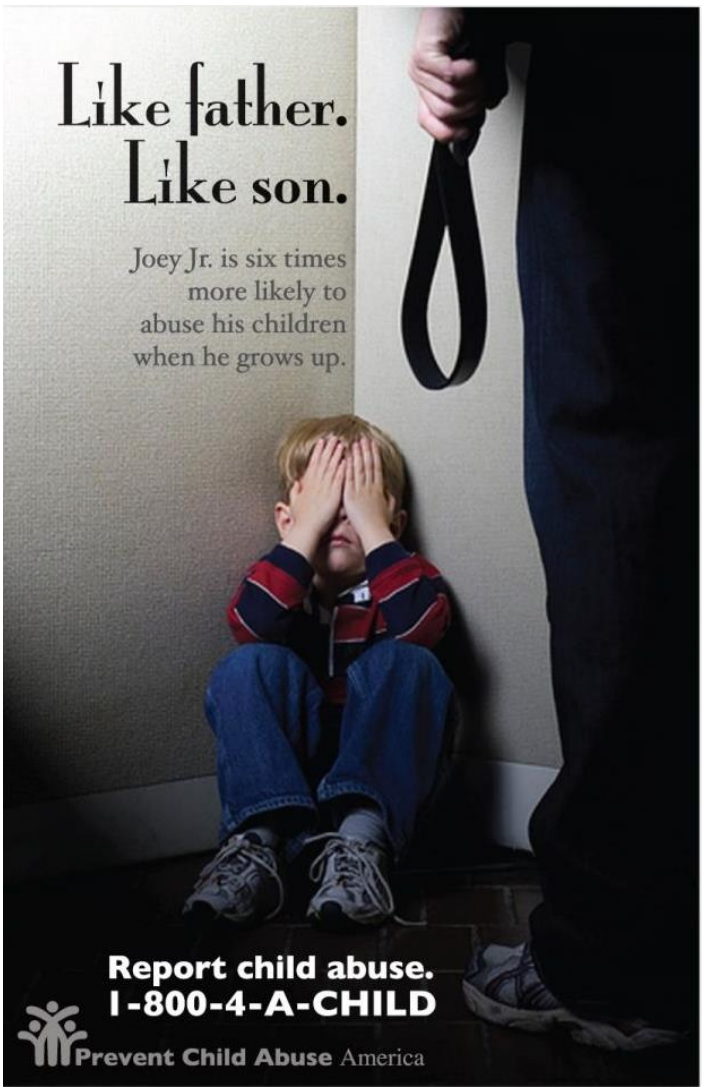

Figure 1. Poster from Prevent Child Abuse America prevention campaign. Reprinted with permission of Prevent Child Abuse America.

Also in response to the Sandusky scandal, a number of states revised their laws, particularly statutes that mandate the reporting of suspected child maltreatment (18, 20). In her study of state legislative reforms resulting from child fatalities, Douglas investigated the question "whether high levels of media attention about agency involved [child maltreatment fatalities] spurs legislative change in the statehouse that is intended to prevent future deaths, as opposed to symbolic system reform" (11). She found a statistically significant relationship between increased newspaper attention to child maltreatment fatalities and subsequently enacted state legislative changes addressing the child protection system. These changes were related to preventing child abuse and neglect related deaths rather than to ancillary issues.

Broad based PR media campaigns aimed at the general public have proven to be a useful tool in addressing a wide range of public health problems. This type of campaign plays an important role in reducing and preventing cigarette smoking and in the reduction of drunken driving (21, 22). Such campaigns may utilize a combination of methods. Some of these include public service announcements on television, radio and on the world wide web, billboards or posters placed in high traffic areas (e.g., alongside major highways or in the lobbies of public buildings), newspaper articles, and social media blasts. The specific tools used in such PR campaigns are often tested in focus groups to assess their effectiveness and may be modified based upon feedback provided by the participants. Charest and her colleagues describe one such focus group process involving a physical abuse prevention campaign poster that highlights major issues affecting any such campaigns, including the negative response to the issue, belief that child maltreatment occurs in limited, outlying segments of society ("not us") and misunderstanding of the governmental responses (23).

PR campaigns typically seek to change social norms and perceptions regarding a particular activity (e.g., use of corporal punishment). These campaigns seek to raise consciousness of the issue to effect behavioral change and, therefore, they necessarily take a long-term perspective (24). One example of a successful campaign of this type has been Prevent Child Abuse America's *Pinwheels for prevention*®. Broadly speaking, the goal of this campaign is to induce "individuals and organizations alike, to take action by learning more about prevention, supporting child and family friendly policies and services, and volunteering at the local, state, and national levels" (25).

SOCIAL MEDIA

In recent years, social media has become ubiquitous. As a result of the user's ability to communicate quickly and directly with an audience, it plays an increasingly important role, both in the spread of stories about child maltreatment and in prevention-related public relations (PR) campaigns. Its role has been largely, though not exclusively, to magnify what is reported—for good or for bad—about child maltreatment and its prevention. So, it has contributed to both greater understanding of the causes and prevention of child maltreatment and to the distortion of the public's understanding of child abuse and neglect. Social media outlets may be a source of accurate, dispassionate information about the causes, consequences and prevention of child maltreatment. Today, nearly every reputable child organization involved in child abuse prevention has an active presence on social media. One among many

examples of such efforts is Darkness to Light's® *Prevention is possible* sexual abuse prevention campaign (26).

Unfortunately, because of its open source formatting, lack of involvement of professional journalists, its lack of fact checking and its lack of editorial supervision, social media can be a significant source of misinformation and distortion regarding the problems of child abuse and neglect and its prevention. One particularly compelling example of social media's negative impact was a claim during the 2016 presidential campaign and since that one candidate, Hillary Clinton, was operating a child sex trafficking ring out of a Washington, DC pizza parlor, which was largely fueled by social media. As this chapter is being written, posts on social media have suggested that the pop singer Justin Bieber and a number of other celebrities are somehow involved in this trafficking ring. There is no evidence that such a child sex trafficking ring exists, but because of the prevalence of the conspiracy theory and its persistence on social media, the story has made its way to the pages of some of the nation's largest and most well-respected newspapers, which have endeavored to debunk the belief that such a trafficking ring exists (27).

HELPING THE MEDIA GET PREVENTION RIGHT

What is needed for child maltreatment specialists to assist responsible members of the mass media to provide balanced and informed reporting about the causes and consequences of child maltreatment and its prevention? First, it is crucial that child maltreatment prevention professionals possess a realistic understanding of the media's exigencies of operation. The contemporary news world moves extremely fast. With around the clock news channels on television and the move from printed newspapers to online formats the media operates constantly, twenty-four hours a day, seven days a week. News cycles that once were days are now hours. This has caused a tremendous competition to "get the story" and to get it now.

In the hypercompetitive world in which the media operates, sensationalism and controversy often wins out over more detached, rational and careful reporting, discussion and debate. General media outlets rarely have the time and resources to provide sustained attention to stories; this is particularly true of newspapers. Financially dislocated by the current environment, many newspapers have gone out of business, shrunk or moved their operations online. Many have had to cut staff in order to remain in business (9). For example, when the author practiced law in Detroit beginning in 1989 and for years afterward, the Detroit *Free Press* had a reporter dedicated to reporting stories about child maltreatment and related matters. The paper consistently ran thoughtful and detailed articles about the challenges faced by CPS, families and children. That resource (the reporter) for informing the public and holding public officials accountable no longer exists.

The reduction of staff and resources by major, general interest, general circulation media outlets and online publishing has allowed for the creation of specialized media outlets. For example, *Youth Today* (28) and *The Chronicle of Social Change* (29) exclusively cover issues related to youth, but they reach a narrow audience of readers, many of whom are already well-informed about the issues they address. Similarly, there are blogs dedicated to child maltreatment and prevention (30, 31), but they lack a broad readership among the populous. One problem with blogs is that they can be quite partisan. A single individual or a small group

of people generally writes them to be consumed most often by others who agree with what is written. It is easy to choose what you want to read and then choose the blogs with that content. When someone outside the circle writes a post, it is generally in lock-step agreement with those inside the circle. Want a child-focused blog about the child protection system and its efforts? Read the *Child Welfare Monitor* blog (30); prefer one focused on parents' rights? Go to *Rethinking foster care* (31). Still, maintaining a blog dedicated to child maltreatment prevention can be an effective way of raising awareness, sharing information and highlighting important programming. And, because advocates from all sides of child protection debates agree on the need for and value of prevention, such a blog could serve as a common forum and a place of common agreement.

PRACTICAL ADVICE

The purpose of this section is to provide suggestions to those professionals interested in maltreatment prevention to assist them when dealing with the media. Of course, public agencies and large private organizations may have elaborate, professionally planned and implemented media strategies. Often, though, child protection agencies lack the budget to hire professionals and may have no ready access to professional public relations personnel to assist with their work in and with the media.

Do you want to say anything?

Perhaps the first decision to make when contacted by a member of the media is whether you want to say anything. Because journalists want to provide "balance" in their reporting, they are susceptible to projecting a false equivalency. Under the guise of providing "balance," some highly reputable news outlets have published articles that mislead. For instance, the *New York Times* Magazine published an article suggesting that medical professionals harbor deep and widespread disagreement about whether abusive head trauma in the form of Shaken Baby Syndrome continues to be a valid diagnosis (32). In fact, the overwhelming majority of medical subspecialists (33) and most every professional medical organization agree that there is no question that the diagnosis is valid (34). But contributing to such an article may suggest that there is in fact a controversy. And controversy draws attention. It may be more effective simply to refuse to participate and allow the story to fade away more or less quickly.

Be proactive

Because of the frantic pace of the contemporary media, it is important that you are proactive and know before a member of the media reaches out what story you want to tell. Your story should be clear, concise and memorable; it should fit on a bumper sticker. In fact, the author keeps two bumper stickers on the bookshelf in his office that he sometimes refers to when the media calls. One reads, "It is never okay to hit a child;" the other, "Poverty is violence." Adults must find other ways to express disapproval, frustration or anger than by hitting children. If we

address the underlying causes of child maltreatment—poverty being one—we can go far toward preventing maltreatment. You may want to make clear that although there are identifiable contributors to child maltreatment, they do not excuse it.

Move from the reporter's story to yours

Reporters from the traditional media are most likely to contact you regarding a breaking story or spot news. It is important to be responsive when reporters call regarding these breaking stories. Members of the media may, however, have determined what they want the angle of the story to be before they call, they may not tell you, and the story they want to tell may be different from the story you want to tell. For instance, a reporter may want to talk about the horrific case of maltreatment that was just discovered and you may want to talk about how we prevent horrific cases from happening. A technique that you can us is called 'bridging" or, sometimes, "blocking and bridging" (35). When the reporter asks about the awful case, you can respond by saying, "Yes, that is unfortunate, but what we really need to do is focus on how to prevent these in the future, which we can do by doing these three things . . . ."

Having three at the ready is no accident. In many areas of communication, from cartoons to political writing, people organize things in threes. So grouping things in threes is an effective rhetorical device (e.g., Huey, Dewey and Louie; "life, liberty and the pursuit of happiness"). A classic paper published in 1956 documented that human beings struggle to retain bits of information beyond seven (quick, name the seven dwarfs) (36). For the quickest recall, the researcher found, three bits of information is best if you want to enhance recall or communicate a message. Today, this is sometimes referred to as "the rule of 3" (37).

Take opportunities to educate

Prevention experts should use reporting regarding high profile cases as an opportunity to educate both journalists and the public about child maltreatment prevention through both traditional platforms and social media. For example, when high profile cases are the subject of stories in local or national media, advocates can write either letters to the editor or longer opinion articles ("op eds") for publication that discuss the importance of prevention, how maltreatment may be prevented, and local or national prevention programming. Like high profile cases, the publication of new research presents an opportunity to promote maltreatment prevention through the expression of opinion in both traditional and social media.

Similarly, programming during April, which has been designated child abuse prevention month in the United States by Presidential proclamation since 1983, should include media campaigns to stress the importance of preventing child maltreatment. Discussing factors that elevate the risk of maltreatment are important topics for discussion in the media. As this chapter is being written, there has been media attention focused on home schooling as a risk factor for child maltreatment. A number of recent high profile cases in which children have suffered severe abuse and neglect while being home schooled have driven much of this discussion. So, too, has the publication of a bestselling memoir as well as academic books and articles on the subject (38-40).

It is helpful to know the numbers or rates of child maltreatment in your state or community. You should also be prepared to talk about the underlying causes of child maltreatment including such things as substance abuse, mental illness and the lack of access to adequate treatment for these conditions, and the role poverty plays as a contributing factor. The consequences of child maltreatment, both its impact on the individual in the short- and long-term (e.g., toxic stress and its long-term impact on health) and its economic consequences are important messages to convey.

Tell a story

Never underestimate the power of a good story. Child abuse prevention month can be a good time to feature a human-interest story about prevention. A new program, a successful intervention with a family, or a program that may be lost if funding is cut can all make an effective human-interest story that may be of interest to members of the media and to the general public. Be sure to consider how such a story can help to place child maltreatment into broader sociopolitical context.

As this suggests, it is important to prepare before you speak with reporters. You should know what you want the headline for the story to be and convey the message that supports that headline. Organize your thinking and anticipate questions the reporter is likely to ask. Begin and end your interview with your most important points. Doing so helps you to place an individual case into the broader context of what we know about child maltreatment and effective means of prevention. An individual story is a chance to bring attention to the broader problem of child maltreatment. A child's death, for instance, is a chance to educate the public that there are officially some 1770 child deaths from maltreatment annually in the US and that this is widely believed to be an undercount. While you want to support your story with facts, you do not want to overload the reader with a lot of statistics or other information. This is not a scientific paper; you are speaking to a general audience, so use enough factual material to support or illustrate your points, but not so much that you overwhelm them.

Your story should be simple, clear and concise. Talk in soundbites whenever possible, something memorable that the reader or listener will remember long after the interview. Also, be precise in your use of language. If you are talking about sexual abuse do not reframe it as "sexually inappropriate behavior." Use language consistently. If you are talking or writing about "child fatalities" due to abuse or neglect, use this phrase consistently and do not refer to "child homicides."

Focus on positives. When discussing child fatalities, for example, be sure to emphasize that child abuse fatalities are preventable. Focus your message on programming both broadly (e.g., "we can stop child maltreatment if we are willing to focus on prevention") and more specifically (e.g., "we need to expand access to high quality substance abuse treatment" or "we need to expand home visiting programs, which have proven effective at preventing child abuse").

Interviews

Journalists working in television, radio or online may conduct interviews. When being interviewed, it will be helpful to keep the following suggestions in mind. As with print media, it is sometimes important to reframe a question in your answer as discussed earlier.

In audio or video interviews, you will want to keep sentences short. Your tone is important. You want to sound authoritative but not pedantic. You want to sound like you are having a conversation not like you are giving a lecture. You should be hyperaware of the microphone at all times—assume it is on. Many a politician has met grief because they made a comment not realizing there was a "hot" microphone nearby.

In addition, when giving television interviews, your appearance will be important. You want to look professional. You will also want to attend to the lighting. What is in the background of the shot? You want a background that is not distracting or offensive to the viewer. In a video interview, body language will be important. You will want to appear engaged in the topic, so sit up straight or lean slightly forward into the interview. When being interviewed in person, look at and make eye contact with the reporter who is asking you questions. If the interview is remote or over satellite or on online platform such as Zoom®, look into the camera. In this type of remote interview, you will often be responsible for your own equipment, so make sure your video and microphone are working well before the interview begins. Be aware of your gestures and how you are framed in the video so that you are close enough to be seen but not so close that you overwhelm the screen (41).

CONCLUSION

Responsible professional journalists want to get their story right. You can help them to do so by understanding how to use the media to advance your efforts to prevent child maltreatment. By being proactive and having a story to tell about the causes and consequences of child maltreatment and how to prevent it from happening, you will be most effective in conveying your message. Organizations working to prevent child maltreatment will want to have thoughtful, positive, well-developed multimedia PR campaigns that utilize both traditional and social media platforms to advance the cause of keeping children safe.

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Chapter 11

CREATING A NATIONAL FOUNDATION TO END CHILD ABUSE AND NEGLECT

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ABSTRACT

Child abuse and neglect has been viewed as a social/legal issue in the United States. When one looks at the past 50 years of progress in the eradication and/or amelioration of nearly all pediatric (and adult) diseases, the massive investment of research and training dollars by the US National Institutes of Health has driven these reductions of morbidity and mortality. Behind each of those pediatric and adult diseases stands a not-for-profit organization raising money for patient programs, training and research. Child abuse and neglect has had no such organization and has been inadequately funded by the NIH. The child welfare approach to child abuse has not impacted the mortality for children, and children abused and neglected outside the family are ignored. Even though we are 50 years behind, if we are to eliminate child abuse and neglect in our lifetime, a national foundation is a necessary pre-requisite.

INTRODUCTION

Right around the time one of us (LEP) was born, the other of us (RDK) spent a year in Washington, DC on a Health Policy Fellowship. During that summer, we had a seminar with Robert Ball, who was the first commissioner of the Social Security Administration. Among the many pearls he dropped during our two-hour seminar, was this: "The American people have charity in their hearts—but not every day. And in tough economic times, the days get further

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apart. Further, they only really support those things that they can relate to." That observation was prescient because the first budget that the Ronald Reagan administration put forward called for 30% reductions in the budget for all health and social programs funded by the then US Department of Health, Education and Welfare. During the ensuing congressional session, the only two HHS programs that avoided cuts were Medicaid and Head Start. Ball pointed out that "everyone understands the need for health insurance and pre-school." But there was little support for programs that focused on the poor living in inner cities such as lead-based paint abatement, poisoning prevention, urban rat control and others that the middle class had no analog for in their communities.

Another lesson learned during that time and subsequently is that the health side of HHS, most especially the National Institutes of Health, has had 50 years of sustained support to fund research and training for research on nearly every adult and pediatric disease. The NIH budget in 1968 was approximately $100 million. It is now over $40 billion! That 40,000% growth has been fueled by an incredibly strong "health lobby" including *Research!America* and hundreds of individual not-for-profit organizations, many of which are members of the National Health Council. They advocate collectively and individually for increases in the federal research budget. There is no analog on the Human Services side of HHS that has been as successful.

Table 1. Members of the National Child Abuse Coalition

Alliance for Strong Families and Communities
American Academy of Pediatrics
American Bar Association Center on Children and the Law
American Professional Society on the Abuse of Children
American Psychological Association
Childhelp, USA
Child Welfare League of America
Children and Family Futures
Children's Advocacy Institute
Children's Trust Fund Alliance
Committee for Children
Family Focused Treatment Association
Futures Without Violence
National Association of Social Workers
National Center for State Courts
National CASA
National Children's Alliance
National Family Support Resource Network
National Foundation to End Child Abuse and Neglect
National Respite Coalition
Parents Anonymous
Prevent Child Abuse America
Ray E. Helfer Society
Within Our Reach
Zero to Three

That is not to say that there is no lobbying for child welfare and other programs—there is, and specifically in the child abuse area, the National Child Abuse Coalition has existed since 1982. The list of the members of the Coalition is shown in Table 1. During its 38 years, the Coalition has focused on trying to preserve funding for the Child Abuse Prevention and Treatment Act (CAPTA). The money appropriated by CAPTA goes to State Child Welfare agencies for use by the state or county CPS agencies. Federal funding for research in the child abuse field is siloed and sparse. The National Institutes of Health has some funding for child abuse, as does the National Institute of Justice. The Administration on Children and Families and the US Health Resources and Services Administration provide grants for programs, but investigator generated research programs in the area of child abuse are limited to NIH and NIJ.

There are 4,178 not-for-profit organizations listed in GuideStar (www.guidestar.org) doing work in the child abuse space in the United States. The overwhelming number if these are local and raise money for specific programs or clinics that provide direct services for children and families. There are several national not for profit organizations that work in the area of child abuse and neglect (e.g., Prevent Child Abuse America, Child Help, USA, National Family Resource Centers). There are others that focus on single areas (Parents' Anonymous, National Exchange Clubs). To our knowledge, there are no not-for-profits in the child abuse field that support research and/or training. This, combined with the paucity of NIH funding for child abuse and neglect, leads one to believe the field appears to us to be 40 years behind in its development. Unlike nearly all other health issues, child abuse and neglect are underfunded and under-studied. They lack a unified, trained research community as well as a clinical practice rooted in a scientific base. It was this observation that led to a decision in 2017 to explore the feasibility of starting a national foundation with the mission of ending child abuse and neglect in our lifetime.

C HENRY KEMPE AND WHY CHILD ABUSE IS VIEWED AS A "SOCIAL" ISSUE

C Henry Kempe (1922-1984) is credited with the paper (1) and the early legislative lobbying that led to the establishment of the child protection system in the United States and around the world. In 1962, the estimate was that there were 749 battered children in the United States. In those years, county and state child welfare agencies were helpful and provided services to families that needed assistance. Kempe and his colleagues pioneered multidisciplinary approaches to the recognition *and* treatment of abused children *and* their families. The third edition of their book *Helping the battered child and his family* described treatment approaches and how to use the civil (family) courts that in some cases helped child welfare get access to families that required evaluation and services (2). Outcomes were very good in those days. Thousands of programs like this model have sprouted this last 40 years, however, each one is most often under-funded, lacks a multi-disciplinary support around them and is attending only to the needs of those in front of them. The health system—which had no interest in dealing with abuse initially—was relegated to being "mandatory reporters." Sadly, the early successes of the child welfare system evaporated in the decade of the 1980's. There were many contributing factors to the demise of the system, among them the explosion of reports to CPS (from 669,000 in 1979 to 2.4 million in 1990), and most importantly, the explosion of sexual abuse cases

which completely changed the character and mission of child welfare from being a helping agency with civil court approaches to being an investigative one where parents were now subject to criminal court involvement. It was hard to convince parents you were there to help when your law enforcement partner was reading parents their right to remain silent. The devolution of the helping child protective services system led to the formation of the US Advisory Board on Child Abuse and Neglect. The Board found CPS in the United States was failing and this was a "national emergency" (3). Nothing changed, and, in 2016, another commission on child abuse fatalities (4) also reported and the result was minimal. No substantive changes have been made since these reports.

THE PROCESS OF BUILDING A FOUNDATION

In 2017, we received a small grant from a Denver-based foundation, which afforded us the time and travel money to explore whether the need for a national foundation was prevalent or necessary along with a greater understanding if there was someone who currently existed to help enhance the field by funding, uniting and bridging. We had decided to try to emulate the success of the myriad of national health foundations. To do so, we needed to approach child abuse and neglect as not just the social and legal issue most people thought if it as, but as a health, mental health and public health issue. We were able to initiate contact with the organizations listed in Table 2. We met with current and/or former CEO's of several major national health foundations, long-time colleagues and thought leaders in the child abuse field. One of the organizations we met early on was the National Health Council. It is the association of nearly all the individual health/disease advocacy organizations (URL: https://nationalhealthcouncil.org/), and it became clear when we met with them that we could fill a niche that had not been addressed by the council as an entity or by the members individually. Many told us "there must be an organization that does that already". Our response was to ask if they knew one since the work of starting a national foundation from the ground up is slow and expensive and we said, "We are open to be adopted." After four months, it was clear there was no analog to the Leukemia Society, American Heart Association or the Juvenile Diabetes Association. *Further, it became clear that the issue of child abuse and neglect was not acknowledged or recognized as a contributing factor* to the work of organizations such as the Mental Health Association, the American Foundation for Suicide Prevention, or the Obesity Society. Yet we know that child abuse and neglect are contributing factors to many issues that are within the purview of these organizations' focus. Some portion of the patient populations served by these organizations have experienced child abuse and neglect and may need support and unity around this topic.

Finally, we had conversations with the National Child Abuse Coalition (NCAC) and the national organizations who have been working in the child abuse and neglect field for decades. Previous experience with the National Call to Action, an effort led by Blair Sadler and Dr. David Chadwick from 1999-2002 (5), showed that we continue to miss the mark on collaboration and partnership to collectively support significant collaboration. Each of the several dozen organizations that came to meetings in those days were primarily there to be sure that the National Call to Action was not going to harm them by diverting resources that each entity relied upon for their own efforts. As someone noted once, "When you are chronically

fiscally hungry, it is hard to have good table manners." Perhaps times have changed and there is a greater understanding and evidence for collaboration, such as with other major issues like heart disease, breast cancer, suicide and teen pregnancy. We found a continuous desire from colleagues and neighbors to make this national foundation work. And, so, in December 2017, we incorporated and filed our 501(c)(3) application with the US Internal Revenue Service.

Table 2. Key informants

American Academy of Pediatrics
Academy Health
American Foundation for Suicide Prevention
American Heart Association
APSAC
Association of American Medical Colleges
CASA
Casey Family Programs
Child Help, USA
Children's Hospital Association
National Alliance of Children's Trust Funds
National Association of Counsel for Children
National Child Abuse Coalition
National Children's Advocacy Centers
National Council on Child Abuse and Family Violence
National Health Council
NICHD
NIMH (Suicide Prevention Branch)
Prevent Child Abuse America
Ray E. Helfer Society
Robert Wood Johnson Foundation
Zero to Three

Note. We met with the executive directors or heads of each of the agencies listed above. In addition, we interviewed dozens of professional colleagues individually over coffee at professional meetings. Not listed are the directors of a dozen health related foundations in Colorado who gave us their advice and opinions (but no money since we were not one of their funding priorities).

What is in a name?

We chose our name after several options and renditions. The first name was the Kempe National Fund; we had thought of it in honor of Henry Kempe who was a pivotal player in the child abuse space, and what better way to remember a man of great impact than to name a national organization after him. We learned quickly though that the name did not hold as much meaning for others, and specifically those who were not working the in the child abuse space. We were often asked after telling people who we are, "What does that Kempe National Fund do?" and we responded, "We are a national foundation working to end child abuse and neglect." And, so, after several months of a long explanation, and fabulous advisors with wits about them, we thought 'how about we just call ourselves exactly that.' And it was on a Monday in April

2018, when we decided to change our name to The National Foundation to End Child Abuse and Neglect, EndCAN for short. Several years later, identifying what we are doing is not an issue, everyone knows and asks how they can help, and we are on our way to doing exactly that: helping.

The best laid plans….no rollout of a new foundation is a straight line

On June 18, 2018—the day that immigrant children were removed from their families and caged in detention centers at the US-Mexican border—then Governor John Hickenlooper helped us launch our foundation with a press conference at the Colorado Capitol. We had certainly not planned for a national child abuse case on the doorstep of our local launch in Denver. Although, we felt it quite fitting for the issues at hand. The media at the capital that morning were eager to get a response from the governor regarding the children being removed from their families at the border. And on our first Proclamation Day, we were able to stand with the thousands of professionals stating that removing children unjustly from their families was/could/would be an abusive act and to create systems, security, and boundaries around the process. This was our first united message.

Three months later, we traveled to New York City to appear with Megyn Kelly on the NBC *Today* show. We shared our story of coming together and the long-term impacts of child abuse on the body, self, and community. What an honor to be on the *Today Show* so early in our development as an organization and to follow it with a national launch the next day in Washington, DC at the National Press Club. We planned a national summit meeting in Denver for March 13-15, 2019, where we would bring together thought leaders in the space, have deeper conversations about child abuse and neglect (CAN) and how we can be collective and inclusive as a field. We also announced the winners and presentations of three papers we'd commissioned to disrupt the current systems as we know them (knowing what we know now about CAN, if we could start over, what would we do differently). Leave it to mother nature. A "Bomb Cyclone" hit Denver and prevented a third of the speakers and half of the confirmed attendees from attending by way of cancelled flights, unsafe conditions and a lockdown at the hotel for 3 days. For those who had made it, we simply relished in working and communicating together, for those who did not we promised a next time.

MISSION, VISION AND APPROACH

One of the recurring themes during our initial listening tour was resistance to having the words "child abuse and neglect" in the name of the foundation. We were told it was a turn off; that the words were too negative (or hard to hear for many) and that we should find a more positive name. We understood the shared data that found a disagreement in naming child abuse and neglect out loud. We deliberately ignored and then rejected this advice for several reasons. First, we knew it was a risk, but we chose to model possibilities wanting people to see the impact of not diluting the experience that was/is lived by millions of survivors. Second, we believe that if the words are never spoken, it is easier to believe that the problem does not exist. Third, using terms such as "childhood trauma" and "adverse childhood experiences" glosses

over the reality that the most important components of childhood trauma and adverse childhood experiences *are* physical, sexual, emotional abuse and physical and emotional neglect. Ignoring, sanitizing and/or blurring these very specific forms of abuse and neglect that have specific impact on children and adults—in our view—has slowed the advancement of the field, ultimately ignoring millions of children. Fourth, "gaze aversion" (6) has been a problem for individuals, families and agencies in the field for decades. Not using the term would perpetuate it.

The primary goal for EndCAN is to change the perception of child abuse and neglect from being just a social or legal issue (which it is) but also having the public see it as a health, mental health and public health issue. The Adverse Childhood Experiences Study (7) had shown this clearly, but 22 years had passed since its first publication and there was little change in public or professional perceptions about abuse. Our approach was to first engage with *Research!America* to assess what the public perception was with regard to child abuse and neglect. A cross section of the US population agreed that child abuse and neglect were significant public health problems. To have 42% of the public call child abuse a major public health issue (behind only Cancer, Drug Abuse and Obesity and ahead of Alzheimer's and Heart disease) was on one hand reassuring; on the other hand, it showed how far we need to go. We will periodically resurvey the public to measure the effectiveness of our work and public awareness messages.

THE PSA CAMPAIGNS

Changing public perceptions is difficult work. We found help in several advertising agencies. The first was Ogilvy, in New York. We worked with Ogilvy to create a movement action campaign during the months of our launch—Give Five—to address the five children per day who die from child abuse and or neglect in our country. The campaign was nice, positive, and humbling. It was also a hard and fast lesson in the cliché that it is not what you know, but who you know. So, we learned that we needed friends, and fast. We were referred by a consultant to the Ad Council, which has been producing Public Service Announcements (PSA) for decades, and specifically working with public issues that were for the greater good. We knew we were a 'shoo-in.' And, understandably, we learned the cost of doing "free business" —that really nothing in life is free. We needed to raise $2-5 million to fund the production of the PSA's through the Ad Council. So we paused and got back to our roots. What is our message? What are our colleagues saying? Why are we not working with them? And how do we build this army with realistic expectations while at the same time helping to advance the field? We took these questions to a second PR firm, Fortnight Collective, an international firm headquartered in Boulder Colorado. There we met Andy Nathan, the CEO and dear friends (and former staff) of those at Ogilvy Advertising. Andy's team took us through a "hack" which is ultimately the hyper version and new age time warp of marketing. We had about 15 people in a room for 2 days listening to us tell what we are doing and hoping to do. We then left them to brainstorm together and, in the end, each of their teams presented PSA plans for us, from which we simply could not turn our eyes. They developed two short videos that spoke precisely to our message, our focus and our work to come together, unite our voices and allows us to start this movement. The first, "Louder Than Silence," (URL: https://endcan.org/louder-than-

silence/) is intended to show the value of speaking out, speaking up and speaking loudly about CAN, so we, collectively have a charge to break the silence and come together. The second, "We Are All Survivors" (URL: https://endcan.org/we-are-all-survivors/) speaks to the population at large. It shows the impact of abuse on all of us, how every one of us is a survivor and that together, we can end child abuse and neglect. It talks about the long-term impacts of abuse and how the ripple of it is vast and wide. These PSAs are only a beginning of the work and voice needed to do something and work together to end CAN. We will continue to join partners, friends and communities to speak out about CAN and create community around our messaging campaigns until there is no more shame, guilt or remorse for a survivor speaking out to stop it.

FUNDING RESEARCH

We noted previously the siloed nature of the field and the paucity of research—basic, clinical, translational and especially outcomes research. We have never worked in an area that has done so much to so many children and families with so little data to support their work. Further, the decade-old subspecialty in child abuse pediatrics began despite there being no NIH or other support for research or research training. Thus, unlike every other pediatric subspecialty that has had NIH support for the past 40-50 years, the field is not positioned to follow the path of the neonatology, pediatric oncology, endocrinology and dozens of others that have steadily reduced the morbidity and mortality of the children with prematurity, leukemia, diabetes and many other diseases. Behind every one of the institutes that supports research and training for adult and pediatric diseases is a distinct 501(c)(3) organization that has raised money for pilot research grants and lobbied Congress for dramatic increases in funding for "their" disease. Child Abuse and Neglect has never had any sustained advocacy for research and training. As a pilot to explore the mechanics of grantmaking, we decided that we would offer small research grants to child abuse pediatric fellows in order to (ideally) support the growth of an academic subspecialty. We are 1.5 years into this program, and we have successfully collaborated with the Ray E. Helfer Society research committee on implementation. There were four applications in the first round of grant awards in 2018. Three were funded: one each at the University of Pennsylvania/Children's Hospital of Philadelphia, Baylor University College of Medicine/Texas Children's Hospital and the University of Toronto/Hospital for Sick Kids. The second round of applications only attracted two applications, and one award to the University of Washington School of Medicine/Seattle Children's Hospital. We know that as this program expands, and trainees learn of the funding opportunities, in addition to advancement and collaboration of this field, that more applications will come in, creating expanded research to help this field improve, and ultimately a greater understanding will be achieved.

In the long-term, we hope that we can stimulate collaboration between child welfare agencies, court systems and service providers to help them develop quality and outcomes science so they can measure the quality and outcomes of their practice. Without knowing these outcomes, the public (and other professionals) will not trust that the child protection system is helping parents and children instead of trapping them in what sometimes seems to be a punitive and monitored system. Ideally, these practice measurements will be published on their websites,

along with standards of care, quality control and improvement, as has happened in the health care system over the past 20 years since the National Academy of Medicine's *To Err is Human* report (8). Without such a massive change (which will require resources and help), child protective services (CPS) and the civil legal system will continue to respond to the inevitable abuse fatality in a child with an "open case" by either changing their director, or changing the direction of their policy ("saving children v. preserving families").

DISRUPTION PAPERS

We believe that the US's approach to child abuse and neglect has been stuck for more than 30 years. There has been *no* response by Congress, federal and state governments and the child welfare system to four national advisory boards, commissions, and National Academy reports that described the child protection as an "emergency" or highlighted child abuse fatalities (which have been at a level which was unchanged or increased for decades in contrast to every other pediatric disease). All calls for change have fallen on deaf ears. Given this landscape, we determined that as a new foundation, funding more of the same would be unconscionable. We decided to have a contest to see whether the field could think "out of the box". We invited "Disruption papers" in four areas: Clinical, Research, Prevention and Training. In essence, we asked the field to answer the question: "If we were starting over (pretend it is 1962 and we have just become aware of "Battered Children") BUT we know everything we know now, how would we design our clinical child protection system so that all children who are abused and neglected would not only have the maltreatment stop, but they and their families would get the treatment they needed and heal?" How would one design research programs such that the basic, clinical, translational and outcomes research could inform our practice? What would be the approach to prevention that could assure that the 3.5 million children born next year in the US could have an abuse and neglect free childhood? And how should we be educating the professionals in child welfare, medicine, nursing, the mental health professions, law enforcement and the judiciary to provide the research, prevention and clinical programs we need in the US? We asked for three-page letters of intent and got a swarm of responses. We had them peer reviewed and then asked 25 teams to write full papers. The peer panel identified one "winning" paper ($10,000 prize) in each of the four areas and 1-2 "honorable mention" papers. All have now been published in the *International Journal of Child Maltreatment Research, Policy and Practice.* We hope these papers may advance the field and will give us some ideas for future funding of programs.

The search for resources

EndCAN is a fundraising organization. Our intention is to raise money for this field, to amplify it, lobby it, bring a voice to it, help better support it, and ultimately eliminate it (by way of ending child abuse and neglect). We will be exerting our efforts to focus on bringing resources together by mobilizing a large national advocacy group. We will be sharing and spreading the message about surviving and thriving after child abuse through communities, through partnerships, with adults and children, to best improve the response and to end child abuse and

neglect in our lifetime. We will work with other agencies that are interested in a variety of projects, programs, education, models, disruptive thoughts, restructure, PSA's, blogs, pod casts-you name it- we want to help and be a part of it. We have made a lot of friends over the last few years (and more in our previous years in the professions) but we have a long way to go and will befriend everyone and every agency until we collectively "raise the waters" and "raise all boats." Ultimately, we want to fund the field.

The effort to generate resources to support a national foundation is complex. Because our non-profit foundation will give grants to support research, existing non-profits supporting child abuse programs were not interested in giving money. They want to give support to non-profits that provide direct services to abused and neglected children. In our first year, we were fortunate to receive a one-time general operations grant from the Robert Wood Johnson Foundation ($500,000) and a $50,000 grant to support our research grant program from Casey Family Programs. The Haruv Foundation provided $30,000 to a partner with our Disruption paper program. *Friends and Family* provided additional resources ($250,000). We had two development directors who found the task too difficult and moved on. After a year, it became clear that what was needed to be successful was a grass roots advocacy effort.

Many of our colleagues in the child abuse field wondered who the advocacy group would be. They could not imagine that the parents who were caught in the child protection system in the US would be supporters. What those who focus only on the child protective services system miss is that there were millions of abused and neglected children in the US over the past fifty years who never came to the attention of CPS. Many were abused in their families but never reported; many were abused by someone outside the family and ignored by their local CPS agency; and many others (especially boys) were abused by coaches, priests, teachers and others and never disclosed it to anyone. A limitation in our child protective system has been that, when abuse or neglect occurs at the hands of someone outside the family by adults who are not legally responsible for the child, the case falls outside CPS's purview. Many children have survived with little or no sequalae; many more have suffered significant health, mental health and substance abuse challenges. With formal and/or informal treatment most adults who were abused as children survive, but because of the shame and stigma that all feel, they never talk about it. We decided that we needed to find and give a voice to these individuals and hope they will do for child abuse and neglect what the survivors of breast cancer, leukemia, diabetes, heart disease and suicide have done for those conditions over the last 20 years.

Can we bring the field together?

Given the history of the *National Call to Action*, we wondered whether our emergence would be welcomed or not. One of the hopes for our initial March 2019 Summit was to bring major national child abuse organizations to Denver to meet and have time to see what the potential was for collaboration. We were able to link with Prevent Child Abuse America and several other organizations, and decided then to follow up with meetings that included the National Alliance of Children's Trust Funds, the National Family Resource Centers, the National Association of Counsel for Children and the National Children's Advocacy Center among others. These first meetings indicated a willingness to collaborate. Then the Covid-19 pandemic made travel and the ability to meet more difficult. We have been granted $25,000 by the Children's Hospital Association (which was matched by an anonymous donor) to hold a summit

as soon as the pandemic will allow. Having the children's hospitals in the US engaged in helping to shift the conversation from abuse as a social/legal issue to an important health, mental health and public health issue brings heavy artillery to the challenge. Ideally, an organization that can meld the members and work of the National Child Abuse Coalition with the National Health Council and *Research!America* could have the most success. If we can mobilize the millions of abuse and neglect survivors to be part of this effort and follow the lead of the March of Dimes, Susan Komen Foundation and so many others, we believe children in the US will someday grow up in an abuse and neglect-free environment.

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SECTION III: TARGETED PROBLEMS AND POPULATIONS

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Chapter 12

INFANT CRYING AND THE PREVENTION OF ABUSIVE HEAD TRAUMA

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ABSTRACT

The history of abusive head trauma (AHT) has been long, but the history of programs implemented to prevent AHT has been brief. Clinical and developmental studies have confirmed the importance of prolonged unsoothable crying in normal infants as a trigger for AHT. This has provided a window of opportunity to adopt a public health strategy for prevention of AHT through parental education efforts around the birth of newborn infants. Demonstrations of prevention effectiveness have been faced with predictable challenges posed by the low incidence and high variability of AHT admissions, implementation fidelity and the unexpected confounder of the Great Recession. Nevertheless, the evidence to date is encouraging that primary universal prevention strategies are feasible and may be both successful and very cost effective. Given our society's moral obligation to protect defenseless infants, this progress is hopeful that prevention can contribute to giving otherwise normal infants a "good start" in life.

INTRODUCTION

No member of society is as dependent and defenseless as newborn infants in the first few months. In principle, the infant's family provides a supportive system that gives each newborn

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a good start in life. Tragically, this is not true for all. In the 19th century, Ambroise Tardieu (1818-1879) is credited with providing the first definitive description of child abuse (1). In 1971, the first description linking shaking ("whiplash") injuries to cervical trauma was published (2). Not surprisingly, such maltreatment is not recent. Archeologists in Egypt unearthed a child's skeleton dating from AD 50 to AD 450 the fracture pattern of which led them to conclude that "…someone grabbed the child's arms and used them as handles to shake the child violently"(3). Prevention efforts, however, are relatively recent, especially for the form of infant physical abuse known as abusive head trauma (AHT; previously Shaken Baby Syndrome [SBS]).

AHT/SBS are forms of non-accidental inflicted brain injury to infants due to violent shaking, impact to the head, or a combination of both. SBS is a subset of AHT, where the mechanism in a specific case is known to be shaking (4). AHT, in turn, is a subset of physical abuse. Typical injuries include head trauma consisting of subdural hematoma, diffuse axonal injury, cerebral edema and/or retinal hemorrhages, sometimes with fractures of the long bones or ribs but usually little or no external evidence of trauma (5). The outcomes for infants, their families and society are devastating. Up to 25% of hospitalized babies die, and up to 80% have significant lifelong brain injuries (6-8). Estimated societal lifetime costs for a surviving AHT victim are $2.6 million, including $224,500 for medical and direct costs (9). The rationale for finding successful prevention strategies is compelling.

We consider here one conceptual strategy for prevention; namely, universal primary education of parents around mother's maternity stay aimed at reducing frustration with infant crying. Because crying presents to clinicians as "colic," extensive academic and non-academic literatures (including blogging sites) describe perceived causes and therapies of troublesome crying. Despite many hypotheses, few therapies for reducing crying or colic with any empirical support exist. Similarly, empirical support for AHT prevention strategies is limited and the results mixed. Only two programs implemented regionally or state-wide reported whether they reduced cases of AHT/SBS. One is the *Period of PURPLE Crying* program from the National Center on Shaken Baby Syndrome (dontshake.org/PURPLE Crying). The other is referred to as the "Dias model" after its author Dr Mark Dias. This chapter reviews the current status of these programs.

WHY CRYING?

In an early seminal article (10). Henry Kempe (1922-1984) captured the essential ambivalence of caregivers when confronted with their infant's inconsolable crying: "The baby cries and the mother feeds it, it cries more, the mother changes it, it still cries, and there comes that dreadful moment in every parent's life when love and desire to care for the child is mixed with incredible disappointments, anger, and even hate. It is surprising not that there are so many battered babies, but that there are so few." As Kempe describes—and contrary to common descriptions—crying is not simply an aversive stimulus, but functions both to attract supportive caregiving (holding and feeding) and to provoke frustration, anger and abuse, especially when soothing fails (11, 12). Despite a significant literature on the acoustic properties of individual cries, the critical variables for abuse are more likely crying bout characteristics, such as duration, frequency and bout length. In particular, the 5-10% of crying bouts that are prolonged, resistant to soothing (inconsolable), unpredictable and unexplained are those that make

caregivers feel helpless, frustrated, guilty and angry (13, 14). Inconsolable crying is more associated with maternal frustration and depression than frequency or duration of crying or fussing (15, 16).

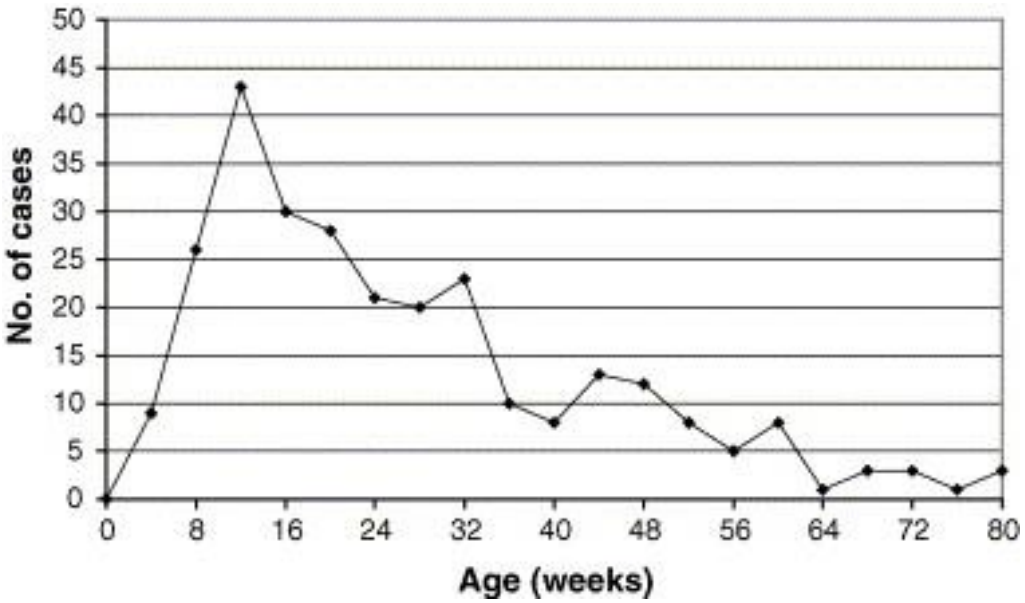

Figure 1. Age-specific number of hospitalized cases of Shaken Baby Syndrome in California hospitals from October 1996 through December 2000, in 4-week brackets. This figure was published in *Child Abuse and Neglect*, v. 30, Barr RG, Trent RB, Cross J, Age-related incidence curve of hospitalized Shaken Baby Syndrome Cases, pp. 7-16, Copyright Elsevier, 2005.

Kempe's observations have been confirmed in numerous clinical studies (2, 17-21). Additional evidence derives from studies of developmental crying patterns in normal infants. Overall crying per day (fussing, crying, inconsolable crying) increases weekly, peaks in the second month and recedes to lower stable levels by the fourth month--typically referred to as the "normal crying curve" (22-24). If crying is a significant stimulus, then the age-related pattern of AHT cases would have a similar developmental curve. Indeed, such a curve was described from California hospital discharge summaries (see Figure 1) (25) and replicated in four other studies (26-29). In all, AHT hospitalizations began in the first month of life, peaked in the third, and diminished subsequently. Recognition of crying as a stimulus has led to its incorporation into prevention recommendations by the American Academy of Pediatrics (5) and the Canadian Joint Statement on SBS (30).

The AHT and crying curves make AHT a candidate for prevention through a public health strategy. First, AHT has a clear risk behavior (infant shaking) and a clear stimulus (crying) that permit specific targeting of prevention messages. Second, the outcomes are severe for the infant and his/her family and financially substantial (9, 31). Third, although mixed, there is increasing evidence that it is preventable (32-34). And fourth, the age-related incidence curve clearly indicates that prevention needs to be introduced prior to two weeks of life (25-27, 29). Fifth, parents very much want to know about crying. Parents are rarely aware that crying will increase, sometimes to greater than five hours/day, during the second month. Sixth, a baby's birth is a life-changing event providing a context for adult learning (33).

This approach differs from most clinical approaches to crying and maltreatment prevention programs. AHT is conceptualized as the outcome of an interaction failure between normal caregivers and crying in normal infants (13). Caregivers do not have to be "at risk" or challenged by mental health concerns. Of course, shaking and abuse can occur with caregivers embedded in sets of risk factors or with infants with abnormal cries. However, a prolonged, inconsolable, ambiguous cry that transforms initially altruistic responses into egoistic frustration, anger and abuse can occur with any caregiver and any crying infant (13). No risk factor and no clinical "cause" need be present. Consequently, prevention strategies must be primary (delivered prior to abuse occurrence) and universal (all parents, not just "at risk" parents) (35).

PROGRAM COMPONENTS

Period of PURPLE Crying

This program is offered by the National Center on Shaken Baby Syndrome (dontshake.org; Farmington, UT). It is structured with three "doses." Dose 1 is delivered during maternity admission and includes: 1) a five-minute scripted interaction between the maternity nurse (or midwife) and mother, with father present if possible; 2) a 10-page educational booklet used as the stimulus for discussion; 3) viewing a 10-minute educational film (The *Period of PURPLE Crying*: A new way to understand your infant's crying) when possible; 4) emphasis on key program messages (Talking Points); and, importantly, (5) providing the booklet and DVD—now available as an app—to parents on discharge. The messages describe the developmentally normal crying curve, inconsolable crying and the dangers of shaking if frustration becomes too great. A second film (Crying, Soothing and Coping: doing what comes naturally) was added focusing on soothing techniques and parental coping when soothing fails. Two important messages are that: 1) soothing techniques work some of the time, but nothing works all of the time; and 2) inconsolable crying bouts do not mean your baby is abnormal.

Dose 2 is message reinforcement, specifically the Talking Points, by any professional having contact with parents within two weeks of discharge. In British Columbia (BC), mothers are assigned a Public Health nurse post-discharge who makes contact within two weeks. All health professionals relevant to post-maternity care (e.g., family physicians, pediatricians, crisis lines, nurse phone-in lines) need to be trained to assure consistent and accurate messaging.

Dose 3 is public education, currently the annual CLICK for babies (CLICKforbabies.org) campaign. Volunteers knit purple caps that are distributed to hospitals offering the *Period of PURPLE Crying* program whose nurses give them to parents with the program.

The Dias model

This program has been implemented in upstate New York (Western New York and Finger Lakes Region, referred to as Safe Babies New York) (33), Westchester county (Hudson Valley Shaken Baby Syndrome Initiative) (34) and statewide in Pennsylvania (Pennsylvania Shaken Baby Syndrome Prevention Program) (36). Program components consist of: 1) a brochure; 2)

an 8-minute video (Portrait of Promise; subsequently A Life in your Hands); 3) asking questions of a nurse; 4) signing a commitment statement; and 5) maternity unit brochures ("Never, never, never, never shake a baby"). In Pennsylvania, reading a "crying card" and signing a response card (similar to the commitment statement) in pediatric offices was added (36). Since only 30% of offices participated and participation was unrelated to AHT rates, this was deemed ineffective.

CHALLENGES TO PREVENTION

Although the case for prevention is compelling, implementing prevention is challenging (35). Three challenges are particularly relevant to understanding the current status of AHT prevention.

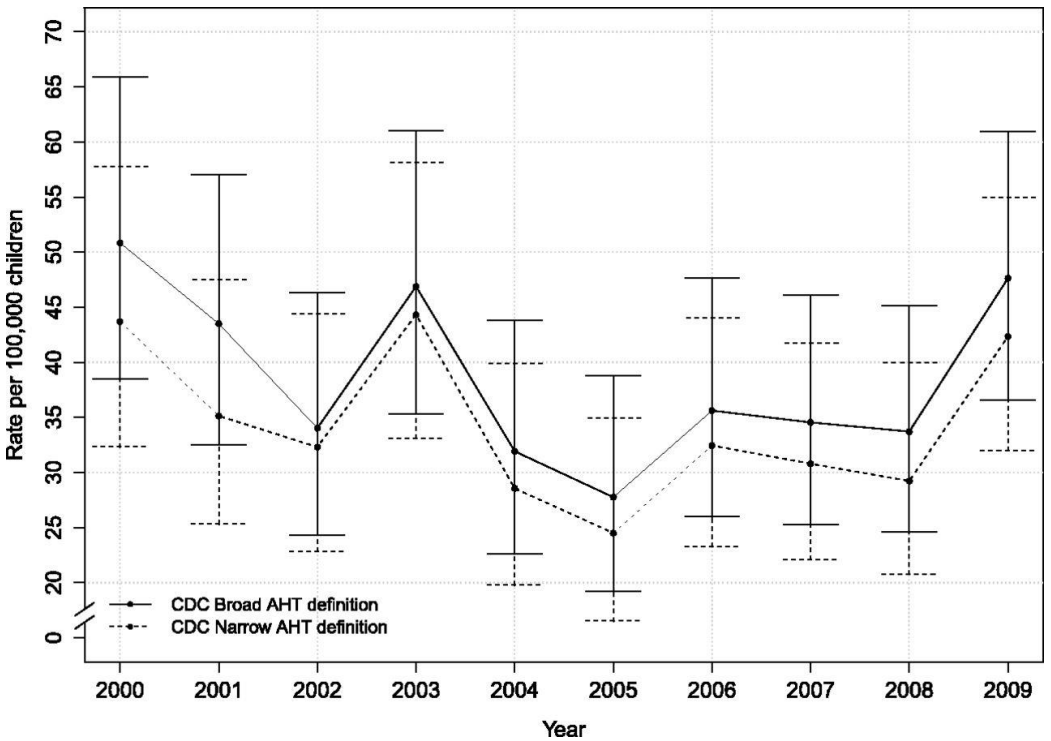

Figure 2. Abusive head trauma rates (with 95% confidence intervals) in North Carolina by CDC AHT definition among children less than 1 year of age (2000-2009). Upper line represents the "broad" definition of AHT; lower line represents the "narrow" definition. Reproduced with permission (37).

Power to detect a positive outcome

Because of its severity, there is no dispute that the AHT incidence is higher than it should be. Nevertheless, it is relatively rare with large year-to-year variations in incidence. Figure 2 depicts the year-to-year AHT incidence rates in North Carolina over 10 years (37). The upper line represents rates for "broadly" defined cases; the lower line rates for "narrowly" defined

cases according to the CDC algorithm using ICD-9-CM coding (38). The overall mean annual AHT incidence is 38.5 and 34.2 cases/100,000 children <1 year of age for "broadly" and "narrowly" defined cases respectively. There is no significant trend over the 10-year period. Notice the very wide 95% confidence intervals around each annual mean. Because of this, none of the year-to-year variation is statistically significant. Impressive year-to-year differences (e.g., the 33% drop in "narrow" cases from 45 to 30 between 2003 and 2004, or 43% increase in "broad" cases from 35 to 50 between 2008 and 2009) cannot with confidence be interpreted as due to any factor other than chance. This means that it would be necessary to study very large populations for many years to provide sufficient power to demonstrate a decrease in rates due to a prevention implementation (37).

Fidelity

Fidelity refers to a program actually being delivered as intended to achieve explicit program aims. Clearly, if implemented without fidelity, failure may be due to program ineffectiveness, or to its not having been implemented with fidelity (or both) (39). This is not a small challenge. Implementation requires cooperation and commitment from hundreds of institutions, thousands of professionals, and many layers of society (32, 33, 36, 37, 39-41). In BC, implementation included training 5,400 maternity and public health nurses and 4,800 "reinforcement group" practitioners (family physicians, phone-in lines, etc) (32). Fidelity challenges occurred for both AHT programs. For example, in the Dias program, the maternity video was consistently rated as the "most important" component (36) but was actually seen by fewer than one-quarter of parents in 2005 (33) and fewer than one-half in 2017 (36).

A mid-project review in BC revealed that one region accounted for 40% of AHT admissions but only 15% of births. Two process measures (a Public Health Nurse survey and a Parent survey) were analyzed to understand the anomalous performance. The Public Health Nurse survey asked nurses whether they covered the Talking Points, such as: "Please tell us if you discussed the following *PURPLE* program talking points with the mother: …Watch the DVD and read the booklet" and "…Share the *Period of PURPLE Crying* messages with all caregivers." The Parent survey asked questions about crying advice, such as: "Did someone at the hospital talk to you about how babies cry the most at 2-3 months of age?" or "…about sharing the *Period of PURPLE Crying* messages with all caregivers?" In the target health region, affirmative answers were consistently lower than those from four other regions, sometimes by as much as 50%. These and other process indices were presented to a meeting of the Acute Care and Public Health Quality Care Councils (spring, 2014). A re-education plan was designed, including grand rounds, appointments of maternal and public health leads for quality improvement, on-line certification of new nurses, recruitment of midwifery staff and quarterly training reports to nurse managers. The initiative appeared to be successful. In the previous five years, the region experienced seven AHT hospitalizations (1.4/year); in the five years following, only three occurred (0.6/year). This experience underlined the value of process measures to detect fidelity lapses that could be remedied.

Unexpected events: The Great Recession

The primary design has been a pre-post-implementation comparison within a jurisdiction. This is a weak design because it cannot protect against unmeasured influences that may change from baseline to implementation periods, such as new health services, a salient case of AHT (e.g., the conviction of Louise Woodward—the "Boston nanny" case—in 1997) (33), or implementation of social policies that might reduce AHT cases (42). The low incidence high variability challenge previously described makes it very difficult to mount a methodologically stronger randomized controlled trial (33). Alternatively, outcomes can be compared in jurisdictions where the program is not implemented. That has several challenges of its own including comparability of measurement systems, availability and cost of data, and economic comparability (33, 34, 36, 40).

Just such an unexpected event—the Great Recession of 2007-2009—occurred coincidentally with the implementation of both *Period of PURPLE Crying* trials (North Carolina (40) and BC (32)) and one Dias program trial (Pennsylvania (36)). Substantial increases in AHT admissions were documented in eleven other states or regions (Pennsylvania, Ohio and Kentucky, Washington (43, 44); Ohio (45); Arizona, Colorado, Florida, Iowa, Maryland, Massachusetts, Wisconsin (42)) and in a national emergency department sample (46). Elevated AHT admission rates continued in some states post-recession (44). A Cincinnati study (45) is particularly interesting, because it documented a doubling of AHT admissions despite decreases in overall trauma and accidental head trauma. However, increased rates were not found in all comparison states and regions (36, 37, 40), making clear interpretations of recession effects difficult.

Period of PURPLE Crying program development

The *Period of PURPLE Crying* program has two major goals: first, to support caregivers in their understanding of early crying; second, to reduce the AHT incidence. There have been two major implementations of the *PURPLE Crying* program: North Carolina (June 2009 to September 2012) (40) and British Columbia (January 2009 to December 2016) (32). The booklet and DVD underwent extensive prior testing and development beginning in 2002. Because the program is a primary, universal public health program independent of risk factors and targeting all parents of newborns, the content had to meet criteria of being attractive, consistent, meaningful, and positive for multiple caregiving cultures. For example, unless carefully conveyed, the message to "put the baby down and walk away if the crying is too frustrating" would be less acceptable in cultures where crying is universally interpreted as meaning the infant needs to be with its mother. Furthermore, the messages and images needed to be consistent with professional practice norms (e.g., safe sleep, breastfeeding). Some recommendations may be in flux or even conflicting among professions (e.g., swaddling (47, 48)). If practice beliefs—even if controversial—are firmly held by committed professionals, messages conflicting with those beliefs would not be conveyed to parents regardless of how preventative they might be.

The materials progressed through many iterations within the National Center on Shaken Baby Syndrome (NCSBS). They were then subject to professionally led focus groups (ten in the USA; eight in Canada) including fathers, couples, maternity and public health nurses, First

Nations peoples, and physicians. In a rigorous separate process, materials were translated into 10 languages. The eight-step translation process included groups of professional interpreters and parent native-language speakers, a translation decision meeting, and an independent professional back translation. The process proved valuable. There were recurring sets of difficult-to-translate words. One of the most difficult was "to shake" or "shaking." Words chosen by South American Spanish speakers were translated back into English by Mexican Spanish speakers as "dusting." Consequently, the English message "Never hurt or shake your infant" would have come across as "Never hurt or dust your infant"! Translated DVD editions were produced with a professional production company using experienced voice-over talent.

The English materials were subjected to two randomized controlled trials (RCTs) in Vancouver and Seattle to assess whether they changed maternal knowledge about crying and dangers of shaking, and some behaviors relevant to preventing shaking (49, 50). These were the first RCTs of AHT prevention materials (51). Subjects received the *Period of PURPLE Crying* program during maternity (in Vancouver) or during prepartum classes, maternity or pediatric visits (in Seattle). They completed a four-day diary (52) at four weeks, and a telephone interview at eight weeks postpartum. In both studies, parents receiving the *PURPLE* materials had significant increases in knowledge about crying (49, 50). Increases occurred on all scale items. The two items with the greatest change were whether a good parent should be able to soothe a crying infant (14.5% improvement; correct answer: no, because some crying bouts are inconsolable) and whether a normal infant can cry five or more hours/day (22.5% improvement; correct answer: yes). Seattle parents receiving *PURPLE* materials increased knowledge of the dangers of shaking; there was no difference among Vancouver parents. Vancouver *PURPLE* mothers shared advice about walking away if frustrated, the dangers of shaking and crying characteristics; Seattle mothers shared advice about walking away and dangers of shaking. In the diaries, Vancouver mothers receiving *PURPLE* were 1.7 times more likely to walk away when frustrated by inconsolable crying. Cohen's effect size for change in crying knowledge was 0.46, about twice that reported for short-term interventions in parenting knowledge studies (53).

NORTH CAROLINA IMPLEMENTATION (JUNE 2009 TO SEPTEMBER 2012)

By June 2009, 100% of birthing hospitals in NC were implementing the *PURPLE* program and 88% of parents of newborns received the materials. In addition, most pediatric offices were reinforcing the messages at first month visits. There was a nine-month media campaign in three large markets in the state with paid radio announcements (January to September 2009).

To assess behaviorally whether the program supported parents, telephone calls to an after-hours nurse advice line for 68 physician practices were monitored from January 2006 to December 2010. Rates for calls regarding "crying" without other symptoms were compared three years prior and two years post implementation. For infants 3-12 months of age, calls declined by 12%; for infants <3 months, calls declined by 20% (40).

To assess AHT admissions, state-level inpatient databases for NC and five other states with available data at low cost but few or no AHT prevention programs were used. A difference-in-difference analysis compared rates before and after implementation while attempting to control

for economic variables (unemployment, mortgage foreclosures). As previously discussed, state AHT rates varied widely (37, 40). There was no statistically significant decline in AHT rates attributable to the intervention (40).

The reduction in nurse advice line calls implied that the program was being delivered and that the messages helped parents understand frustration with early crying. Despite using comparison states and economic indicators, interpretation of the null results for AHT admissions remained complicated by the coincidence of the Great Recession, the possibility of being underpowered, a too brief follow-up and unmeasured confounders (40).

BRITISH COLUMBIA IMPLEMENTATION (JANUARY 2009 TO DECEMBER 2016)

Province-wide implementation in 49 maternity units and 112 public health offices was reached in January 2009 (49). Parent participation averaged 90% and remained high throughout. Three tracking systems ascertained program material use at home (booklet, DVD, either). Within two weeks, 23%-32% of mothers had watched the DVD and/or read the booklet. By 2-4 months, 71% of mothers reported having read and/or watched the DVD—better than a doubling in actual use of the materials. Both the booklet and DVD were important, since approximately 50% reported reviewing each. Importantly, nurses were successful in presenting *PURPLE* with the father present 74% of the time.

The aim of behaviorally measuring whether the program supported parents' understanding of crying was assessed by visits to the medical emergency room (MER) of the only children's hospital in the province (54). Electronic medical records were used to ascertain what percentage of 30,790 MER visits were for crying complaints without an organic cause between January 2002 and February 2012. When plotted by week of age during pre-implementation (to February 2008), the MER crying complaints curve exactly replicated the crying curve in unreferred infants (23, 55). Visits increased until six weeks, and declined thereafter (54), confirming that MER visits reflected crying in normal infants in the community. After implementation, MER visits for crying were significantly reduced by 29.5%. This implies that the *PURPLE Crying* messages were effectively delivered and helpful in supporting parents with crying infants.

To assess AHT admissions, cases were confirmed from a retrospective-prospective review of child protective service (CPS) records between 1995 and 2016, with meetings held quarterly from 2007. Compared to pre-implementation, admission rates fell 33% (10.6 to 7.1/100,000 person-years) for <12 month-olds ($p = 0.09$) and 35% (6.7 to 4.4/100,000 person-years) for 12-23 month-olds ($P = 0.048$). Comparable comparison data from other provinces were not available, but these results diverged from a doubling of AHT rates in neighboring Washington State (43, 44).

The reduction in MER visits for crying complaints mirrored the reduction in nurse line calls in NC, supporting the feasibility of jurisdiction-wide implementation, of reaching and supporting parents, and bringing about behavioral change. The statistically significant 35% reduction in AHT admissions in BC diverges positively from the NC results. This reduction occurred despite the recession in Canada. It also occurred despite a significantly lower baseline incidence of 10.6 cases/100,000 person-years compared to 30 cases/100,000 person-years or greater in NC (40) and most USA studies (37, 56). This study continued surveillance for eight

years following implementation, helping to compensate for the low annual incidence high variability challenge of AHT (32).

DIAS PROGRAM MODEL: UPPER NEW YORK STATE

The initial Dias model regional implementation occurred in Buffalo and eight surrounding counties in upper New York State (33). Implementation began in December 1998. All 16 maternity units participated. Using signed commitment statements as the measure of participation, the implementation accessed 69% of live births. At 7-month follow-up, 95% of parents remembered receiving program components, but only 23% recalled seeing the videotape. This means that only 16% (0.23 x 0.69 = 0.16x100%) of the target population saw the videotape. Nevertheless, AHT admissions dropped from 41.5 to 22.2 cases/100,000 births, a 47% reduction over 5.5 years (33). There was no concomitant reduction in neighboring Pennsylvania. A second implementation was instituted in the 9 county Finger Lakes Region in 2000. Dias later reported persistent reductions of 43% over 15 years and 55% over 13 years in the Buffalo and Finger Lakes Regions respectively (57). These implementations two years apart effectively represent an "interrupted time series" design that is stronger than a simple before-after comparison.

DIAS PROGRAM MODEL: LOWER NEW YORK STATE

Another regional implementation (seven counties, 19 community hospitals, one tertiary care children's hospital) was reported from the Hudson Valley Region of NY State (34). Between May 2005 and April 2008, 85% of parents received the intervention. Of those, 85% of mothers and 40% of fathers confirmed watching the videotape and remembered watching it six months later. Comparing a three-year implementation with a five-year historical control, they observed a statistically significant 75% reduction from 2.8 to 0.7 cases/year in <12 month olds. In three adjacent states (Connecticut, New Jersey, Maryland), there were no changes. This small positive replication was encouraging for the concept of prevention during maternity stays.

DIAS PROGRAM MODEL: PENNSYLVANIA (JANUARY 2003 TO DECEMBER 2013)

This statewide implementation began in 2003 in all 67 counties. By 2007, participation rates reached 90%. A fifth program objective was added; namely, encouraging parents to wisely select caregivers that could handle a baby's crying. At the seven-month follow-up, the videotape was again the least frequently remembered component, with less than half recalling having seen it. Interestingly, 75-80% of mothers and fathers recalled the materials when their infant was crying, and 26% said they changed their caregivers based on the program.

When the historical control period (1996-2002) was compared with early (2003-2006) and/or later implementation (2007-2013) periods, hospitalization rates were similar or higher for 0-11, 12-23 or 0-23 month olds during implementation (36). For example, rates for 0-11

month olds moved from 42.7 to 46.1 cases/100,000 population. When rates were compared with five comparison states (Arizona, Florida, Colorado, Oregon, South Carolina), 12-23 month old admission rates favored comparison states.

The apparent lack of effectiveness differed from previous results with this model. The authors speculated about the challenges of maintaining program fidelity when going to scale from regional to state-wide implementations. This included the difficulty in assuring that parents received all or most program components, especially the videotape consistently ranked as the most memorable. They also experienced high turnover among nurse leaders and staff. In addition, this implementation coincided with the 2007-2009 recession associated with significant rises in AHT rates elsewhere.

COST-BENEFITS OF PREVENTION MODELS

Initially, Dias et al. (33) conservatively estimated their intervention cost $10 per newborn. They hypothesized that the program would be paid for if eight cases of infants (at $21,925 medical costs/infant) were prevented annually. Peterson et al. (58) more systematically calculated the inpatient cost at $29,791. More importantly, medical costs initially and four years following admission would average $47,952 (in 2012 dollars) per survivor. These costs excluded educational or other related nonmedical costs. Costs were estimated by comparing AHT survivors to children without AHT over four years, providing an estimate of the specific excess and preventable medical costs of being an AHT victim (58).

In a detailed analysis of lifetime AHT costs, Miller et al. (9) documented that a single surviving AHT victim would require $224,500 (in 2010 dollars) for medical care and direct related costs. If "societal costs" that include lost quality of life and lost work costs were included (disability-adjusted life year burden [or DALY]) (59), each survivor would average $2.6 million in losses. Lifetime societal costs for a death would be $5.7 million. If one breaks out the non-fatal medical cost estimate, costs averaged $34,750 per survivor in the first 3.5 years post-injury, similar to a New Zealand study that estimated costs of $35,300 USD (not including physician's office costs) (60). Considered another way, estimated expected lifetime societal costs of an AHT victim were $3300 per live birth in the United States; out-of-pocket costs were $284 per live birth. This provides an opportunity to estimate breakeven costs for effectiveness. Assuming the current Dias model and *PURPLE Crying* prevention models cost $5 per mother (31, 34, 59, 61), breakeven effectiveness of a prevention program could be achieved with a 2% reduction (5/284 x 100%) in AHT cases.

The 35% reduction with the BC *Period of PURPLE Crying* program (32) provided the first opportunity to report a cost-effectiveness analysis from an actual setting. Beaulieu et al. estimated lifetime costs of AHT events (in 2014 CDN dollars) by severity (least severe, severe, and fatal). They calculated cost-effectiveness both from a "societal" and health services perspective (31). In this analysis, 8% died, 78% were non-fatal severe cases, and 14% were non-fatal least severe cases. The average lifetime cost with the *PURPLE* program was approximately $95,000. It resulted in a $14.49 cost avoidance to the healthcare system or a $273.52 cost avoidance to society per 0-24 months old child. This translates to cost avoidance to the healthcare system if 7% of AHT cases were prevented, and a cost avoidance to society if 2% were prevented. Because of differences in methods, national systems and baseline

currencies, these results are difficult to compare directly. However, bearing in mind the lower baseline rate of AHT incidence of 11.2 cases/100,000 population compared to rates three times higher in most USA studies (32, 56), avoided costs from a 2% or 7% decrease could be greater in regions with higher AHT rates (31).

From the unique perspective of a caregiver's family, Steinbeigle et al. reported a case of the medical and care costs for a severely injured AHT victim from 2.5 months to age 17 (62). Of the total $261,499 costs, $106,607 (41%) were paid out-of-pocket by the adopting grandparents. Of note was the year-to-year cost variability and unpredictability, which, for the grandparents, ranged from $260 to $20,775/year. Although illustrative of a single case, it draws attention to the considerable and unpredictable financial demand on caretaker families over and above guardianship, daily care and emotional and logistical support.

COMMENTARY

Is the focus on crying too narrow?

The peak in AHT incidence in association with the peak of crying in the second month (13, 25, 26) empirically justifies the presentation of educational programs during maternity. However, AHT cases continue through the second, third and even fourth year albeit at less than one-seventh the rate for <12-month olds (29, 32, 36, 63). Although crying continues at lower levels, we understand less about inciting stimuli in older cases.

Nevertheless, inconsolable crying represents the first major behavioral challenge to new parents. Anecdotal stories suggest that infant behaviors that contradict parental expectations for normal development and/or persist despite parental instruction to stop (refusing to eat, bedwetting, temper tantrums) are common causes. Shaking continues to be a means of discipline at rates of >20% in many countries throughout the first two years (64). It would be much more challenging to craft a memorable but brief message covering all sources of parent frustration in the first two years. However, the "lessons learned" around frustration with crying may be helpful when faced with behavioral challenges later.

The challenge of reaching fathers

Perpetrators are most likely related males, followed by boyfriends or stepfathers (13, 29). Fathers or male surrogates are five times as likely to shake infants as their mothers (65). This presents a challenge, since there is no clear public health avenue to all fathers. However, both *PURPLE* and Dias model implementations were moderately successful in reaching fathers. In BC, fathers were present when nurses provided the program 76% of the time, and 50% of fathers viewed or read the materials at home (32). In the three Dias implementations, fathers were participants 76%, 70% and 40% of the time (33, 34, 36). While far from perfect, maternity stays may yet be the most effective means of accessing fathers or male surrogates.

Effectiveness for reducing physical abuse generally?

Although not yet reported, these programs may prevent physical abuse in infants more generally, not just AHT that is their focus. The logic of infant physical abuse prevention is identical; namely, reduction of anger responses to crying, as Kempe's quotation suggested (10). The difference is only in the nature of the inflicted injury. Physical abuse may be less severe since brain injury is not required as a criterion. In the BC program review, physical abuse occurred 2.5 times more frequently than AHT at baseline (14.5 vs. 5.9 cases/year) and was reduced 48% nine years following implementation. From abuse prevention and cost-benefit perspectives, that represents a substantial amplification of the value of this model.

How much intervention is enough?

Following the disappointing Pennsylvania and North Carolina results, Leventhal et al. (66) posed the question as to whether clinicians should expect that a brief intervention after birth would have a lasting effect on future parental shaking in response to crying. They proposed five modifications to strengthen the effects: 1) receiving education from "multiple diverse sources"; 2) focusing parents on their own frustration and anger, rather than their infant's behavior; 3) combining prevention with other forms of parental support (e.g., parental leave); 4) home visiting; and 5) actively including male caregivers. Perhaps ironically, the same investigators reported from a single hospital that infants with parents who received a five-step verbal instruction (Take 5 Safety Plan for Crying) from "medical providers" at discharge were 79% less likely to have AHT than accidental head injuries (67, 68). This intervention focused on their second recommendation only. The BC intervention included virtually the same messages plus understanding the frustrating characteristics of normal infant crying. It also included all or most of the other four recommendations. Exactly what message characteristics are critical remains an open and interesting question.

Is the cup half empty, or half full?

The 2005 Dias model implementation report (33) was seminal in encouraging prevention initiatives based on the concept of educating mothers and fathers during the maternity stay (33). At least 18 states reportedly introduced legislation mandating postnatal AHT education for all parents (33). The small positive replication in lower New York state reinforced its potential value (34). Subsequent apparent failures of state-wide efforts in Pennsylvania (36) and the North Carolina *Period of PURPLE Crying* implementation (40) were discouraging. The BC experience was a positive contrast as the only jurisdiction-wide implementation to date reporting a significant reduction in AHT admissions (32). As a straight "scorecard," the results have been mixed, with three positive and two no change or negative results.

A clear interpretation of these results remains elusive. However, salient challenges were to be expected and did impact these efforts. First, challenges to fidelity became apparent. The recurrent Dias model failure to expose most parents to the videotape, reliably rated as the most salient component, could be a weakness. This was offset in the *PURPLE* program where parents were provided DVDs to take home. Further, in BC the DVD was used in later months when the

crying peak occurred. Second, fidelity challenges were greater when "going to scale" in jurisdiction-wide implementations. All three regional but only one of the jurisdiction-wide implementations were positive. In BC, fidelity for nurse training was facilitated by online training modules that could track which nurses had or had not taken the training. Ongoing tracking surveys of maternity and public health nurses and parents proved critical for demonstrating to health authorities the locus and nature of fidelity lapses. Third, all three jurisdiction-wide implementations coincided with the Great Recession, but only the BC program reported positive findings despite that. Arguably, the other programs actually prevented what would otherwise have been a rise in AHT admissions documented in other states and regions (42-46). Finally, low but highly variable incidence rates made power to find effects difficult, a challenge partially offset in BC by reporting an extended eight-year follow-up.

What is consistent and replicable is the perceived value by nurses and parents of the educational efforts. In a detailed assessment from North Carolina (39), Shanahan et al. (39) documented the successful implementation across all 86 birthing hospitals with a high degree of fidelity. The authors argue that the fidelity was likely attributable to the high levels of acceptance and positive program perceptions by hospital personnel and parents. Positive perceptions were reported in all descriptions of both program models (33, 36, 41). The programs were also effective in changing crying response behaviors (49, 69), sharing information behavior with other caregivers (36, 49, 50, 70), and choosing appropriate caregivers (36). Objective evidence that the programs supported parental crying concerns was seen in the 20% reduction of calls to nurse advice lines (40) and 30% reduction in MER visits for crying (32). Cost-benefit analyses are convincing that the return on a successful implementation can be substantial for defraying both medical and societal costs.

Although there is more to learn, it is probably fair to conclude that the "effective prevention" cup is at least half-full. Progress since Dias' initial report (33) has been substantial, including successful regional replications and one implementation at scale. One can only speculate about how the prevention landscape would have looked in the absence of macro events such as the Great Recession.

The case for greater understanding of prevention is compelling. In the near term, the Covid-19 pandemic has brought an associated recession (71), with historic levels of joblessness and economic hardship. Combined with "staying in place" orders to reduce virus transmission, it is difficult to imagine this being anything but a "double jeopardy" for increased stress in the face of inconsolable crying in new families.

In the longer term, the threat may be more widespread and urgent than imagined even absent recessions and pandemics. Runyan et al. (64) reported that rates of "harsh physical punishment" internationally exceed 14%, or 39% if hitting with an object is included. Shaking as discipline for under two-year olds occurred at rates greater than 20% in many countries and over 60% in some (64). It is not difficult to imagine shaking becoming increasingly repetitive, violent and abusive. An uninvestigated and unanswered question remains as to the burden of clinically undetected shaking (72) secondary to typical caregiving that contributes to mental retardation of unknown etiology, learning disabilities and behavior problems. In that light, these early prevention efforts focused on caregiver-infant interactions have considerable promise as a proof of principle that prevention can work.

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Chapter 13

ELIMINATING CORPORAL PUNISHMENT

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ABSTRACT

Globally, corporal punishment is the most common form of violence against children; almost 250 million children are physically punished on a regular basis in their homes, by their parents or caregivers. Its prevalence is fueled by social norms, laws, and adult perceptions of children. This chapter examines the emergence of corporal punishment within an interaction between a parent and a child, focusing on the cognitive and affective components that erupt in punitive violence. Strategies for prevention are identified for each component of the interaction. A cohesive approach to prevention must include a focus on strengthening parents' problem-solving skills, rather than prescribing alternative punishments.

INTRODUCTION

Globally, corporal punishment is the most common form of violence against children; almost 250 million children are physically punished on a regular basis in their homes, by their parents or caregivers (1). It has been identified by major organizations as a key target in abuse prevention efforts in the US and beyond. For example, the American Academy of Pediatrics aims to "end the use of corporal punishment in the US" (2) the American Professional Society on the Abuse of Children "calls for the elimination of all forms of corporal punishment" (3), and the US Centers for Disease Control and Prevention have identified approaches to reduce corporal punishment as key child abuse prevention strategies (4). On a global level, the United Nations' sustainable development goals include a target of ending all physical punishment by

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2030 (5) and the World Health Organization calls for "the adoption or reform of laws and policies … to prevent violence against children and adolescents, including corporal punishment, in all settings" (6).

These organizations' positions reflect a global transformation in conceptions of children and of violence. Whereas corporal punishment was once considered an effective and appropriate method of socialization, it is now recognized as an act of physical aggression that is, in itself, abusive. This chapter will address the common but false dichotomy between physical punishment and physical abuse, present the research findings that have eroded this dichotomy, and set out directions for policy, law and practice to prevent this form of violence against children.

DEFINING CORPORAL PUNISHMENT

Across recent centuries, corporal punishment was defined as 'discipline' in many countries. It was long considered a method, technique, or strategy to elicit child compliance and recommended by pediatricians, advocated by school boards, and justified by law. Underlying the definition of corporal punishment as discipline was a belief in the value of physical and emotional pain as educational tools; adults' good intentions were given considerable weight. This belief in corrective pain persists in the common bifurcation of physical violence against children into 'punishment' and 'abuse.'

Punishment is generally conceived as a rational and well-intentioned response to a deserving transgression. This conception is embodied in a commonly used research definition aiming to distinguish corporal punishment from abuse: "an act carried out with the intention of causing a child to experience physical pain, but not injury, for purposes of correction or control" (7). Thus, if the adult aimed to correct the child, the act is defined as punishment, not abuse - even if the adult intentionally caused the child pain. In the ongoing effort to distinguish punishment from abuse, terms have been coined such as 'sub-abusive' and 'minor' violence, creating a putative sphere of 'non-abusive aggression.'

Abuse, on the other hand, is generally assumed to be impulsive and intended to injure, not to teach. It encompasses such concepts as 'excessive punishment' and 'inappropriate punishment,' terms conveying that there exists an appropriate level of physical violence that is not abusive. Other notions such as 'punishment that went too far' and 'punishment that escalated into abuse' imply that what began with good intent went awry, exceeding an arbitrary line.

Increasingly, it is being recognized that drawing a line between physical punishment and physical abuse is not only impossible, it is a contributing factor to child maltreatment as it normalizes some level of physical violence against children. As this recognition grows, so does the use of the definition issued by the United Nations Committee on the Rights of the Child (8):

> Corporal punishment and other cruel or degrading forms of punishment…are…forms of violence against children (para. 1). The Committee defines 'corporal' or 'physical' punishment as any punishment in which physical force is used and intended to cause some degree of pain or discomfort, however light. Most involves hitting ('smacking', 'slapping', 'spanking') children, with the hand or with an implement - a whip, stick, belt, shoe, wooden spoon, etc. But it can also involve, for example, kicking, shaking or throwing children,

> scratching, pinching, biting, pulling hair or boxing ears, forcing children to stay in uncomfortable positions, burning, scalding or forced ingestion (for example, washing children's mouths out with soap or forcing them to swallow hot spices). In the view of the Committee, corporal punishment is invariably degrading. (para. 11)

This definition addresses several important issues. First, it does not dichotomize punishment and abuse. Corporal punishment is force administered to the child's body; it is violence with punitive intent. Second, it recognizes that corporal punishment takes many forms, but does not put them into a hierarchy of severity; all are acts of violence. Third, the definition acknowledges corporal punishment's psychological dimension, which is often missed in efforts to create severity hierarchies; it is 'invariably degrading' from the perspective of the child.

The UN's definition of corporal punishment is more than conceptual, however. It is supported by findings of research going back decades that have clear implications for prevention. That body of research will be reviewed in the following section.

EVIDENCE CHALLENGING THE PUNISHMENT-ABUSE DICHOTOMY

Challenges to the punishment-abuse dichotomy have been raised in North America since at least the 1830s (9). In the last half-century, these challenges have gained substantial empirical support, beginning with David Gil's (10) analysis of every incident of child abuse (n = 1,380) reported in 1967-68 through the central registries of all US states and territories. He constructed a typology of causal factors. The most common type involved "incidents developing out of disciplinary action taken by caretakers" (10). Nearly two-thirds of cases were classified as a punitive response to a specific act of the child.

Several years later, Alfred Kadushin and Judith Martin (11) analyzed all reports of child physical abuse substantiated in 1974-75 by the Wisconsin Department of Health and Social Services (n = 830). Their study included extensive interviews with 66 of the parent perpetrators. Almost all saw their actions "as disciplinary procedures required in response to the child's behavior" (11) and 44% reported that they would respond the same way if they had the opportunity to relive the incident. Only 6% of the parents said they had intended to hurt the child. In most cases, parents intended to change the child's behavior (32%), teach the child a lesson (30%), or regain control (14%). For example:

> "By my spanking, she knows that she shouldn't be doing what she's doing" (p 191).
>
> "I did it for them not to do it again" (p 191).
>
> "I want him to listen when people tell him to do things and I want him to do them especially at home…I want him to respect people" (p 191).
>
> "I just wanted him to be good, that's all, and obedient" (p 191).
>
> "I feel it's really important that she learn to obey now or she's never going to obey anybody" (p 193).
>
> "I wanted him to be happy and to learn to mind and behave himself and do what he was told to do when he's asked to do something" (p 192).
>
> "I just wanted him to stop peeing in his pants" (p 191).

> "I hoped to have her understand that she does not wilfully, purposely hurt another person" (p 191).

Such findings have been replicated in numerous studies. For example, Margolin (12) examined 98 cases of substantiated physical abuse committed by babysitters in Iowa in 1985 and 1986. In most cases, the perpetrators had responded with corporal punishment to behavior they perceived as "rudeness, disobedience, and challenges to the sitter's authority" (12). The children were punished for behaviors such as crying, spilling food, making messes, and refusing to go to bed. In at least 21 cases, the child's parents had given the babysitter implicit or explicit permission to use corporal punishment.

The first Canadian Incidence Study of Reported Child Abuse and Neglect (CIS–1998) found that 75% of substantiated child physical abuse occurred during episodes of corporal punishment (13). In the second cycle of this national study, conducted five years later, this proportion had not changed (14). A provincial-level study conducted in Ontario in 2013 found that 80% of substantiated incidents of physical abuse were intended as punishment (15).

Several studies have documented the relationship between 'normative' corporal punishment and child injury. A large Quebec study found that those children who had been spanked on the buttocks or slapped on the hand, arm or leg in the previous 12 months were seven times more likely to be severely assaulted (e.g., punched or kicked) by their parents than those who were not slapped or spanked (16). A US study found that every time children were spanked, their odds of experiencing severe violence (e.g., kicking, punching, burning) increased by 3%; if they were hit with objects, the odds increased by 9% (17). In another US study, infants in their first year of life who had been spanked by their parents in the previous month were more than twice as likely to suffer an injury requiring medical attention than infants who had not been spanked (18). A meta-analysis of 75 studies focused exclusively on 'spanking' (19) identified eight studies examining the relationship between being 'spanked' and being 'physically abused,' all of which found that spanking increased abuse risk.

These findings demonstrate that attempts to distinguish between punishment and abuse mask the reality—that most of what we call physical abuse *is* physical punishment. Thus, an effective strategy to prevent physical violence against children must include the elimination of corporal punishment as a central target. Doing so requires an understanding of why caregivers intentionally hurt children in this way. The factors that contribute to the emergence of corporal punishment range from the individual to the legal. The following section will set out a framework for prevention that addresses these factors in an integrated way.

IMPLICATIONS FOR PREVENTION

Christina Rodriguez has applied a social information processing (SIP) lens to unpack the emergence of physical punishment within a parent-child interaction (20-22). According to the SIP model, the processes resulting in parental aggression are rooted in cognitive and affective tendencies present before the interaction begins. These include parental beliefs in the acceptability and effectiveness of corporal punishment, expectations of child compliance, and low parental empathy. These pre-existing schemas prime the parent to react aggressively as the interaction unfolds over mere moments. In Stage 1 of the interaction, the parent's emotional arousal system is activated, distorting their perception of the child's behavior. In Stage 2, the

parent attributes the behavior to deliberate intent on the part of the child (e.g., disobedience, defiance, testing, stubbornness), amplifying the parent's frustration and anger. In Stage 3, the parent fails to consider non-aggressive response options, due to either lack of knowledge or emotional arousal, and strikes or otherwise hurts the child. An understanding of this process leads directly to entry points for prevention, which are set out in the following sections.

Strategies to change parents' pre-existing cognitive schemas

The SIP model posits that the process leading to parental aggression begins prior to the interaction, in pre-existing schemas regarding the acceptability and effectiveness of corporal punishment, expectations of child compliance, and limited empathy for the child's cognitive and emotional state. Parents' pre-existing schemas are embedded in their own childhood histories. Those who experienced corporal punishment as children are more likely to approve of it and to use it (7, 23-26). From their extensive interviews with abusive parents, Kadushin and Martin concluded: "[parental] acceptance of corporal punishment as a disciplinary procedure is directly related to child abuse" (11).

It is paradoxical that a painful, disempowering, humiliating childhood experience would not only be repeated with one's own children but also viewed as acceptable and effective. After all, a child who is burned by a hot candle generally becomes a parent who seeks to protect their children from the same experience. The internalization of approval of corporal punishment is a complex process, but one key element appears to be the acceptance of the message that it was deserved (27). This message shifts the responsibility for the parent's aggression from the adult to the child—a message made explicit by use of the term 'punishment,' which conveys that the child behaved in a way that warranted the parent's response. The message that 'I deserved it' becomes part of the child's corporal punishment schema, and it is likely to be carried forward into their own parenting (28).

The impact of the message that corporal punishment is deserved was dramatically illustrated in a large US study which found that only 10% of adolescents and young adults who had been bruised; 35-38% of those who had sustained, burns, cuts, or dental or head injuries; and 43% of those who sustained broken bones due to 'discipline' inflicted by their parents believed they had been abused (29). An extension of that study found that "the classification of the experiences as abusive is, to some extent, a function of the degree to which the punitive experiences are perceived as deserved" (30). Such findings demonstrate that the acceptability and justifiability of punitive violence become embedded in the developing brain as the message is internalized that such violence is deserved.

Strategies aimed at reducing intimate partner violence emphasize the message that violence is not deserved. For example, one of the National Domestic Violence Hotline's key messages is, "You never deserve to be mistreated" (31). This message explicitly shifts the responsibility for the violence from the victim to the perpetrator. In the case of parental violence, prevention strategies must similarly place the responsibility for the action on the person inflicting the violence. A key component of this process is a shift in language. We use the term 'partner violence,' not 'partner punishment,' to describe actions committed by one adult against another, even though those actions are often punitive in intent. The word 'punishment' implies that the victim acted in a way deserving of that punishment. Common use of the words 'punishment' and 'discipline' to describe parental violence against children perpetuates the idea that the child

did something to elicit the violence, contributing to the never-ending debates regarding how much violence is acceptable—debates founded on the premise that children deserve it (32).

Mobilize research

A second important strategy for transforming the pre-existing schemas that are enacted in punitive violence is to transform the social norms that normalize and justify it. Knowledge mobilization initiatives can inform the public about the risks and harms of punitive violence, challenge social norms, and provoke change. Research findings are remarkably consistent in demonstrating that even the most socially acceptable form of corporal punishment (known colloquially as 'spanking') predicts solely negative long-term outcomes, including increased aggression and anti-social behavior, slower cognitive development, lower moral internalization, and weaker parent-child relationships (34).

Based on these findings, an increasing number of professional organizations and institutions in North America are issuing clear policy statements calling for the elimination of corporal punishment. A few examples are the American Academy of Pediatrics, American Professional Society on the Abuse of Children, Canadian Academy of Child and Adolescent Psychiatry, Canadian Association of Paediatric Nurses, Canadian Psychological Association, International Association of Forensic Nurses, New York Foundling, and the Public Health Agency of Canada. To date, 650 professional organizations in Canada have called for an end to corporal punishment (35). Such statements can be powerful drivers of social change through awareness-raising and public education. They can launch parent outreach and support programs at local levels, and shift the social norms underpinning the cognitive schemas that initiate the unfolding of punitive violence.

As the SIP model posits, high-risk parents tend to have lower levels of empathy than low-risk parents (36-38). Thus, where they might observe increased child compliance in response to corporal punishment, they do not recognize the emotional impact of their actions. There is a body of research which, if mobilized, could help shift parents' focus from the child's behavior to the child's emotions. For example, children described their feelings about 'smacking' in terms of emotional distress, shame, embarrassment, and dislike for their parents (39). In other studies, children have described hurt, fear, sadness, anger, intimidation, unexpressed hatred, and a desire for revenge (40, 41). By providing a glimpse into the child's experience, such information can help adults to empathize with the child and understand that the deeper destructive impacts of their actions can be hidden from their view.

Children see children learn

Universal public education strategies can be rapid and efficient means of knowledge mobilization. *Children See Children Learn* is a web-based initiative aimed at reducing parental violence and promoting healthy parent-child relationships (33). It provides videos, tip sheets and links to supportive resources. In its first year, it was viewed over 34 million times and shared 1.2 million times.

Change laws

While public education strategies are necessary for shifting normative beliefs, they are undermined by laws that explicitly justify parental violence. Five decades ago, Gil (10) concluded that while child physical abuse is multiply determined,

> its basic dimension upon which all other factors are superimposed is the general, culturally determined permissive attitude toward the use of a measure of physical force in caretaker-child interaction and the related absence of clear-cut legal prohibitions and sanctions against this particular form of interpersonal violence (10)

Laws are manifestations of a society's values. We must reflect on the values represented in laws stating,

> The use of force, but not deadly force, against a child younger than 18 years is justified:
>
> 1) if the actor is the child's parent or stepparent or is acting in *loco parentis* to the child; and 2) when and to the degree the actor reasonably believes the force is necessary to discipline the child or to safeguard or promote his welfare (42).
>
> 'Abuse'… means an act or omission that threatens the health or welfare of a child in one of the following categories: Skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling, or death (43).
>
> 'Abused' means any case in which a child has been the victim of conduct or omission resulting in skin bruising, bleeding, malnutrition, burns, fracture of any bone, subdural hematoma, soft tissue swelling, failure to thrive, or death (44).

The high thresholds set by these laws create a situation in which children can be subjected to frequent parental violence with impunity if it does not visibly injure, maim, or kill the child. The message inherent in these laws is that violence below this threshold is appropriate, acceptable, and justifiable.

In contrast, as of this writing, 61 countries to date have prohibited *all* corporal punishment of children, in any form or setting, beginning in 1979. These countries are located throughout the world, across regions with diverse cultures, faiths, and levels of economic development. They are in Africa (e.g., Kenya, South Africa, Tunisia), Asia-Pacific (e.g., Japan, Mongolia, New Zealand), Europe (e.g., Austria, Scotland, Spain), Latin America (e.g., Brazil, Costa Rica, Uruguay), and the Middle East (Israel). The primary aim of these laws is to set a clear and absolute limit on physical violence against children. Realizing that there is no 'non-violent violence,' these countries have explicitly banned all physical aggression against children, regardless of the form it takes, the adult's intent, or the degree of damage to the child's body. These laws are consistent with the UN definition of corporal punishment set out above. In almost all cases, these laws are in statutes that do not carry criminal penalties; their purpose is to transform social norms so that physical violence against children becomes unacceptable. In countries where population data have been collected longitudinally, there is evidence that this transformation is taking place (45).

In 1979, Sweden became the first country to prohibit all corporal punishment of children. Between 1965 and 1999, public opinion polls showed a dramatic decline in support for corporal punishment, from 53% to 11% (46, 47). By 2011, 92% of parents in Sweden believed that it was wrong to beat or slap a child (48). Virtually every child born in Sweden in the late 1950s had been struck at least once by the age of 16 years, and most were hit frequently. By 1994-95,

66% of 14- and 15-year-olds had *never* been hit (47); by 2011, this proportion increased to 86% (48).

Countries prohibiting all corporal punishment against children

Albania, Andorra, Argentina, Austria, Benin, Bolivia, Brazil, Bulgaria, Cabo Verde, Congo, Costa Rica, Croatia, Cyprus, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Guinea, Honduras, Hungary, Iceland, Ireland, Israel, Japan, Kenya, Kosovo, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Mongolia, Montenegro, Nepal, Netherlands, New Zealand, Nicaragua, North Macedonia, Norway, Paraguay, Peru, Poland, Portugal, Republic of Moldova, Romania, San Marino, Seychelles, Slovenia, South Africa, South Sudan, Spain, Sweden, Togo, Tunisia, Turkmenistan, Ukraine, Uruguay, Venezuela

Germany prohibited all corporal punishment of children in 2000. Between 1996 and 2001, the proportion of parents who reported ever slapping their children declined from 72% to 59%. Over the same period, the proportion who reported ever spanking their children declined from 33% to 26% (49). National youth surveys conducted in 1992 and 2002 found substantial reductions in the proportions of respondents reporting that they had ever experienced light slaps (81% vs 69%), severe slaps (44% vs 14%), beatings with objects (41% vs 5%), and beatings to the point of bruising (31% vs 3%) (49).

In New Zealand, where all corporal punishment of children was prohibited in 2007, the proportion of adults agreeing that "there are certain circumstances when it is alright for parents to smack/use physical punishment with a child" declined from 87% to 40% between 1993 and 2013 (50). National health surveys have found that the proportion of parents who physically punished their children in the two weeks prior to the survey decreased by almost half between 2006/2007 and 2015/2016 (51).

In each of these countries, national campaigns were conducted to raise public awareness of the new laws, and parent support programs were made widely accessible. This raises the question of the relative impact of law versus public education in changing attitudes and behavior. A five-country study examined this question (52). Two of the countries had implemented both prohibitions and public education (Germany and Sweden), one had implemented a prohibition but had not undertaken public education (Austria), one had undertaken public education but had not implemented prohibition (Spain), and one had implemented neither prohibition nor public education (France). Interviews were carried out with random samples of 1,000 parents in each country in 2007. A clear pattern was found in the data.

First, parents in France (neither prohibition nor public education) were the most likely to physically punish their children. Second, parents in Germany, Sweden and Austria (all with prohibitions) were much less likely to physically punish their children than were parents in countries without prohibitions. Third, parents in Austria (prohibition; no public education) were less likely to physically punish their children than parents in Spain (public education; no prohibition). These findings suggest that prohibition of corporal punishment—with or without public education—is more effective in changing behavior than public education alone. (Note—France and Spain both prohibited corporal punishment after the study was completed).

Strategies to change parents' misperceptions of children's behavior

According to the SIP model, parents' pre-existing schemas start to become enacted when they misperceive a specific child behavior due to their own emotional dysregulation (22). That is, the parent's irritability or frustration activates their stress response, triggering their tendency to view typical child behavior as 'misbehavior' deserving of punishment, which further fuels their emotional arousal.

A study in which 35 mothers of preschoolers wore digital voice recorders on four consecutive evenings shed light on this factor (53). Perceived noncompliance was the eliciting factor in 90% of the 41 corporal punishment incidents recorded. Of these 'noncompliant' behaviors, 74% were breaches such as sucking fingers, eating improperly, and getting out of a chair; 10% were perceived acts of aggression and only 2.5% were destructive. These findings demonstrate that a perception of typical child behavior as 'misbehavior' moves parents one step farther along the pathway to violence.

The consistent finding that children who experience corporal punishment tend to have heightened aggression levels is likely a function of this process. As the parent's emotional activation rapidly escalates, the child is thrust into a highly stressed state, amplifying their emotion activation (54). With repeated episodes, the child's brain becomes primed for self-defense, leading to the hyperarousal common in maltreated children (55,56). Therefore, to interrupt not only the process leading to punitive violence, but also its intergenerational transmission, parents need support to enhance their emotion regulation skills.

Enhance emotion regulation skills

Emotion regulation is the "capacity to influence one's experience and expression of emotion" (57). It enables parents to respond calmly and sensitively to dysregulated children, a common challenge. This requires self-awareness, recognition and understanding of mental states, self-monitoring, and inhibitory control, among other executive functions. Punitive violence is particularly likely among parents with emotion regulation difficulties, as they are prone to react with anger, which interferes with flexible and proactive problem solving (58).

Children's own capacities for self-regulation and frustration tolerance are associated with those of their parents. This similarity is likely due to several factors. First, children learn their parents' emotion regulation strategies through direct observation and modelling, acquiring the range of their parents' repertoires (61). In addition, punitive parents are less likely to involve their children in discussions about emotions (62). Second, punishment of children's emotional expression heightens their emotional arousal and lowers their socio-emotional competence (63, 64). Maltreating parents tend to react punitively to children's emotional expression and to invalidate their children's feelings, reducing their children's opportunities to explore and practice self-regulation in a safe environment (65). Children with insecure attachments to parents who are unable to provide a 'safe haven' or help them manage distress use less adaptive emotion regulation strategies than children with secure attachments (66). Third, maltreatment produces long-term changes in the neuroendocrine systems activated by stress, resulting in over-reactivity in the child (55, 67). Therefore, emotion dysregulation becomes a bi-directional process, in which parent and child become hyper-aroused in moments of conflict.

Emotion coaching

Emotion coaching is an approach to strengthening parents' emotional awareness, emotion regulation and empathy – as well as their skills in building their children's emotion knowledge. Parents learn how to validate their children's feelings and how to guide their children's own learning of emotion regulation skills. *Tuning into Kids* is one example of an emotion coaching program. Delivered to groups of parents over 6 sessions, it has demonstrated effectiveness in decreasing parents' emotional dismissiveness and increasing their empathy and emotion coaching skills (59, 60).

Strategies to change parents' attributions

Once the parent's emotional reactivity has been triggered, the SIP model holds that the next step in the emergence of punitive violence is the parent's attribution for the child's specific behavior to deliberate intent, such as 'defiance' or 'willful disobedience.' Violent parents are more likely to attribute their children's behavior to an intentional desire to annoy or challenge them (68). Mothers who physically punish their infants are likely to perceive the child as holding greater power and control (69). Abusive fathers are more likely to interpret children's facial expressions as conveying threat-related emotions, such as anger and disgust. The more parents attribute child 'misbehavior' to causes internal to the child, the more likely they are to respond coercively (70). When a child's specific behavior is interpreted as a direct challenge to the parent's authority, the parent's emotional arousal is likely to increase and further prime them for responding violently (71). There is evidence that parental attributions of hostile intent mediate the relationship between expectations of child compliance and punitive parenting (72) and between parenting stress and punitive violence (73). Corporal punishment, in turn, predicts a hostile attributional style in children that appears to mediate their higher aggression levels (74).

Information that can shift parents' attributions for child behavior from deliberately disobedient to developmentally normative can reduce emotional arousal and open cognitive pathways for constructive responding. Shifting ingrained attributional tendencies requires an intensive focus on increasing parents' understanding of how children develop.

Increase knowledge of child development

Effective prevention efforts need to facilitate parents' understanding of the developmental significance of typical child behavior, such as crying, tantrums, and negativism in early childhood, as well as the psychological challenges of puberty, navigating peer relationships, and establishing one's identity in middle and late childhood. The more knowledge a parent has of developmental processes, the more likely it is that their attributions will reflect that knowledge. This means much more than teaching parents about typical developmental milestones. Parents need to understand the dynamic processes that propel cognitive, emotional and brain development so they may acquire a new lens for making sense of them.

For example, when parents understand the central importance of the drive for autonomy, they will be more likely to view toddlers' desire to do things for themselves as a sign of that drive, rather than as defiance. When parents recognize the process underlying the acquisition of self-regulation, they will be more likely to understand their preschoolers' tantrums as

indicators of their progress on this pathway, rather than as noncompliance or manipulation. When parents understand the core theme of identity development, they will be more likely to see their teens' questioning of values as an exploration of their identity, rather than as a personal affront.

Nobody's perfect

Normalizing child behavior in the context of development is an approach to shifting the hostile and low-power attributions that can trigger parental violence. *Nobody's Perfect* is a community-based program that brings parents of young children together to discuss and normalize child behavior and parental insecurity. Resources are provided on how children develop physically, psychologically and behaviorally to increase parents' knowledge and empathy, and parents are connected to other resources in their communities. Parent self-efficacy and warm/positive parent-child interactions have been found to increase, and angry/punitive parenting has been found to decrease, over the course of the program (75, 76).

Strategies to increase parents' response repertoires

The risk of punitive violence is greater among parents with limited knowledge of response options—and those who know of options but fail to enact them. A father describes it this way:

> "It was to the point where I didn't have time to think or to back off or any – because I had committed myself…And I didn't actually realize where it was going to because I think if I had more or less in the beginning, it would have been enough time then that I could have put the brakes on me. Backed off a bit, but just – it just built and that was it." (11, pp 189-90)

According to the SIP model, the act of striking or otherwise physically punishing a child is the culmination, over moments, of pre-existing schemas, emotion dysregulation, and negative attributions which, together, limit cognitive flexibility and disinhibit aggression. According to interpersonal neurobiologist Daniel Siegel (77), in this final step we "flip our lids" through a combination of the mobilized survival functions of the brainstem and the activated limbic system overriding the executive functions of the pre-frontal cortex. The neurological processes underlying the perceptions, emotions and attributions leading to this point disengage the frontal lobes' inhibitory and rational functions, resulting in maladaptive and violent action.

This process likely plays a role in the intergenerational transmission of parental aggression, as the more frequently a parent responds violently, the fewer opportunities the child is given to observe and internalize non-violent conflict resolution. Thus, the limits of the parent's repertoire are likely reflected in the limits of the child's skills in resolving conflict with their peers, partners and their own children (19, 78, 79). Modelling is a powerful teacher, not only of the aggression itself, but of its implicit message about power and coercion. Therefore, a key component of prevention initiatives must be the teaching, modelling and practicing of non-violent, non-coercive, non-punitive solutions to conflict.

For decades, many societies were heavily influenced by operant learning theory, which holds that behavior is shaped by rewards and punishments. Thoughts and emotions were considered irrelevant to the learning process, and parents were encouraged to punish or ignore 'undesirable behavior' and to reward 'desirable behavior.' It was common through the 1970s and 1980s for professionals to recommend that parents replace corporal punishment with other punishments, such as taking things away from the child or isolating the child in a boring or empty room. Parents were taught to send their children to bathrooms, schools built isolation rooms, and children were deprived of birthday parties and beloved toys as 'humane' alternatives to corporal punishment. This approach is foundational to many parent programs implemented today.

Prescribing such punishments, however, does not do much to change the SIP process leading to violence. These prescriptions affirm pre-existing beliefs in the effectiveness and deservedness of punishment and expectations of child compliance, once again setting the stage for the unfurling of emotion dysregulation, perceptions of child behavior as non-compliance, and hostile attributions. If the parent, in the final moment of the interaction, chooses to force the child to sit on a chair and the child resists, all the processes leading to violence have been put into place. A parent who has been told that these methods shape behavior is likely to insist that the child obey. If the child continues to resist, the conflict can escalate rapidly and, over time, establish patterns of coercion in the family that increase child aggression and resistance (80). By suggesting that all behavior can be shaped through consequences, behaviorist approaches have set parents up for frustration, anger, and escalation of punishment.

Punishment of any kind fails to consider many critical aspects of development, including brain development, which takes place over decades. A two-year-old, for example, cannot simply be rewarded and punished into self-regulating. Teaching parents to punish tantrums, for example, feeds into the pathway to punitive violence and fails to teach children the emotional awareness and regulation skills that are so important to their developing socio-emotional competence (81). Punishment is a simplistic response to complex situations. Replacing one form of punishment with another does not take the parent out of the SIP pathway toward violence; it merely provides another entry point into it.

Build skills in problem solving

By transforming parents' pre-existing schemas, emotional dysregulation, misperceptions and attributions, we lead them toward a different end point. Deepening parents' understanding of the developmental reasons underlying children's behavior will lead them to recognize that hitting, isolating, or taking things away from a child does not increase the child's knowledge, enhance the child's emotion regulation, or model non-coercive conflict resolution. Rather than setting parents on another path to punishment, we can equip them with the knowledge, self-reflection and skills to problem solve. Maltreating parents show deficits in problem-solving, generating fewer possible solutions and fewer types of solutions to parent-child conflict, as well as a greater tendency toward punishment (82). Operant learning approaches affirm those punitive tendencies and perpetuate the limited repertoires of violent parents (83).

Planful problem-solving requires analytical and flexible thinking; accuracy in identifying the problem; emotion regulation and response inhibition; skills in generating, choosing and enacting potential solutions; and comfort in modifying the solution as needed (84). This process is effortful, rather than automatized, as much punitive responding is. Although it places greater

cognitive demands on parents, planful problem-solving is associated with lower levels of parenting stress (85).

Positive discipline in everyday parenting (PDEP)

PDEP integrates the SIP steps into a 9-session parent program (84-86). It begins by shifting parents' focus from short-term compliance to long-term developmental outcomes, normalizing parent-child conflict and emphasizing the importance of a safe learning environment. By taking parents through the process of development from birth to adolescence, PDEP aims to shift parents' attributions from intentionally hostile to developmentally typical and to transform their concept of discipline from punishment to problem solving. The program teaches parents a simple problem-solving framework applicable in a wide range of situations, as well as emotion regulation techniques. PDEP has been found to decrease parents' approval of punishment and their maladaptive attributions, and to increase their confidence in responding non-violently to conflict with their children.

CONCLUSION

This chapter has set prevention within the framework of SIP, which identifies the cognitive and affective factors that contribute to punitive violence. A cohesive approach to addressing those factors is needed to support parents in shifting from a punitive to a problem-solving approach. Of course, there are additional factors that exacerbate risk, such as financial, parenting and other stress, social isolation, dysphoria, mental illness, and substance abuse. Such factors affect cognitive functioning and can overwhelm problem-solving capacities (86). Policies and programs to support families, reduce stress, and address mental health issues are urgently needed as core components of abuse prevention strategies.

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Chapter 14

DISABILITY AND ABUSE: SOME INTERNATIONAL ASPECTS

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ABSTRACT

Children and adults with disabilities are at risk for neglect and maltreatment, and studies have linked adverse childhood experiences to leading causes of adult morbidity and mortality. Abuse and neglect do have long term effects, and it appears that disabilities associated with interpersonal and behavioral difficulties are most strongly associated with victimization risks. In this discussion. International disability prevalence is reviewed and the connection between disability and maltreatment. Stigma, discrimination and ignorance about disability are factors which place people with disabilities at higher risk for violence. Prevention and early detection are therefore important public health aspects.

INTRODUCTION

Children and adults with disabilities have for a very long time, even back to pre-historic times, been subject to abuse and neglect or even in the extreme to murder.

Disability abuse is when a person with a disability is abused physically, financially, sexually or psychologically due to that person having a disability (1). Since some disabled

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people are in need of additional support from others throughout their lives, they are also vulnerable to neglect (1). The abuse is not limited to those who are visibly disabled, such as wheelchair-users or physically deformed such as those with a cleft lip, but also those with learning disabilities or difficulties such as dyslexia and dysgraphia and other disabilities, including Asperger's syndrome, Down syndrome, autism and developmental coordination disorder (1).

Disability is something that can happen to any of us and almost everyone will be temporarily or permanently impaired or disabled during their lifetime or at the end of our lifespan.

Disability is the umbrella term for impairments, activity limitations and participation restrictions, referring to the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors) (2).

DISABILITY AROUND THE WORLD

It is not easy to get a clear picture of the scope of disability around the world. This is due to the multidimensional scope of the issue at hand, definition issues and data collection methods, which vary from country to country.

There are two international surveys that can be used to estimate the burden of disability in the world: The WHO (World Health Organization) "World health survey" from 2002-2004 and the WHO "Global burden of disease study" from 2004 (2).

The "World health survey" was a face-to-face household survey in 70 countries, where 59 countries had wighted data sets that were used to estimate the prevalence of disability in adults aged 18 years and older (2). The average prevalence rate in the adult population aged 18 years and older from these 59 countries was 15.6% or some 650 million people in 2004 ranging from 11.8% in higher income countries to 18% in lower income countries for adults with significant difficulties in function in their everyday life and 2.2% (or 92 million people) with very significant difficulties (2). If the estimate went to cover 15 years and older the numbers were 720 million for significant and 100 million for very significant disabilities (2).

The "Global burden of disease" study started in 1990 on the initiative of the World Bank in order to assess the relative burden of premature mortality and disability from different diseases, injuries and risk factors (2). The analysis of the "Global burden of disease" 2004 data estimated that 15.3% of the world population (some 978 million people in 2004) had "moderate or severe disability", while 2.9% (185 million) experienced "severe disability." Among those aged 0–14 years, the figures were 5.1% and 0.7% or 93 million and 13 million children, respectively. Among those 15 years and older, the figures were 19.4% and 3.8% or 892 million and 175 million, respectively (2).

In the "World report on disability" from 2011 (2) and estimates for the 2010 population based on the "World health survey" and the "Global burden of disease" it was postulated that 785 (15.6%) to 975 (19.4%) million persons 15 years and older were living with disability. Of these, around 110 (2.2%) to 190 (3.8%) million experienced significant difficulties in functioning. Including children, over a billion people (or about 15% of the world's population) were estimated to be living with disability (2).

DISABILITY AND ABUSE AROUND THE WORLD

If it is hard to get data on disability prevalence around the world, then it is even harder to get data on abuse prevalence and people with a disability (3).

One study (4) in 2012 from the United States using an online questionnaire included 7,289 people from 50 states and the District of Columbia with 20.2% having a disability themselves and 47.4% having an immediate family member with a disability. Over 70% of people with disabilities who took the survey reported they had been victims of abuse. More than 63% of parents and immediate family members reported that their loved one with a disability had experienced abuse (4).

Some disability types had a higher incidence of abuse than others. For example, 74.8% of people with mental health conditions reported they had been victims of abuse, while 67.1% of those with a speech disability, 66.5% of those with autism, 62.5% of those with an intellectual or developmental disability and 55.2% of those with a mobility disability reported having experienced such abuse (4).

The people with disabilities in 87.2% reported verbal-emotional abuse, 50.6% physical abuse, 41.6% sexual abuse, 37.3% neglect and 31.5% financial abuse (4). The rate of sexual abuse varied greatly among victims depending on the type of disabilities they had with 47.4% of people with mental health conditions reported they had been victims of sexual abuse, whereas 34.2% of those with intellectual or developmental disabilities, 31.6% of those with a mobility disability and 24.9% of those with autism reported they had experienced sexual abuse (4).

Studies published in the English language during 1995-2005 were reviewed for the prevalence of maltreatment of people with intellectual disabilities (5) and found results from Australia, England, Spain and the United States. Only five studies provided maltreatment prevalence estimates and the limited data suggested that maltreatment was more prevalent for people with intellectual disabilities than for people with certain other disabilities.

A recent report from Mexico (6) based on the results of a year-long study carried out by Disability Rights International (DRI) together with the Women's Group of the Colectivo Chuhcan –the first organization in Mexico directed by persons with psychosocial disabilities. This research included the application of a questionnaire to fifty-one women with psychosocial disabilities who were either members of the Colectivo Chuhcan or received outpatient services at four different health clinics and psychiatric institutions in Mexico City. The report found that an appalling 40% of the women interviewed – all with psychosocial or psychiatric disabilities – had been forcibly, surgically sterilized or had been coerced by their families to undergo the procedure. Additionally, over 40% also reported being abused by their gynecologist, which included sexual assault and rape (6).

In a large British study (7) of 14,256 children participating, 115 had been identified as having been placed on local child protection registers prior to their 6th birthday. Data on the children have been obtained from obstetric data and from a series of parental questionnaires administered during pregnancy and the first three years of life. Significant relationships were found between low birthweight, unintended pregnancies, poor health and developmental problems in infancy and subsequent maltreatment (7).

Dating violence is another topic of interest in this context and one study (8) examined associations of dating violence with health risks by disability status among high school girlsth

data from the 2009 Massachusetts Youth Health Survey. Among high school students who had ever been on a date, girls (25.9%) and boys (9.1%) with disabilities were more likely than girls (8.8%) and boys (4.5%) without disabilities to report dating violence (8). The study indicated that high school girls with disabilities who experienced dating violence were more likely to report feeling sad or hopeless for two weeks or more in the past year, suicide ideation in the past 12 months and drug use in the past 30 days compared to those with disabilities who did not report dating violence and those without disabilities who reported and did not report dating violence.

A study from Uganda (9) of 3,706 children and young adolescents aged 11-14 years were randomly sampled from 42 primary schools, and 8.8% of boys and 7.6% of girls reported a disability. Levels of violence against both disabled and non-disabled children were extremely high. Disabled girls report slightly more physical (99.1% versus 94.6%) and considerably more sexual violence (23.6% versus 12.3%) than non-disabled girls, while for disabled and non-disabled boys, levels are not statistically different (9).

A study from Hong Kong (10) with 5,841 school-aged children aged 9-18 years found the prevalence of disability among children at 6% and children with disability were more likely to report victimization than those without disability: 32% to 60% of the former had experienced child maltreatment and 12% to 46% of them had witnessed inter-personal violence between parents or in-law conflict. Disability increased the risk of lifetime physical maltreatment by 1.6 times.

RISK FACTORS

Stigma, discrimination and ignorance about disability are factors which place people with disabilities at higher risk of violence. Placement of people with disabilities in institutions or supported care can increase their vulnerability to violence. Safe Place (11) have listed some risk factors in this population:

- Persons with physical disabilities may rely on others to meet some of their basic needs. Care providers may be involved in the most intimate and personal parts of the individual's life, which can increase the opportunity for abusive acts. Persons with physical disabilities may also be less likely to defend themselves or to escape violent situations.
- Persons with cognitive disabilities may be overly trusting of others and easier to trick, bribe or coerce. The individual may not understand the differences between sexual and non-sexual touches.
- Persons with cognitive disabilities who are abused may not understand that the violation is not alright, especially in cases of sexual abuse.
- Persons who are deaf may not be able to report due to barriers with communication (including lack of an interpreter and/or assistive devices).
- Persons with disabilities that impact articulation may have limited vocabulary or communication skills that can pose barriers to disclosing abuse. The individual may be misunderstood or viewed as intoxicated or making a prank call when making a report. Communication boards need to include vocabulary for reporting abuse and neglect.

- Many people with disabilities are taught to be obedient, passive, and to control difficult behaviors. This compliance training may teach the individual to be a "good victim" of abuse.
- Many persons with disabilities grow up without receiving sexuality education, abuse prevention information or self-defense training. Individuals may lack knowledge about their bodies, healthy relationships, and how to protect themselves.
- A person who has a mental illness can be at risk for victimization if they have difficulty discerning between reality and fantasy, are dependent on others for their mental and physical care, view themselves as unworthy, do not trust their instincts, and/or misinterpret the intentions of others.
- Persons with disabilities may be perceived by offenders as easy targets based on a perceived lack of credibility within society, and a lower likelihood that the person will not speak out.
- Society generally views people with disabilities as non-sexual, lacking intelligence, and not credible witnesses.
- In general, social isolation is associated with higher risk for sexual abuse. Unfortunately, many people with disabilities still face barriers to fully participate in the community and remain socially isolated.

This are just some of the risk factors that we must have in mind when providing care to people with disabilities in order to prevent maltreatment.

In a representative national sample of 4,046 children aged 2-17 years of age from the 2008 National Survey of Children's Exposure to Violence, the associations between several different types of disability and past-year exposure to multiple forms of child victimization were examined (12). It was found that attention-deficit disorder/attention-deficit with hyperactivity disorder elevated the risk for peer victimization and property crime, internalizing psychological disorders increased risk for both child maltreatment and sexual victimization, and developmental/learning disorders heighten risk only for property crime. Physical disability did not increase the risk for any type of victimization (12).

RIGHTS

The United Nations Convention on the Rights of Persons with Disabilities (CRPD), adopted in 2006 with its comprehensive new model of care, has created an opportunity for change, which over time should provide better integration, inclusion, quality of life and health for this group of people. The convention is also a tool or instrument for health care professionals to use in order to create and demand better healthcare and services from their government or ministries (13).

Articles 15, 16 and 17 are important and relevant in the context of this discussion:

> **Article 15:** Freedom from torture or cruel, inhuman or degrading treatment or punishment
>
> 1. No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.

2. States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.

Article 16: Freedom from exploitation, violence and abuse

1. States Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.
2. States Parties shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, inter alia, appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognize and report instances of exploitation, violence and abuse. States Parties shall ensure that protection services are age-, gender- and disability-sensitive
3. In order to prevent the occurrence of all forms of exploitation, violence and abuse, States Parties shall ensure that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities.
4. States Parties shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services. Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs.
5. States Parties shall put in place effective legislation and policies, including women- and child-focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.

Article 17: Protecting the integrity of the person

Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.

This convention and its more comprehensive and multidisciplinary model for care, service and rights will ensure that people with a disability have the right to be full and effective members of society and live a life without neglect or maltreatment.

PREVENTION

Children with a disability are abused more frequently than children in the general population (14). The Child Welfare Information Gateway (15) suggested three levels of prevention strategy in this population:

Community level prevention

- Ensure community members are aware of the heightened risk in children with disabilities
- Help others see children with disabilities as valued and unique individuals
- Promote inclusion of children with disabilities in everyday life.
- Encourage communities to share the responsibility for the well-being of children with disabilities.

Family focused prevention

- Home visiting
- Parenting clases and education
- Support groups
- Respite care

Child focused prevention

- Help children protect themselves
- Maximize children's communication skills and tools
- Reduce children's social isolation

Pediatricians, health visitors and health nurses and other community professionals all have important roles to help in prevention and awareness and monitoring this population at risk.

CONCLUSION

Children and adults with disabilities are at risk of maltreatment and are often not noticed or detected by the professionals or systems taking care of them. Early intervention and prevention are important public health issues in this context.

One study (16) linked adverse childhood experiences to leading causes of adult morbidity and mortality. Compared to those who reported no adverse childhood experiences exposure, the adjusted odds of reporting myocardial infarction, asthma, fair/poor health, frequent mental distress, and disability were higher for those reporting one to three, four to six, or seven to nine adverse childhood experiences. Odds of reporting coronary heart disease and stroke were higher for those who reported four to six and seven to nine adverse childhood experiences, while odds of diabetes were higher for those reporting one to three and four to six adverse childhood experiences. So abuse and neglect does have a long term effect and it appears that disabilities associated with interpersonal and behavioral difficulties are most strongly associated with victimization risks.

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Chapter 15

A CRITICAL ANALYSIS OF EFFORTS TO PREVENT THE SEXUAL ABUSE OF YOUTH

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The prevention of childhood sexual abuse is of obvious value to society both in terms of limiting suffering of children but also in reducing the costs of social, medical, and legal interventions in the lives of children who are abused and the adults who influence their lives. The field of prevention has blossomed with ideas for policies and practices to prevent sexual abuse. While encouraging and even hopeful, many of these ideas have been implemented without clear data on their power. In this chapter we will critically analyze a number of these current prevention ideas in the hopes of supporting a more focused and evidence-based prevention effort.

INTRODUCTION

Awareness that prevention of the sexual abuse of youth would be a good thing has been part of professional and lay concerns since virtually the rediscovery of child sexual abuse (CSA) in the early 1980s. Early efforts were based on an awareness that children often did not understand what sexual behavior was, did not understand that they did not have to consent to what older persons wanted, and did not know how to respond once in a sexually abusive situation. "Say No, Run and Tell" became the central prevention idea shared with children in books, films, plays, and in classroom training sessions. Since those early prevention efforts, there has been an explosion of ideas about policies and practices that might protect children from being sexually abused. Many of these efforts are untested but nonetheless disseminated with great enthusiasm and perhaps not always with the caution with which policies and practices of unknown power should be viewed. Our intention here is not to detract from the enthusiasm but

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to urge professionals to take a more cautionary view of some efforts and to support increased evaluations of prevention efforts before they become institutionalized.

SAFETY EDUCATION

Safety education is the longest standing child sexual abuse prevention effort. It is an intervention primarily providing children with concepts and some behaviors (e.g., how to say "No" in a loud clear voice) which are believed to help them identify potentially abusive behaviors (e.g., good touch vs. bad touch); identify risky situations; overcome the natural tendency of children to obey older persons; develop knowledge about bodies and boundaries; and encourage assertive self-protection and telling an adult about abuse. A considerable body of outcome research has demonstrated that children can in fact learn the concepts taught in safety education (1, 2). Whether children are actually able to use the concepts to prevent or escape abuse has generally not been well studied. Two important questions about child-focused safety education desperately need researched answers: first, does safety education actually help children prevent their own abuse, and second, does safety education impact disclosures from youth? Some professionals do not view disclosure as a prevention strategy, apparently believing that once a child is abused prevention is no longer possible. However, since the vast majority of youth are abused more than once and often frequently over extended periods of time, helping youth disclose earlier rather than later is in fact a prevention effort well worth the energy.

An early and often cited study by Finkelhor, Asdigian, and Dziuba-Leatherman (3), based on a national telephone survey of youth ten to sixteen years of age, examined the effects of safety education over two interviews, with the second interview held eight to twenty-four months after the first. Twenty-eight percent of youth reported victimization (only 6% sexual assault). The authors report that 58% of children had no training. The authors conclude that there was no evidence of a decrease in actual victimization, although there was an effect for disclosure. Although the authors are cautious in the presentation of findings, an essential concern in the research is that the time interval between time one and time two varied and was very short. There is no way to know what the expected rate of victimization among youth ages ten to sixteen should be in any given short period when incidence estimates are generally reported over many years of childhood. In an early and methodologically sophisticated study, Kolko, Moser, and Hughes (4) report on an experimental design evaluation of the Red Flag/Green Flag prevention program and found that, at follow-up, 11% of trained children reported an experience of physical touching (not necessarily just sexual touching). Oldfield, Hays, and Megel (5) report on an evaluation of an elementary school prevention program with a three-month delayed post-training follow-up with a large sample of 685 trained youth and a control group of 611 students. One student in the control group reported physical abuse, and four disclosures were made in the training group (two were new disclosures).

Given the large number of children who are sexually abused over time, and that some programs have been delivered to large numbers of children and never had a disclosure, it is logical to ask if these programs are somehow giving a message to children that they do not really want to know what is happening to the child. Topping and Barron (1), in their review of research, note that only about one-third of the studies they reviewed (6 or 7 studies) report disclosure rates at all, and rates are below what would be expected by the prevalence of

childhood sexual abuse. The expected rate of victimization in any given year or years is a complex question. Estimates of the rate of victimization are typically based on reports of youth looking back over extended number of years (e.g., "before the age of 14 were you abused?"). Evaluating a prevention program a few months or even a year or so after being delivered and determining the number of disclosures is important, but it is unclear what number of children in the study might reasonably be expected to be abused in that short time period. Nonetheless the failure to follow up on children's experiences including disclosures over time is a significant limitation of current prevention knowledge.

Identifying children at risk for or currently being abused is clearly partly an adult responsibility and requires informed and observant adults who care for and interact with youth. Yet equipping youth with the knowledge and skills to get out of abusive situations is as important, if not more important, than preparing observant adults. Although there has been quite a bit of research on disclosure (6), there has been insufficient research from the child's perspective on factors that work to prevent youth from disclosing.

Youth perceptions, developmental capacities, and individual life experiences obviously vary widely across children. Clinical work with youth victims suggests a wide range of reasons that they do not disclose. Young children may not appreciate that what is being done to them is wrong. The fundamental purpose of grooming (7) is to identify a vulnerable child, remove the child from the protection of other adults, become an important person in the child's life by providing emotional, psychological, or material support and gifts, convince the child that the relationship is a real one of care and concern for the child, and slowly increase the level of touch. We know that some youth may for a time believe that the sexual contact is something they want and even at times enjoy. Some youth fear negative consequences if the abuse is revealed, either because of threats made by the abuser or for fear that they have done something they will be punished for. Other youth fear the investigation and the consequences thereof to them, their families, or even at times the abuser. Older youth might also understand the stigmatizing nature of anything that involves sexual behavior.

It is recognized that some abuse is disclosed because someone asks the child what is going on in their life (8). If (and we appreciate that it is a *big if*) society really wanted children to disclose, professionals would develop programs to deal specifically with the reasons children do not disclose and to encourage disclosure. Some have suggested that regular screening for sexual abuse be part of well-child pediatric appointments (9). Common groups of youth, including in schools, sports, youth groups, faith-based youth groups, and other settings, could regularly review policies about sexual abuse and provide youth with the means of talking about worrisome situations and disclosing when necessary. (See video series *Stop the secrets that hurt.* URL: www.fightchildabuse.org). The reasons adults do not take a more active interest in supporting disclosure and asking children about abuse experiences has not been well studied. Clinically, adults express different reasons, including a belief that system intervention will be harmful to the child and family, fear of retaliation from the alleged offender, and confusion over what it means to report when one "has a reason to believe" abuse has taken place or may take place. Innovation in efforts to get youth to disclose when necessary, and in programs to get adults to be more proactive in identifying and supporting youth who need to disclose, are priority prevention possibilities.

COMPREHENSIVE PREVENTION FRAMEWORKS

As this chapter illustrates, there are many innovative and potentially powerful prevention ideas. Organizing them both to support social policy efforts but also to direct research activities has significant value. The National Coalition for the Prevention of Sexual Abuse and Exploitation (10) has proposed six pillars of prevention:

1. Strengthen youth-serving organizations' sexual abuse and exploitation prevention capacity.
2. Support the healthy development of children.
3. Promote healthy relationships and sexuality education for children and youth.
4. End the demand for children as sexual commodities.
5. Have sustainable funds for prevention.
6. Prevent initial perpetration of child sexual abuse and exploitation.

In addition, the Coalition has prepared a National Plan to Prevent Sexual Abuse and Exploitation (11) that provides specific areas of needed action, including addressing pornography (see below), developing stronger and more engaged communities to protect children, increased funding, better *Awareness-to-Action*, and others. Activities are suggested and provide a framework for the field for increased research, ending the demand for children as sexual objects, developing and implementing organizational, local, state, and national policies and practices, encouraging greater cross-sector collaboration, and increased funding.

The slogan "it takes a village to raise a child" may have been overused, but after almost four decades of modern awareness of childhood sexual abuse it has to be abundantly clear that renewed, coherent, collaborative, and powerful action is going to be necessary if preventing the sexual abuse of children is to become a reality (12). Given that most adults express disgust when they hear about the sexual abuse of a child, it is not clear what prevents a more organized and funded approach to prevention. This would be an ideal area of opinion research to help clarify the attitudes that prevent greater prevention action. While the suggestions of the National Coalition may not all have equal research support, the Six Pillars provide a framework that professionals and organizations concerned about sexual abuse prevention should find useful in establishing their own work plan. It also provides an outline of areas that beg for research. Perhaps its greatest contribution is in providing a comprehensive framework to think about prevention activities that link different prevention interventions and approaches.

POLICIES AND PRACTICES TO PROTECT CHILDREN

Simon (unpublished report) completed a content analysis of periodic professional and grey literature on policies and practices to protect children in out-of-home care. There are a number of recommended policies and activities that are believed to protect children. Overall these policies and practices involve the following:

- *Organizational policies* which focus on child safety (13), supervision and monitoring of staff and volunteers, training of staff and volunteers on child sexual abuse and child

safety, encouraging and protecting whistle blowers who raise child safety concerns, and others.

- *Environmental safety* which includes evaluation of environments to identify areas where youth and adults cannot be physically observed, requiring two youth per one adult in activities, having youth form buddies who accompany each other through activities, periodic surprise observation of adults and youth, and others.
- *Hiring, screening, and supervision* of staff and volunteers in contact with youth, including through background checks, reference checks, checks for revocation of relevant licenses (e.g., educational), risk assessments of staff and volunteer positions, written information provided by the applicant on possible past involvement in criminal activity or resignation or dismissal from a youth-serving organization due to misconduct, as well as personal interviews to identify possible risk factors for child sexual abuse (14).

It should be noted that virtually none of these potentially good ideas have been evaluated. Many of them no doubt make for the sound management of organizations, staff, and probably strong programs, but whether they prevent sexual abuse is far from a known fact. A difficulty in developing a shared understanding of the value of these various practices is that, to do so, organizations need to be able to share successes, and even more so failures, that occur even in the face of a specific policy or practice. Understandable concerns for liability and attorney advice to "say nothing and admit to nothing" makes it difficult for the kind of collaborative analysis that would move the field forward. Other fields, such as medicine, have long understood that a systematic review of medical errors is a way to improve practice (15). The systematic analysis of organizations in which sexual abuse takes place should help identify factors that allow sexual abuse to occur in spite of policies and practices intended to prevent sexual abuse.

It is beyond our space allocation here to review every possible policy or practice. We are suggesting that adoption of any policy or practice be based on a critical review and that such review should be undertaken in part by professionals who were not involved in the development of the policy or practice, understand the processes whereby older persons groom children, and imagine how an older person who abuses could circumvent the policy or practice. Most critically, it is important to note that any one policy or practice is unlikely to provide comprehensive protection and that all current policies and practices should be evaluated.

One good example is that of a *Code of Conduct* (COC) for adult behavior, which is frequently cited as a prevention practice. The nature of a COC depends on the nature of the service provided by the organization (e.g., a school is different from a sports team, which is different from a mentoring program) and the nature of involved youth (e.g., age). For example, a COC may indicate that adults should not be with less than two children at any time, may not communicate with youth digitally, may not have contact with youth outside of the organization, may not provide gifts to youth, and may not interact with children where interactions cannot be observed (e.g., no frosted glass doors or windows in gyms, classrooms, or studios). Staff and volunteers can be asked to review the COC annually and sign an agreement to comply. A COC may specify that other staff or volunteers have a mandated responsibility to identify and report the appearance of adult violations of the COC. Youth could even be made aware of the COC and annually be asked to report on whether they are aware of any violations (16).

Research determining whether staff and volunteers actually know and genuinely support the elements in a COC, and how best to educate and train adults and youth on the COC, would be helpful in understanding the ultimate value of a code. It is generally understood that ethical principles are not about getting people to *do* what is right but rather to *know* what is right. So the prevention problem remains that while a COC may make for a good program alone, there is no reason to believe that an older person intent on sexually abusing a youth would be deterred by it. For example, while a code may require that staff and volunteers not be alone with less than two youth, older persons intent on being sexual with youth will nevertheless do so. This would be one reason that regular monitoring of older persons is important, as well as why sharing conduct rules with youth is also important, so that youth may report apparent or clear violations of the two-for-one rule. Reporting also is insufficient if the adults who receive reports do not take them seriously, do not investigate them, and do not prioritize protecting youth over adults. Supervision of staff and volunteers, monitoring of adult behavior whether in-person or by video, encouraging reports by youth and other adults of suspicious behavior, and other management efforts are as important as Codes of Conduct but are beyond our capacity here to discuss (17, 18).

Addressing potential abusers is a prevention effort that begins even before adults enter a program. Certain practices such as background checks are routinely called for, including in government-issued best practice guidelines (18), to deter applications from, as well as identify and remove from the application process, persons who may pose a sexual risk to children. Nevertheless, the effects of hiring and screening practices on the perpetration of child sexual abuse in youth-serving organizations has not been evaluated (19) and the important question of whether they can actually prevent such abuse remains to be answered. Whether it is possible to identify adult sexual abusers through screening measures has itself been called into question, given that most abusers (20), as well as the vast majority of applicants to youth-serving organizations (Choice Point, as cited in (21)), do not have a known history of offending. To this end, Abel et al. (21) recently tested the validity and reliability of a three-measure screening instrument to identify applicants who may pose a sexual risk to children (i.e., hidden abusers and persons with cognitive distortions that encourage their own violations of child sexual boundaries or the tolerance of others' violations). The measures: (a) matched job applicants to a group of child sexual abusers who are concealing their abusive behavior or to a group of adults who are not child sexual abusers; (b) allowed job applicants to admit having abused a child sexually; and (c) allowed job applicants to endorse "yes" to having extreme beliefs or cognitions related to the rights of adults to have sexual interactions with youth (21). Using secondary data on child care job applicants and adults evaluated by sex-specific therapists after being accused or convicted of sexually abusing a child (N = 19,145), the authors reported that the screen correctly identified 77% of the men and more than 72% of the women who posed a sexual risk to children (21). While these results are promising, that 23-28% of potential child sexual abusers went unidentified is demonstrative of the notion that it is very unlikely that any single screening practice will effectively identify all such adults. Regardless, given the proliferation of various screening practices across youth-serving organizations, longitudinal and prospective evaluations of their effects on the perpetration of abuse within organizations, as well as the identification of applicants who pose a sexual risk to children, are warranted. Proprietary systems marketed to youth-serving organizations which rely on data that have not been made public and independently evaluated should be viewed with great caution. Although methodologically and ethically difficult to undertake, an effort to evaluate screening practices

and measures in the general population would be quite valuable (e.g., identifying adults who self-report problematic behaviors).

DECREASING THE DEMAND

The ultimate sexual abuse prevention strategy would be to eliminate any interest in older persons wanting to or being willing to have sex with youth. Needless to say this is an incredibly complex task to begin with because having sex with a child is a behavior that can have origins in many and at times fundamentally different reasons. Not all sexual behavior is the same. It is also complicated because society states that certain kinds of sexual contact between certain relationships between people are not appropriate (i.e., illegal) and some officials (e.g., law enforcement or child protective services) may approach situations between youth with a different perspective than that of the youth. For example, two youth of the relative same age engaging in completely mutual exploration of each other's bodies may be differently viewed as inappropriate by law enforcement vs. their parents vs. child development professionals. Attitudes toward sexual behavior with youth vary greatly by race, religion, SES, and other factors (22).

The relationship between parties in a sexual encounter is of obvious legal and social significance for the very reason that such relationships are regulated. What is less clear is whether the relationship is of as much significance in etiology or prevention efforts, at least for some situations. For example, 35.6% of youth are abused by peers (23). Are the relevant etiological factors the same in peer on peer, as sibling on sibling, as teacher on youth abuse? Maybe, but not clearly so. Recent efforts have been made to theoretically and comprehensively integrate different biological, developmental, ecological, and situational factors that may be related to sexual offending (24, 25), and research that evaluates these is needed. While numerous theories exist to explain sexual offending, no single theory will likely describe every factor that contributes to the behavior.

Some theoretical explanations of sexual offending behavior have been supported by subsequent research. Seto, Kingston and Stephens (26) provided an excellent summary of this information, and Ward, Polaschek and Beech (25) review and describe theories of sexual offending at length. Finkelhor (27) suggested that an offender must meet four preconditions to sexually abuse a child: possessing (a) a motivation to sexually abuse a child (perhaps involving a level of emotional congruence with a child, or an inability to get their sexual needs met in appropriate relationships), and abilities to overcome (b) internal inhibitions (e.g., moral) and (c) external barriers (e.g., supervision) to sexually abusing a child as well as (d) the child's resistance to the abuse. Marshall and Barbaree's (28) integrated theory points to biological variations, such as hormonal functioning, and early childhood experiences of maltreatment as possible contributors to sexual offending behavior. Malamuth and colleague's confluence model of sexual aggression against women (29, 30) posits hostile masculinity, a construct that combines gratification from dominating or controlling women and an orientation that is hostile, insecure, and defensive, and impersonal sex, "a non-committal, game-playing orientation in sexual relations," as factors influencing offending behaviors. Finally, in their self-regulation model, Ward and colleagues (31, 32) theorized that different pathways to sexual offending

exist, as characterized by an offender's goal (to avoid or "approach" abusing), offending strategy used (active or passive), and affect before and after offending (positive or negative).

It appears that sexual abuse of children is a "behavior" that probably has multiple origins. For example, some older persons who sexually abuse children may do so out of a sexual arousal to children or an inability to overcome inhibitions related to sexual offending (33); some may act out of a reaction to or learned behavior from their own maltreatment, particularly sexual abuse as children (34), or some biogenetic risk factor (e.g., hormones) (35); some may act from a lack of social competencies (36); among other possible explanations (26). Additional research (37, 38, 39) has supported the descriptions of different pathways to offending behavior presented by Ward and colleagues' self-regulation model (31, 32).

As with adult offenders, research on adolescent perpetration of problematic illegal sexual behaviors against other youth has identified multiple possible etiological risk factors. Seto and Lalumière's (40) meta-analysis comparing male adolescents who committed a sexual offense (n = 3,855) versus those who committed a nonsexual offense (n = 13,393) found that, ranked by effect size, youth who had committed a sexual offense were significantly more likely to have (a) atypical sexual fantasies, behaviors, or interests (such as nonconsenting sex, finding a 5 or 8 year old sexy, or incest with a sibling), (b) a history of sexual abuse, (c) a less extensive criminal history, (d) fewer antisocial peers, and (e) fewer substance abuse issues. Although these results suggest adolescents' problematic sexual behaviors cannot simply be attributed to general antisocial tendencies or delinquency (40), the pathways connecting such behaviors to these risk factors are not clearly understood.

Nonetheless, the meta-analysis indicated support for several possible etiological explanations for youths' problematic illegal sexual behavior. The authors noted only limited consistency between these explanations and with theories of sexual offending that have found support with adult samples (40), pointing to the likelihood that youths' pathways to problematic illegal sexual behaviors differ from adults' in some ways. Explanations that were supported by the research included (a) sexual abuse history and (b) exposure to sexual violence, followed by (c) other abuse or neglect, (d) social isolation, (e) early exposure to sex or pornography, (f) anxiety, and (g) low self-esteem (40). Explanations that did not receive support included (a) attitudes and beliefs about women or sexual offending, (b) family communication problems or poor parent-child attachment, (c) exposure to nonsexual violence, (d) social incompetence, and (e) low intelligence (40). To clarify the pathways that lead youth to problematic illegal sexual behaviors, the authors note that studies are needed that compare youth who have committed sexual offenses vs. committed nonsexual offenses vs. not committed any offenses, distinguish typologies of youth who commit sexual offenses (e.g., those with young child victims vs. peer or adult victims), and utilize structural modeling (40).

Although atypical sexual interests may be the most significant risk factor for adolescent engagement in a sexual vs. nonsexual offense, they may not be common in a majority of cases. Existing research suggests that adolescents with "deviant" sexual arousal (i.e., arousal to prepubescent children younger than 12 and at least 4 years younger than the adolescent, or to sexual violence) make up a minority of adolescents who commit sexual offenses (41). Among adolescent males who have engaged in a sexual offense, arousal to prepubescent children and/or sexual violence has been found to range from 25-39% (42-45), indicating that most (61-75%) youth who do commit sexual offenses are primarily interested in consenting sex with near-age peers (41). So while sexual interest in much younger children may help explain adolescents' illegal sexual behavior problems in some instances, it may often not be etiologically relevant.

Moreover, possible developmental or other factors that may contribute to or influence the emergence of deviant sexual arousal, such as a history of childhood sexual abuse, are not clear (40). As Chaffin et al. (46) point out, sexual arousal of youth to youth is conceptually distinct from adult arousal to youth. Nonetheless older youth who sexually abuse younger youth, often with violent or perverse behaviors, do so for reasons that are knowable. Whether repeating what was done to them, doing what they saw done in pornography, or expressing more negative internal states (e.g., anger or hatred), understanding these motivations would be helpful in designing prevention interventions.

A significant link between experiencing sexual coercion and subsequently enacting it has found support in studies with representative general populations (47) and population-based samples (48-50), though questions remain about what other factors may explain this link. For example, in a representative study of high schoolers, Seto et al. (48) found that sexual coercion experience was significantly related to, but only accounted for 18-25% of, sexually coercive behavior. Casey et al. (47), one of the only studies of factors related to sexual coercion that includes a general population sample of adolescents (but which also includes young adults), offers another example. The authors found that while childhood sexual abuse history was predictive of engagement in sexually coercive behavior in early adulthood, so too were physical abuse history, delinquency, and early sexual initiation, suggesting multiple and complex pathways to coercive behaviors (47). They speculate about the possible influences of one's reaction to the trauma of victimization, or of family, peer, or community-level factors, as areas for future research seeking to explain the link between experiencing and enacting sexual coercion. As yet, however, this relationship is not fully understood, and further studies are needed that are longitudinal, and which use general population samples of youth only, to help explain this and other possible pathways to sexually coercive behavior in adolescence.

The research on factors leading to the sexual abuse of children is complex, at times contradictory, and without clear implications for prevention. A number of factors need to be kept in mind while thinking about the implications of this large body of research. Samples are often based on adult offenders who have had long histories of sexual misbehavior. But the factors that explain the development of a particular sexual interest (e.g., the first offense) vs. those that maintain it over time (e.g., through reinforcement) may be different. For example, an adolescent may start sexually abusing a younger peer or neighbor by repeating what was seen in pornography and may continue to select younger victims throughout adolescence instead of engaging in same-age sexual behavior because access to the former is easier, leading to a conditioned sexual interest in children. Had the same hypothetical adolescent had same-age experiences during adolescence, an adult interest in children may not have been conditioned. A second issue is that much of the research on sexual offending is based on adult offenders and youth with illegal sexual behavior problems who have been identified and often adjudicated, rather than with general population studies. For example, Seto & Lalumière's (40) meta-analysis draws largely upon youth samples from detention centers or correctional facilities, courts, and residential or treatment settings. It is not clear to what extent such samples are similar or different to persons who have engaged in sexually abusive behaviors against youth but have not been identified or caught. Generating knowledge based on the study of individuals who have "unsuccessfully" committed a sexual offense (i.e., those who have been caught) vs. those who have committed multiple offenses without being caught may inhibit a greater understanding of how sexual abuse of youth develops. Additionally, conflating sexual abuse and delinquency by examining variables in samples of adolescents incarcerated for a sexual

offense makes it difficult to understand the origins of sexual offending in "non-delinquent" samples.

Our purpose here is not to discount a significant body of research on factors associated with sexually abusive behaviors but rather to caution professionals in looking too uncritically to that research to support ideas about the primary prevention of sexual interest in children. A clear implication of the research to date is that primary prevention of the sexual abuse of children will require different interventions to address the disparate etiology of the behavior. Of considerable importance is research in the general population of unidentified (unadjudicated) persons who engage in abusive sexual behavior with youth and the development of meaningful typologies which discriminate between types of offending behavior. Youth who engage in sex with younger children who do so because access to the child is easier than other potential partners vs. youth who act out what has been viewed on pornography vs. youth who are generally antisocial are likely to need very different prevention interventions. Primary prevention directed toward reducing the demand for children as sexual objects is an important and urgent need for future prevention efforts.

For the time, renewed focus on specialized interventions with youth victims, especially males, which target risk factors associated with the development of sexual interest in children and cognitions associated with offending seem important. To the extent that youthful sexual abuse of children is associated with the youths' own trauma experiences, longitudinal studies of current evidence-based treatments both to track long-term effects and the occurrence of sexual offending behaviors would be helpful in understanding prevention with youth who have been traumatized. Although the role of sexual arousal and interest is not completely clear, interventions that target youth consumption of pornography and reduce its negative effects are also a priority for prevention.

PROMISING INTERVENTIONS

We appreciate that some readers may react to the following suggestion by thinking that we are too reductionist. We appreciate for all the reasons we note above and a host of other practical and methodological issues that understanding the nature and etiology of something as complex and consisting of such different types of behaviors as sexual abuse of youth cannot be solved by any single focus. Nonetheless, in an effort to target prevention efforts we are suggesting that adolescents' consumption of pornography, bystander interventions, and consent culture are focal areas for important and preliminary prevention efforts.

Pornography

While sexual development in youth is a normal developmental process impacted by biology, experiences, modeling, and underlying personality factors (51), it also appears increasingly clear that the widespread availability of pornography may be a major factor in youth sexual development. Adolescents often seek out pornography in response to natural, developmentally appropriate curiosities about sex or desires for sexual excitement which adults will never be able to curb, no matter how much they want to (52, 53). Today, teens can easily and discreetly

access pornography online via smartphone, tablet, or computer. Data indicate that 62% of girls and 93% of boys were exposed to online pornography before age 18 years (53), and that 42% of 10 to 17 year olds who used the internet saw online pornography in the past year (54).

Pornography teaches youth what sex "is" (55), often before they have had much experience with developmentally appropriate exploration of sex themselves. Popular pornography commonly exposes youth to extreme forms of sexual behavior and themes of aggression, degradation, or objectification (56). Acts of physical aggression depicted in popular pornography include spanking, open-handed slapping, hair pulling, choking, and forced gagging and vomiting (57). More extreme sexual acts with inappropriate sexual partners and painful and humiliating behavior are readily available on porn sites. A general rule of behavioral reinforcement is that any powerful reinforcement loses its power after repeated exposure (i.e., satiation) so youth turn to ever more exciting and often more perverse pornography. Exposure to pornography has been shown to increase adolescents' sexual preoccupancy (i.e., being distracted by, frequently thinking about, or being very interested in sex) (58), and more frequent use has been found to increase perceptions that scenarios depicted in pornography are realistic and often occur in real life (59). Pornography may also act as a form of cognitive rehearsal where youth imagine how they will behave in interpersonal situations. For example, a recent vignette-based study describing a scenario in which, after kissing and engaging in foreplay, a female tells a male "that she does not want to engage in sexual behaviors with him," found that college males' likelihood of responding to the scenario with an act of illegal sexual coercion was significantly associated both with a greater frequency of pornography use and number of modalities used to view pornography (e.g., internet, books, magazines, movies), as well as with their perceptions of how well they could imagine themselves as the male in the story, the victim's willingness to have sex in the story, and how much pleasure she received in the story (60).

There remains debate in the research about the extent to which pornography consumption is linked to actual sexual aggression (61). As in so much research, there are a host of methodological issues investigators confront in doing this type of research (61, 62), including how sexual aggression is defined and measured (e.g., coercion vs. aggression), what the reliability of self-reports of aggressive behavior is, the sample used (e.g., based on youth with identified sexual behavior problems vs. youth in the general population), and how pornography is defined. In this regard, a report has indicated that erotic R-rated films shown in theaters have the same effect as pornography (63).

While the role of sexual arousal in youth who engage in sexual abuse of other youth or more generally, the role of pornography in any sexual aggression may be debated, it is evident that pornography has a corrosive impact on some aspects of development, particularly for males. Males who use pornography are more likely to hold attitudes conducive to sexual violence, especially if the porn viewed depicted violence (56, 57, 64). This includes being accepting of interpersonal violence or rape myths that blame victims of violence, such as: "most victims of rape are promiscuous or have a bad reputation," "people can resist rape if they really want to," "hitting a partner is sometimes justified," and "women are turned on by being roughed up" (65). Males who view pornography that depicts violence are also less likely to engage in pro-social *bystander behavior* (57, 66), which means intervening to support another person before, during, or after they are sexually victimized (67). Pornography that depicts acts of physical violence or someone being hurt may in particular be linked to adolescents' own perpetration of various forms of sexual violence. In a national, longitudinal study of factors

affecting sexual violence perpetration among 1,586 youth ages 10 to 21 years, Ybarra and Thompson (68) found that use of violent, but not non-violent, pornography significantly increased odds for perpetrating sexual harassment more than four-fold, sexual assault more than six-fold, rape more than seven-fold, and coercive sex more than ten-fold. In earlier findings from the same dataset, Ybarra et al. (69) reported that among 1,577 youth ages 10 to 15, intentional exposure to violent pornography, but not non-violent pornography, was significantly associated with a nearly six-fold increase in sexual aggression (i.e., in-person sexual assault and technology-based sexual harassment and/or solicitation), even after accounting for generalized aggressive behavior, alcohol and drug use, and witnessing parental violence.

The cognitive effects of viewing pornography identified in research have been so strong that investigators have had to create written or videotaped educational, debriefing interventions for research subjects that describe and moderate pornography's corrosive effects on subjects' attitudes. For example, in a study of 150 undergraduates comparing the effects of a written debriefing intervention that described the fictional nature of pornographic depictions and which discussed and debunked rape myths, participants who received the debriefing intervention after being exposed to a written pornographic depiction of rape were significantly less likely to believe certain rape myths (i.e., rape is caused by the victim's behavior or a woman's secret desire to be raped) ten days later than participants who had been exposed to a written depiction of mutually consenting sex but who did not receive the debriefing intervention (70). That study was included in a meta-analysis of ten studies on the mitigating effects of educational debriefings on exposure to violent sexual material, which concluded that debriefing interventions were associated with either complete or partial decreases in rape myth acceptance despite exposure to sexually explicit material (71). Studies included in the meta-analysis varied in terms of the sexually explicit material used however, with some using slasher films as stimuli, which might not be what is ordinarily thought of as pornography.

No matter how much parents and other adults imagine, hope, or even pray that they are going to keep youth away from pornography, it is simply too available and too appealing to youth to keep them away from it. Discussions with youth about pornography are critical and yet incredibly hard for most adults and parents. There are a number of well-developed internet-based interventions for youth that teach the effects of pornography use (72), and for parents that teach about pornography-related conversations with their youth (73). Faith communities where issues of relationships and appropriate behavior flow naturally are also excellent places to have discussions about pornography and abuse. These discussions can be difficult as they relate to faith-based attitudes toward sexual behavior, but it should be noted that the topics of safety education or anti-pornography interventions are not the same as that of sexual behavior.

Research interest in the development and effectiveness of interventions that address the negative effects of pornography use, particularly on young people's attitudes, has been renewed in the digital age and is emerging. Having parent-child conversations that are critical of pornography (e.g., refuting or condemning), also known as negative active mediation, is one informal strategy that has received early support (74). A retrospective study of 300 emerging adults ages 18-25 years found that receiving negative active mediation more frequently during adolescence was significantly associated with presently having less positive attitudes about pornography (e.g., being more likely to endorse that pornography "degrades women" or "increases violence towards women") (74). This suggests that parents may be able to influence adolescents' attitudes in a manner akin to written or taped debriefing interventions. Another

more structured intervention, "porn literacy" education, has been delivered in discussion-based group settings to teach critical awareness of pornography use and address related attitudes, including the perceptions of women as sex objects and of pornography as realistic (75, 76). These results are promising and more research is needed to determine whether these effects endure over time, extend to larger samples and in controlled settings, are affected by increased exposure to pornography including violent pornography, as well as whether participants' sexually aggressive behaviors are impacted. Future efforts that recognize that youth are not likely to stop viewing pornography, but instead develop harm reduction interventions that appeal to youth seem of considerable importance in primary prevention efforts.

Bystander interventions

An increasingly popular prevention method is to engage youth who are third parties (i.e., neither perpetrator nor victim) in instances of risk or sexual violence. Bystander programs are educational interventions that target such individuals and aim to teach concepts related to sexual and dating violence and, ultimately, motivate participants to intervene in the future when they notice someone at risk of harm. These programs are intended to promote active or engaged bystanders who, in contrast to the passive witnesses that bystanders are typically thought to be, behave in protective and pro-social ways. Bystander interventions thus address the would-be bystander's needs to be able to recognize situations of potential violence, identify appropriate courses of action, and assume a personal commitment to intervene.

Bystander interventions are delivered in a variety of formats but generally teach similar concepts and behaviors related to prevention. Common topics include sexual assault (e.g., prevalence, nature, risk situations or warning signs), consent, empathy, communication skills, rape culture and rape myths, and gender roles (e.g., gendered socialization, social scripts, masculinity), as well as examples of how and when to intervene in instances of risk or sexual violence. Bystander behaviors may include verbal or physical acts of support, such as: walking a friend who has had too much to drink home; talking to the friends of a drunk person to make sure they do not leave their drunk friend behind at a party; asking a person who seems upset if they are okay or need help; speaking up against racist or sexist comments; or distracting a peer who appears to be about to abuse another peer, so that the peer at risk can escape the situation (67).

Meta-analytic studies have identified at least three likely beneficial effects of bystander interventions that indicate it may be a promising prevention practice. Bystander programs are associated with small, significant reductions in rape myth acceptance (77, 78) and small-to-moderate increases in bystander efficacy (one's belief in one's own ability to be an effective bystander) (77-79). Bystander programs are associated with moderate and significant increases in participants' intentions to intervene as a bystander (77, 78). Perhaps most interestingly, bystander interventions are associated with small but significant increases in participants' actual subsequent bystander behavior (77-79), lasting up to three months post-intervention (77, 79). These results should be interpreted as preliminary findings given the limited number of studies (≤27) included in each meta-analysis, studies' reliance on self-report measures, and a disproportionate focus on interventions that were delivered in-person rather than by other means, and with college student samples that limit the generalizability of findings.

The more important question of whether bystander programming actually decreases instances of sexual violence remains unanswered. Two meta-analyses have assessed the impact of bystander programming on individuals' likelihood to perpetrate sexual violence and tentatively reported, each based on few studies (≤6), no significant effects (77, 78). Moreover, studies have not generally reported on the incidence rates of sexual violence in a given environment before and after a bystander program has been introduced, obscuring its possible influence. Further rigorous, longitudinal, and representative studies are needed to determine whether and to what extent bystander interventions prevent sexual violence.

With their effects still being clarified, bystander interventions present the field with risk as well as opportunity. A notable point of caution is that interventions that increase bystander behavior may inadvertently expose bystanders themselves to harm. For example, one non-representative study of 1,703 individuals ages 11 to 70 found that one in six (17.8%) individuals who intervened as a bystander during a sexual assault were themselves hurt or threatened in the process (80). On the other hand, if bystander interventions are indeed successful in reducing sexual violence, they may be poised to become an especially powerful prevention tool that can be disseminated online, cheaply and widely, to a more universal audience. Most critically, if bystander attitudes and behaviors become more widely accepted, multiple individuals may act as engaged bystanders and support each other in doing so.

Consent

An intuitive prevention strategy receiving growing attention is that of consent, specifically, increasing the proportion of sexual interactions that are consensual vs. non-consensual. An increasingly used standard of consent, known as affirmative consent, has been incorporated into state and educational institutions' prevention policies over the past decade and is relatively complex and explicit (81, 82). *Affirmative consent* is generally described as a voluntary, mutual, and clear agreement between people to engage in a particular sexual behavior, that is made without incapacitation (e.g., by age, intoxication, disability, consciousness, etc.) and in the absence of coercion, and which is predicated upon ongoing verbal and/or nonverbal communication (82-84). Specific behaviors used to communicate consent when initiating and changing sexual behaviors may vary by person or instance. These can include, for example: asking questions (e.g., "is this okay?"), providing statements of explicit agreement (e.g., "yes" or "I'm open to trying"), or using physical cues to indicate comfort (e.g., smiling, nodding, mirroring someone's touch, or placing someone's hand on a part of one's own body) (82). By definition, affirmative consent must be actively communicated, may be withdrawn at any time, and may never be assumed, including by silence, a lack of protest or resistance, or previous experiences of consenting sex between partners (82-84). It has been argued that establishing a *consent culture*, in which affirmative consent is socially considered a prerequisite standard for all sexual activity, would contribute to sexual violence prevention (84). Emerging research on perceptions of affirmative consent have found that individuals may understand its basic principles (85) and find it favorable (86), but also awkward or uncomfortable to practice (87).

The evidence suggests that both males and females, including adolescents (88), commonly perceive consent as a mutual willingness or agreement to engage in sex (89-91). However, studies have found that, in practice, individuals communicate and interpret consent in a variety of ways, including: verbal cues that are explicit (e.g., "I want to have sex") or implicit (e.g.,

asking a partner to get a condom), nonverbal cues that are explicit (e.g., moving a partner's hand toward one's genitals) or implicit (e.g., eye contact) (91, 92), and not resisting or saying "no" (83, 92). For example, a recent study of 589 women diverse in race/ethnicity (33.6%% Hispanic/Latina, 33.1% non-Hispanic/Latina Black, and 33.2% non-Hispanic Latina White) and age (M = 36.03, SD = 12.39) (92) found that participants endorsed having used a range of cues to indicate consent: no response (48.1%), implicit verbal (44.7%), explicit verbal (39.2%), implicit nonverbal (33.8%), and explicit nonverbal (15.1%). A comprehensive review (83) additionally reported that both males and females use nonverbal cues more frequently than verbal cues to indicate their own consent, and to perceive their partners' consent. Affirmative consent moves away from implicit signals or the lack of specific permission to engage in behavior.

Increasing affirmative consent or creating a culture of consent is an intervention intended to change social norms that "script" sexual behaviors. Researchers have commented that the perception of verbal consent as unnecessary, and the finding that women are more likely than men to indicate consent through verbal cues, reflect the "traditional [hetero]sexual script" which presumes men as sexual aggressors, considers a lack of protest or the absence of a verbal "no" indicative of consent, and perceives women as responsible for communicating consent through active resistance (83). More concretely, Hust et al. (93) found in a sample of 313 undergraduates that increased exposure to men's magazines that adhere to this sexual script was significantly associated with lower behavioral intentions to seek consent and to adhere to consent decisions.

It remains to be seen whether actual consent communication practices can be increased through participation in an intervention (94) and future research should prioritize answering this question. Longitudinal, experimental studies of interventions that aim to teach knowledge and skills related to negotiating sexual consent may help clarify this. As most studies on consent have been based on white, heterosexual, and cisgender college student samples, more representative research is also needed to establish a clearer understanding of how people of color, LGBTQ people, and adolescents view and practice sexual consent. Knowledge of adolescents' consent negotiations, and whether they can be altered through an intervention, will be particularly important for prevention efforts given that more than one-third (35.6%) of all reported sexual assaults against children are perpetrated by other youth (23).

PARENT-FOCUSED PREVENTION STRATEGIES

While the majority of CSA prevention efforts to date have been directed at educating children, parenting has also been identified as a critical component of preventive efforts. As most perpetrators are known to the victim (95), parents' social proximity to CSA exposure offers a unique and important role in prevention (96, 97). Parents can contribute to abuse prevention via regular and consistent communication, including talking with children about sexuality, boundaries, and personal safety, as well as effective monitoring and supervision (e.g., limiting child exposure to potential perpetrators) (96-100). Finally, responding appropriately to children's disclosure of abuse may help prevent future abuse from occurring (97, 99).

Parent-focused prevention programs include content on basic CSA knowledge as well as other strategies and skills related to CSA prevention. A recent effort to create a curriculum on

CSA prevention as part of a generalized parent-education (PE) curriculum convened parents, experts, and providers. This convening identified the following as essential components of parent-focused prevention programming: "basic knowledge (i.e., definitions, myths); communication (i.e., talking about sex with children, discussing rules with other adults); safety education (i.e., supervising and monitoring, vetting adults with whom they leave their children, environmental and child cues); sexual development (i.e., normative and non-normative behaviors); internet safety (i.e., exposure to media, children's activity, access by other adults); and facilitating disclosure (i.e., what to do if CSA is suspected, how to respond to a disclosure)" (101). It is believed that education allows parents to create safer environments for their children through accurate information about how and when abuse occurs.

Studies demonstrate that most parents lack basic knowledge of CSA (99, 102) and that prevention interventions can increase parent knowledge and reduce adherence to CSA myths (e.g., "stranger danger") (103, 104). Research also suggests that participants retain knowledge over time (105, 106). Program participation also results in an increase in protective behaviors, including parent conversation with their children regarding CSA (103, 105), or greater motivation to talk to their children about CSA, indirectly impacting an increase in self-reported conversations (104). Further, participants report an increase in conversation with other adults about safety topics (103, 105, 106), monitoring their own children and others' children (105) and modeling privacy in the home (103). Research also suggests educational programs may result in an increase in reporting behavior, which could reduce risk of future CSA events (107).

Despite potential benefits, a multitude of barriers hinder parent-focused prevention efforts, including reaching parents of children at risk for abuse. Obstacles include community resistance due to the emotional intensity of CSA and the stigma surrounding sexual and criminal activities (97, 108); denial or lack of understanding children's vulnerability to abuse (99, 108); lack of funding for prevention efforts (108, 109); and accessibility/relevance across culturally diverse families (97, 99). Families at heightened risk for maltreatment are less likely to participate in interventions and drop out more frequently if they do (110), so content and delivery must be specifically targeted for these populations (e.g., single-parent families, families living in poverty) (97).

Future research will need to determine if parent-oriented efforts actually reduce the rate of child sexual abuse. However, other impacts such as increased parent-child communication, increased child self-confidence and personal efficacy, and other child factors are likely to have positive impacts on child development independent of the long-term goals of reducing victimization. Research which examines the parent attitudes (e.g., cultural or religious beliefs, personal histories) that negatively impact their willingness to engage with their children around prevention would also be useful in creating more targeted parent prevention interventions.

COMMUNITY-FOCUSED PREVENTION STRATEGIES

Child sexual abuse interventions at the community and population levels reflect a shift from the individual to the environment as a target for prevention (96). Community-focused prevention strategies can have two major goals: (a) to raise awareness of CSA and provide skills and actionable knowledge to ultimately change behavior and (b) to contribute to macro-level societal shifts (e.g., policy change) via community member activation, promoting new

perspectives and solutions, and influencing policy-makers (111). Mass media campaigns have been utilized in CSA preventive efforts to influence knowledge, attitudes, and behavior. A review of media campaigns pertaining to a wide range of health-risk behaviors found that mass media campaigns are able to change population health behaviors (112).

Advocacy organizations such as *Darkness to light* and *Stop it now!* have developed media campaigns to educate the public about CSA and promote preventive behaviors. These initiatives demonstrate promising impacts on CSA knowledge (113-115) and a positive impact on primary prevention behaviors assessed with hypothetical vignettes; however, no significant impacts were found for several other behavioral indicators (113). These findings suggest that media campaigns may impact knowledge, but implemented alone may not be sufficient to influence primary prevention behaviors (113). A review of CSA public awareness campaigns confirms this challenge of translating awareness to action (111).

A case study of the *Enough Abuse Campaign* describes a multidisciplinary, state-wide strategy to prevent CSA in a multi-phase program inclusive of developing state-level and local infrastructures for CSA prevention; assessing public opinion; providing training programs on perpetration prevention; and initiating an advocacy-based movement for CSA prevention (116). An evaluation of the campaign demonstrated a positive impact on adult responsibility for CSA prevention, claiming that adults, not children, should be responsible for CSA prevention: an increase in those endorsing this concept from 69% in 2003 to 93% in 2007 (116). A decline in CSA incidence was also noted over the intervention period, with substantiated reports of CSA in Massachusetts decreasing by 69% between 1990 and 2007 (116). Finally, the campaign impacted the system-level context of CSA by extending the statute of limitations, the legal window for the authorities to file criminal charges against their abusers, from 15 to 27 years past the victims' 16th birthday (116).

An empirical case study of *Stop it now! Georgia* documented the statewide initiative across a five-year period (117). The effort focused on behaviorally-specific interventions and involved dissemination of CSA prevention materials and messages, a statewide helpline providing callers with support to respond to CSA suspicions and engage in protective behaviors, and a statewide training and education program. During the implementation period, a decrease in CSA incidence was noted for 4 of the 5 years of the initiative, though a causal correlation with the prevention program cannot be confirmed (117). While media campaigns and larger scale community and population-focused preventive efforts may impact knowledge and behavior, and ultimately reduce incidence rates, more rigorous evaluations of both the strategies employed and the outcomes on prevention are needed to contribute to the evidence-base of proven CSA prevention strategies.

CONCLUSION

We have reviewed a wide range of prevention activities and, as we have repeatedly pointed out, many lack research support. This does not mean that communities should stop innovations in efforts to prevent the sexual abuse of youth but it does call upon scholars who support the field to collaborate with community prevention professionals in a concentrated and coordinated research effort to support ongoing activities and innovations. Such an effort will require scholars to address issues important in practice and prevention programs, and to be willing to

face whatever results the research demonstrates. The need for validated prevention policies and practices should override any pride in ownership. Following the data is our best hope of moving toward real prevention of childhood sexual abuse.

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Chapter 16

CHILD ABUSE PREVENTION IN THE FAITH-BASED ENVIRONMENT

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ABSTRACT

Faith-based environments or houses of worship have the potential to be a significant positive factor in a child's life but have the potential to be abusive as well. This harm may occur directly from the actions of clergy, adults in the faith-based community functioning in an authority role, as well as from peers or children and adolescents who are older. The harm is compounded by the mishandling of the abuse by clergy, religious institutions, and their faith community. Several common factors contribute to this poor institutional handling, including a mistaken understanding or misapplication of religious doctrine, reverence for clergy and other faith leaders, and the instinct to protect the institution from outside interference. This chapter summarizes the progress that has been made within well-established faith-based organizations to confront and address the issue of child sexual abuse and highlights changes that continue to be necessary to bring faith-based environments into concordance with accepted child abuse prevention practices. The chapter also provides a framework of recommendations for child advocates and faith leaders in order to achieve increased safety and healing.

"Faith communities offer children wonderful opportunities to develop spiritually and to be part of a larger, caring community. Close caring relationships with adults are an important protective factor for children. … Unfortunately, as in all organizations where adults and older youth interact with children, faith communities can unintentionally provide opportunities for … sexual behaviors towards children." Stop it Now! 2020 (1)

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INTRODUCTION

A large and growing body of research documents that maltreated children are not only impacted physically and emotionally but also spiritually (2, 3). Faith-based environments can positively impact a child's life or enable maltreatment to occur. Such harm may be caused by clergy, adults in positions of authority, peers or older children. The harm may occur because an offender references religion, perhaps noting a child's biological reaction to sexual touching and then declaring, "You are equally sinful; God holds you as much to blame as me." A spiritual injury may also occur when a child prays that God stop the abuse, yet the maltreatment continues. This sense of betrayal can impact the child's view of God, understanding of the world, and sense of self (3).

Children may also experience spiritual injury separate from the abuse itself, caused by clergy, religious institutions, and faith communities mishandling the abuse. For some children (a term which, for our purposes, includes teens as well), this secondary trauma causes deeper spiritual injury than the original abuse, undermining core religious teachings of support for the victim, including Isaiah 1:17 and Leviticus 19:16, and leading to an awareness of betrayal perpetrated by those the child might have approached for help. In the words of one survivor, "the trauma of the abuse is nothing, absolutely nothing…compared to the trauma of not being believed" (4). Research on institutional betrayal supports this survivor's account, finding that an institution's failure to prevent sexual assault or support victims can exacerbate posttraumatic symptomology (5). At the same time, a growing body of research demonstrates that spirituality is a significant source of resiliency for maltreated children and that victims who turn to their spirituality fare better in the short and long term (6-8). One report found that clergy in particular have a central role to play in helping survivors cope with trauma: "during a trauma, victims are five times more likely to seek the aid of clergy than any other professional. Clergy are people they know and trust" (9). Unfortunately, though, the very institutions best equipped and most trusted to address the spiritual needs of children and adult survivors may have been involved in their abuse or in suppressing the crimes of abusers (10). This tendency has both damaged the credibility of faith communities and resulted in many survivors losing their faith or their connection to organized religion.

In recent decades, responses to the maltreatment of children by faith leaders has improved incrementally. However, much more must be done if houses of worship are to be places of safety and healing for children. This chapter summarizes some of the progress within well-established faith-based organizations and highlights necessary changes that will bring faith-based organizations into concordance with best practices in child abuse prevention. While houses of worship differ widely in world view and traditions, child abuse prevention efforts largely align. The authors of this chapter, from Christian and Jewish traditions, agree on the potential efficacy of these efforts despite their faiths' differences.

ABUSE BY CLERGY

Prominent in any discussion about child maltreatment in a faith-based environment is the US Catholic Church's clergy sexual abuse crisis, uncovered in the early 2000s. Prior media coverage of sexual abuse cases had episodically occurred in the 1980s and 1990s, but the series

of exposés in the Boston Globe beginning in 2002 catalyzed a vigorous public response that included outrage from lay members and leaders of the Catholic Church (11, 12). In a report commissioned by the United States Conference of Catholic Bishops (USCCB), researchers concluded that from 1950-2002 child sexual abuse committed by priests or other Catholic leaders was "widespread," with more than 95% of dioceses impacted (13). The public outcry in America drew attention to abuse worldwide (14, 15).

Similar tragic situations have unfolded in Protestant communities. For example, the Southern Baptist Convention, the nation's largest Protestant denomination, issued a report in 2020 in response to what it called a "sexual abuse crisis" (16). Other Protestant denominations, as well as Jewish and Muslim communities, have also undergone scholarly analysis in this area (17-21). Although less extensive research exists on abuse in other faith traditions, there have also been high profile cases of abuse within the Church of Jesus Christ of Latter Day Saints (22), Jehovah's Witnesses (23), and others. Despite the many positive aspects of faith-based organizations, it appears that no house of worship, regardless of faith tradition, is free of the risk for child maltreatment.

ABUSE IN THE HOME AND COMMUNITY

Although the focus on child sexual abuse perpetrated by faith leaders is justified, we must recall that most maltreated children are not abused by a faith leader but by a parent, family member, or an adult known to the family. Beyond adults in the child's environment, the US Department of Justice reports that approximately one-third of child sexual abuse is perpetrated by other youth (24), and a recent study puts this number at more than 70% (25). According to the Fourth National Incidence Study, more than 90% of physical abuse, emotional abuse, and neglect cases involve a parent or significant family member as the perpetrator (26). In cases of sexual abuse, a parent or other significant family member is the offender approximately 60% of the time (26).

This fact is critical for three reasons. First, when faith communities develop policies focused only on protecting children from sexual abuse in a house of worship, they may overlook their moral and, often, legal obligation to protect children from sexual abuse in the community at large, as well as from physical abuse, emotional abuse, neglect and other forms of maltreatment. Second, because some individuals who abuse children are skilled at identifying signs that a child has endured the trauma of abuse or neglect and then abusing the child again, faith communities need to address abuse within the home in order to prevent abuse in a house of worship. "Poly-victimization research" demonstrates that a child who has been abused in multiple ways in his or her own home is at greater risk to be abused by others (27).

Third, although sexual abuse by church leaders requires specific prevention and response measures, focusing exclusively on clergy abuse ignores abuse among peers and by older youth (28). Preventing youth-perpetrated child abuse requires: a) an understanding of cultural factors within and outside the house of worship that may contribute to risk; b) prevention efforts that include children and center their voices in the initiative, incorporating developmentally and culturally appropriate messages of healthy sexual relationships, boundaries, and consent; and c) responses to sexual harm beyond the outdated "predator" model, recognizing, for instance, the numerous factors that can contribute to juvenile offending. We must move beyond teaching children to avoid harm and teach them to avoid causing harm and to intervene if they see other

youth causing harm; but even in teaching children this necessary knowledge, we must remember that the burden of responsibility falls firmly on adults and that children are not responsible for protecting themselves or each other. Furthermore, initiating direct dialogue on these topics need not be antithetical to religious doctrine; it can be centered on religious values and text, including grappling with difficult passages. For example, Heart Women and Girls, which works with Muslim communities, and the Our Whole Lives curriculum, designed by the Unitarian Universalist Association, work within faith traditions to provide developmentally appropriate sexuality education.

Attention to the risk of maltreatment in the US Catholic Church is mirrored by other national efforts to address child sexual abuse, including well-documented efforts in Australia and Ireland (29, 30). These prevention imperatives aim to establish "safe-environments," which focus on both training and on designing policies to protect children in the faith-based environment.

CONCERNS UNIQUE TO FAITH-BASED COMMUNITIES

Child maltreatment is not a religious phenomenon; it is a human one, often compounded by poor institutional response. Within faith communities, however, universal risk factors, including social and psychological impediments to responding appropriately to abuse, manifest in unique ways that must be explored and understood. Three factors that seem to be shared across faith traditions include: a) a mistaken understanding or misapplication of religious doctrine (31-34); b) reverence for clergy and other faith leaders (31, 35); and c) a cultural or religious instinct or even obligation to protect the institution or faith community, especially from outside interference (20, 34, 36, 37).

The first factor, mistaken understanding or misapplication of religious doctrine, can sometimes manifest as a concern for modesty that results in resistance to education for both adults and children and may impede reporting due to discomfort in discussing sexual matters (31). Some may even believe that such behaviors couldn't occur in their religious communities because of laws that limit contact between the sexes. Such a belief is mistaken both in fact and theology. Sexual abuse can be perpetrated against a child of the same sex and often occurs within the family unit. Religious sources, far from denying the existence of incest or other forms of abuse, name it, teach about it, and prohibit it. For example, Leviticus 18 enumerates and prohibits various permutations of incestuous and other abusive relationships and, far from a topic meant to be kept silent, this chapter is publicly read on Yom Kippur – the holiest day on the Jewish calendar. Other examples of misapplication of religious doctrine include pressuring a victim to forgive; looking the other way when faced with clearly abusive or grooming behaviors in order to judge favorably or not slander another; and permitting a person who has previously caused harm to have access to children due to mistaken notions of repentance (31). Similarly, safe environment training has been occasionally conflated with sex education, leading to concerns that the Catholic Church was interfering with the proper role of parents and family by providing developmentally appropriate abuse-prevention education to their children (38). A committee of theologians and child protection experts reviewed these concerns and clarified that the Church's efforts were consistent with Article 364 of the

Catechism of the Catholic Church, which states, "the human body shares in the dignity of the image of God" (39).

The second factor, reverence for clergy, appears as a central cultural, and even canonical, tenet in many faith traditions. In Judaism, this concept takes different forms, including *k'vod harav*, literally, the rabbi's honor, and *da'as torah*, interpreted by some as a requirement to seek guidance from a rabbi before making major life decisions (31). In the Catholic context, this enormous deference to the role of the clergy is referred to as clericalism, which Cannon lawyer Doyle describes as a concept "whereby the clergy consider themselves as somehow set apart, special, and above the laypeople" (35). The institutionalization of these values in a faith tradition's hierarchy can have implications for prevention efforts, such as the requirement, or at least encouragement, in some Jewish and Muslim communities that an individual consult with a clergyperson before reporting child maltreatment to governmental authorities (20, 31).

Reverence for faith leaders also impacts response efforts, such as when review boards tasked with making safety recommendations must defer to senior clergy who are vested with ultimate authority (40). Because some faith communities view clergy as representative of a higher moral authority, possessing some amount of divinity, they are provided with a level of trust and access not granted the average layperson and thus with more opportunities to abuse. In the Catholic Church, this view of leaders representing a higher moral authority is steeped in historical tradition:

> "In a hierarchical system, overladen with the trappings and values of monarchy, accountability is painfully difficult. Basically, it flows from the bottom up: the laity and lower clergy are accountable to the hierarchical leadership, the bishops to the pope, but there is no accountability to those whom the ecclesiastical leaders are supposed to serve." (37)

When clergy do abuse, a religious child's entire world view—including clergy as paradigms of virtue—may be shattered and the trauma compounded by damage to the child's connection to organized religion and spirituality (3). Faith leaders can use their power to cause harm, but, conversely, they can use it to support victims, prioritize communal education, and create opportunities for dialogue.

The third factor, a resistance to outside interference, stems, in some religions, from necessary self-protection. One such example is the Jewish prohibition against *mesirah*, reporting a fellow Jew to secular authorities, which has its roots in the Talmudic era, when reporting a Jew for even a minor infraction could mean persecution or even death (18). At other times, the protective instinct is reputational, a religious or cultural obligation to avoid bringing shame upon the community. Hutchinson et al. (20) explained that, in some Muslim communities, "Not reporting an offender to the authorities, for example, might be considered as protective if the matter is sufficiently dealt with by the family and local community because it would prevent the child from being blamed for bringing shame to the community and/or his family or kinship network" (20). In Jewish communities, causing a *chilul Hashem*, or a desecration of God's name, is considered a legal prohibition (41). All would agree that abusing a child constitutes a *chilul Hashem*, but it is not uncommon for communities to blame the whistleblower rather than the abuser. Moore, writing from a Southern Baptist perspective, argues that churches should welcome external scrutiny as a force for transparency and accountability:

> "A church that excuses, say, sexual immorality or that opposes missions is deemed out of fellowship with other churches. The same must be true of churches that cover up rape or sexual abuse… No church should be frustrated by [a] media report, but should thank God for it. The Judgement Seat of Christ will be far less reticent than a newspaper series to uncover what should never have been hidden." (36)

Most frequently, especially in insular faith communities, there is a distrust of outsiders who may not respect values the community holds dear; this worry impedes collaboration with secular organizations and governmental agencies in both the prevention of and response to child maltreatment. This distrust is not unfounded, as child protection professionals from outside the faith community may be ill-equipped to support the community in protecting children. One solution is to better train outside professionals to interact in a culturally sensitive manner; a better option involves training those within the community in child protection.

RESPONSE AND PREVENTION EFFORTS

Houses of worship and their related entities (like day-cares, schools, camps, and extracurricular activities) can be envisioned as youth-serving organizations (YSOs). As such, the 2007 Centers for Disease Control (CDC) report, *Preventing sexual abuse within youth serving organizations: Getting started on policies,* provides a useful prevention framework upon which to build policies and procedures that can guide prevention efforts (42). Central to this approach is a focus on careful screening of adult employees and volunteers, training for both adults and children to create a culture of safety, on-going monitoring to ensure compliance with best practices, and procedures for responding to policy violations. YSOs ideally provide opportunities for children to grow and to engage in meaningful activities, but they may also be places where children experience harm.

US Catholic response and prevention efforts

The current framework for the US Catholic Church's response to the problem of sexual abuse perpetrated by clergy, referred to as "A promise to protect/pledge to heal," is contained in the Charter for the Protection of Children and Young People (43). Over time and through multiple iterations, the Charter, a document outlining best practices in sexual abuse prevention, was developed in 2002 and took its current form in 2018 (43). The Charter contains 17 articles outlining how Church leadership will work towards protecting children from sexual abuse. Among the key elements is a commitment to:

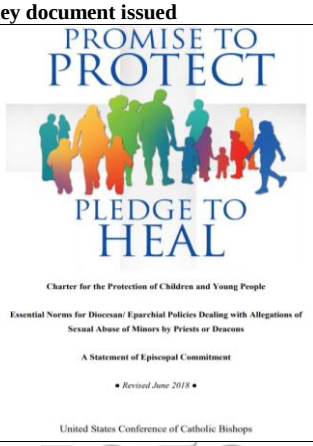
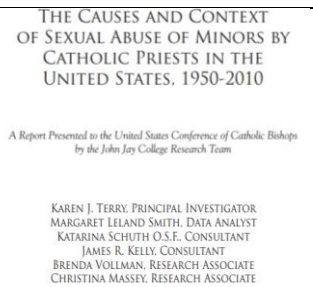
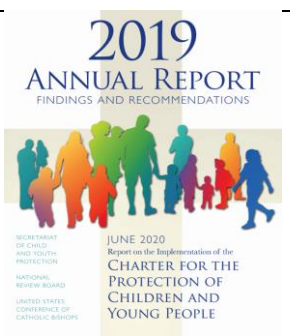
- Remove from ministry clerics who have credible allegations of sexual abuse against a minor (the so-called zero tolerance rule);

- Designate a non-cleric victim assistance coordinator in each diocese to receive initial disclosures of abuse and interface with the victim;
- Designate a safe-environment coordinator in each diocese to organize and oversee prevention efforts, including mandatory training for both adults who come into contact with children and for children who come into the Church environment;
- Report all reasonable suspicions of abuse to the appropriate civil authorities;
- Establish a local review board at each diocese composed primarily of lay Catholics who advise the bishop on child protection issues, investigations related to clergy accused of child sexual abuse within the diocese, and policies and procedures designed to keep minors safe;
- Establish the National Review Board (NRB) composed of lay Catholics working to ensure that minors are protected against child sexual abuse while in the Church's environment;
- Support two academic studies to determine, first, the epidemiology and baseline data concerning clergy-perpetrated child sexual abuse and, second, how best to use this knowledge of the causes of abuses to lessen the risk;
- Ongoing annual audits of compliance by each diocese (43).

Preventing abuse, the focus of this chapter, relates closely to how the Church responds to victims. The USCCB Charter aims to create faith-based environments where children are free from harm, both the harm of abuse and the harm of mishandled revelations of abuse. The enormity of this undertaking becomes clear when reviewing the annual audits of Diocesan compliance with training requirements. For example, in 2019 just under 99% of priests—over 33,000 individuals—participated in training, and similarly high percentages of deacons and ordination candidates participated in training as well (44). In addition, over three and a half million children participated in training, which represents almost 92% of children from Catholic dioceses nationwide (44).

The safe environment trainings vary from locally developed offerings to commercially available curricula. In response to concerns around the effectiveness of safe environment training programs, the USCCB commissioned a review of relevant research, which concluded that such trainings effectively teach children about sexual abuse, equipping them with skills to seek assistance, and increasing disclosure rates (45). The literature review also found that parents generally support sexual abuse prevention trainings, that programs tend to increase dialogue between parents and children on this topic, and, in cases where abuse has occurred, that children who have gone through training experience less self-blame and believe that they acted to protect themselves. Finally, negative emotional reactions to the trainings were short lived and favorably balanced by the positive effects (24, 38, 45-47). Surveys further confirmed that the majority of training programs incorporated the best practices; those that did not were provided with a checklist for future use (38). Table 1 summarizes key documents in the Catholic response to child sexual abuse within the church.

Table 1. Promise to protect/pledge to heal, 2002

Key document issued	Brief description
	Charter for the Protection of Children and Young People • Originally issued in Summer 2002 after meeting of United States Conference of Catholic Bishops (USCCB) • Contains US Catholic Bishops collective apology for the leadership failures associated with clergy abuse and articulates a commitment to confront the problem and to prevent future clergy abuse • Contains 17 articles that detail a comprehensive approach related to sexual abuse of minors in the US Catholic Church • Revised 4 times since its initial publication in 2002 • Among other components establishes - Lay advisory board, National Review Board - Commits to regular auditing process and public reporting of compliance with 17 components Requires all dioceses to institute "safe environment" training for children and adults (including clergy, staff and volunteers) in church environment
	Nature and Scope Study released 2004 • Conducted by John Jay College of Criminal Justice at The City University of New York • Key Findings around the epidemiology of clergy sexual abuse between 1950 and 2002: - Documented 10,667 minors known to have been abused by clergy in that 52 year period. - Documented 4,392 priests and deacons who had credible allegations of clergy sexual abuse against them. This was out of a total of 109,694 clergy in ministry during those years (~4%). - Majority of reports (44%) received between 2000 and 2002 with many demonstrating a 20 to 30 year lag time between abuse and reporting Cases peaked the end of 1960s and throughout 1970s with steady decline during 1980s and 1990s
	Causes and Context Study, released 2011 • Conducted by John Jay College of Criminal Justice at The City University of New York • Key Findings around factors that led to the surge of abuse cases identified in Nature & Scope Study. Explored factors at: - seminaries - parish level - society at large - leadership level Recommended situation prevention efforts to create an environment where sexual abuse of minors by clergy or other adults would become more difficult to commit
	Audits (conducted annually since 2003) • 194 of 197 dioceses participated in the annual audit • Between July 1, 2018 and June 30, 2019, 4,434 allegations of abuse were reported by 4,220 victims/survivors of child sexual abuse by clergy from the 194 participating dioceses. - Most were historical reports of now adults who reported past abuse when they were minors - 37 of the 4, 434 allegations were by current minors - 8 were substantiated - 12 remained in investigation - 7 were unsubstantiated - 6 were indeterminate - 3 were referred to a religious order and 1 to another diocese for investigation

Select Christian denominations' response and prevention efforts

In the early 2000s, Basyle Tchvidjian founded "Godly response to abuse in the Christian environment" (GRACE). As a former child abuse prosecutor and the grandson of Billy Graham, Tchividjian enlisted support from prominent experts in the field and across the faith community. GRACE conducted child abuse investigations at major Christian institutions, including Bob Jones University and New Tribes Mission. In addition to assessing past failures to address child abuse, GRACE launched an initiative called the "Safeguarding Initiative" which provides in-person training and direct assistance to churches in developing policies uniquely tailored to their ministries (48). GRACE's Safeguarding Initiative (www.netgrace.org/safeguarding-initiative) is a comprehensive process that includes:

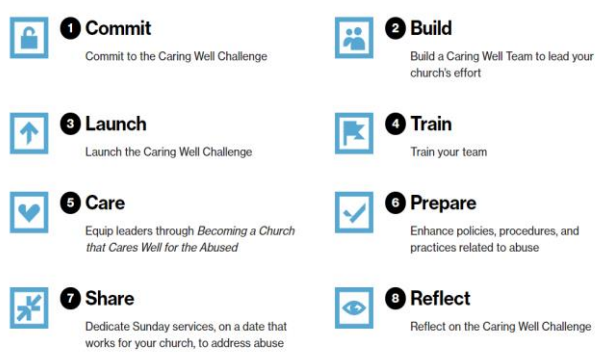
- In-person, expert training for every level of the church: leadership, adults, youth, and children;
- Establishing a safeguarding team to help implement all policy "best practices" customized to the church's ministry;
- On-site building risk assessment;
- Implementing specific steps to create a healing environment for survivors.

In 2019, the Southern Baptist Convention launched an initiative called "Caring well," which includes free online training, a hiring guide for screening employees and volunteers, a listing of recognized training programs, and other resources (16). This report was commissioned by the President of the Southern Baptist Convention (SBC) to address the crisis of sexual abuse within its congregations. The report led to a "Caring Well" (https://caringwell.com/) initiative designed to provide education on child abuse, to assist congregations in implementing policies, and to address the spiritual needs of survivors of abuse. The report was published in 2019.

Table 2. Caring well

https://caringwell.com/

This report was commissioned by the President of the Southern Baptist Convention (SBC) to address the crisis of sexual abuse within its congregations. The report led to a "Caring Well" initiative designed to provide education on child abuse, to assist congregations in implementing policies, and to address the spiritual needs of survivors of abuse. The report was published in 2019.



The Wisconsin Evangelical Lutheran Synod, the third largest Lutheran body in the United States, has developed a special ministry on child abuse called "Freedom for the Captives," a phrase drawn from the words of Jesus (Luke 4:18). The ministry includes a free online training as well as assistance to churches in receiving in-person training (49). The ministry has developed a number of resources to assist congregations not only in policy development but in ministering to the spiritual needs of abused children and adult survivors. Freedom for the Captives seeks to empower the Christian community to respond with excellence to the sin of child abuse. To this end, Freedom for the Captives: (https://freedomforcaptives.com/)

- Provides resources to pastors, teachers, and lay Christians that will deepen their understanding of child abuse and improve the Christian response to the physical, emotional and spiritual impact of maltreatment;
- Offers resources for survivors including recommended readings and guidance in selecting counseling or other services;
- Gives direct assistance to individual survivors who may have a spiritual question not addressed on the website or who need assistance in finding a counselor.

Victor Vieth, the Director of the Zero Abuse Project, offers a practical ten-step outline to faith-based organizations interested in developing and implementing policies to create a safe environment for children in their houses of worship (50):

1. Consult with at least one child abuse expert in developing policies.
2. Understand that insurance providers and some law firms have a vested interest in preventing future abuse as well as suppressing information about past abuse.
    a. Victims often want an explicit apology, and hearing only silence engenders anger and a sense that litigation is their only recourse.
    b. A thorough review of all potential abuse by an alleged perpetrator is essential in order to avoid overlooking other possible cases.
3. Limit the opportunity for sex offenders to access children through:
    a. Ensuring two-deep leadership; children should always be in the care of at least two church workers;
    b. Respecting the privacy of children and adolescents when in locker rooms, showers and restrooms;
    c. Separating sleeping accommodations for children and unrelated adults;
    d. Limiting or prohibiting events at workers' homes and, if these events are deemed necessary, implementing appropriate policies;
    e. Prohibiting employees and volunteers from wearing t-shirts or other apparel with sexually explicit language or images that may create opportunities for inappropriate sexual conversations or behaviors with or around youth;
    f. Prohibiting sexual jokes, comments and behaviors;
    g. Requiring windowed rooms and open doors, reinforcing that adults and children not be isolated or not visible to others;
    h. Prohibiting corporal punishment.
4. Conduct a background check and oral screening of workers and volunteers.
5. Teach personal safety to children in faith-based schools.
6. Don't investigate; report.

7. Develop church policies for sex offenders who wish to attend services or to join a congregation.
8. Be cognizant that some offenders are seeking "Cheap Grace:"
    a. Mouthing words of repentance may mask the manipulative intent of someone who seeks to take advantage of the church's desire to support those who are remorseful.
    b. Offenders must be willing to comply with accountability measures and appropriate notifications and safeguards to be permitted to be in the church environment.
9. Develop policies for responding to an allegation within a faith community.
10. Policies must be accompanied by training.

Each of these steps, when undertaken thoughtfully and with expert guidance, can help to ensure that faith-based organizations protect youth through education, transparency, planning, and policy-making.

Selected Jewish response and prevention efforts

Sacred Spaces was founded in 2016 to address issues of institutional abuse in Jewish communities across North America. Operating with a partnership rather than advocacy lens, Sacred Spaces supports Jewish institutions in developing comprehensive, culturally-specific, abuse prevention programs and in responsible and ethical handling of instances of abuse. In the Summer of 2017, "Institutional abuse in the Jewish Community" was published by The Rabbinical Council of America and explored three foundational categories of error in Jewish communal responses to reports of sexual abuse – psychological, legal, and *halakhic* (Jewish legal) – and provided recommendations for avoiding these common missteps (31). Also in 2017, a Jumpstart report focused on the state of child safety in Jewish Day Schools and summer camps noted that schools in particular lack robust training and comprehensive policies. In the spring of 2020, Sacred Spaces launched a cutting-edge child safeguarding initiative called Aleinu (www.AleinuCampaign.org), Hebrew for "It's on us," emphasizing the need for adults to take the lead in protecting children. By using an interactive web-platform, Aleinu minimizes costs to increase accessibility for individual institutions. Aleinu outlines ten best practices in child protection, providing step-by-step goals and resources for implementing them in Jewish communities, and provides participating organizations with a community of practice and biweekly office hours for expert consultation. Aleinu's Best Practices include:

- Form a child safety committee;
- Create opportunities for community dialogue;
- Screen employees and volunteers;
- Assess your space;
- Implement guidelines for interacting with youth;
- Train adults;
- Support victim-survivors;
- Develop protocols for responding;
- Empower youth;
- Maintain & evaluate your Child Safety Program (51).

Each best practice includes multiple user-friendly resources and opens with a Hebrew quote, framing that particular safeguard as a moral Jewish imperative. In addition, tools are tailored to provide specific, practical guidance within a framework of safeguarding and Jewish faith. For instance, Best Practice 2: Create Opportunities for Community Dialogue, includes Jewish text studies clergy can use to engage their congregations and root the work in Jewish values and tradition; Best Practice 8: Develop Protocols for Responding, includes rabbinic rulings addressing Jewish legal constructs (*halakhah*) that might hinder reporting, such as the prohibition against slander or the requirement to judge another Jew favorably. The online platform allows youth-serving organizations to extend their safeguarding work to virtual spaces to meet the challenges of increasing online programming for youth. In addition, in the spirit of ecumenism and sharing of best practices, two Christian organizations have begun to adapt some of Aleinu's resources (www.AleinuCampaign.org).

LOOKING FORWARD

Despite the profound need articulated at the outset of this chapter for more work to be done in confronting and eliminating child maltreatment in houses of worship, it is encouraging to see the range of efforts across faith traditions that have emerged from a concerted effort to address child maltreatment. Recognizing that houses of worship are indeed places where maltreatment occurs, we must remind ourselves and one another that the risk of "gaze aversion" remains. Coined by Krugman and Leventhal (52) in their description of society's general response to child maltreatment, gaze aversion is the intentional or inadvertent disregard of our moral imperative. "To directly look means tackling the problem head on, and that requires an effective" set of structures and response approaches "commensurate with the extent of the problem" (52). The approaches outlined in this chapter highlight faith-based communities' newfound willingness to look directly at the issue of child maltreatment, acknowledge its presence, and create the necessary tools to fight it.

Situational prevention approach

The content presented herein also demonstrates the relative complexity of this task, both within and across houses of worship, owing to faiths' varying traditions, worldviews, and governance structures. With such diverse organizational issues, embracing a paradigm that allows for broad application of principles to a set of varying contexts offers the most flexibility and pragmatism moving forward. Kaufman and colleagues (53-55) suggest such a paradigm, the Situational Prevention Approach, that focuses on refinements in children's environments. This approach is currently being modified and applied to YSOs that serve young elite athletes who are training and competing with the Olympic/Paralympic movement.

Situational Prevention strategies have also been explored by criminal justice scholars Terry and Ackerman in the context of the US Catholic Church (56). The components of the Situational Prevention approach have somewhat counterintuitive labels but are nonetheless promising in this field. The four components are: 1) increasing effort; 2) increasing risk; 3)

controlling prompts; and 4) reducing permissibility (56). Applying these four subcategories to the prevention of clergy sexual abuse produces these suggestions:

1) Increased effort (referring to reducing the opportunity for abuse): This component refers to increasing the effort an individual would need to expend in order to offend. It includes screening those with a known history or particular red flags as well as reducing situations where individuals will be alone with children.
2) Increasing risk (which means increasing the likelihood of detection): This step begins with education and training around risky situations as well as implementing policies and procedures that limit risk and enhance surveillance within the environment.
3) Controlling prompts (referring to identifying and removing situational triggers): This step reminds organizations to eliminate situations that may prompt an individual to offend, such as having access to an isolated area with a single child.
4) Reducing permissibility (which means enhancing accountability): This step teaches organizations to have codes of conduct that clarify clergy and adults' responsibilities, set clear rules, and clarify consequences for policy violations as well as for actual incidents of maltreatment (56).

These four components of the Situational Prevention model are general enough to be widely applicable and specific enough to guide action. Consistent with the various calls to implement safe environments in faith-based communities, this approach is worthy of further consideration. An overarching model guiding action can, over time, prompt additional improvements, with enough flexibility to allow for refinement.

Although the Situational Prevention model holds promise, this approach has its critics and is best viewed not as a panacea but as a first step. Given the need to also address physical abuse, emotional abuse, neglect and other forms of maltreatment, as well as the need to address abuse in the home, we also include a broader approach in our recommendations below.

RECOMMENDATIONS

Faith communities can respond to the information contained in this chapter in a number of important ways. We have enumerated some of these steps below. While each of them is ultimately necessary, taking any first step may be the most difficult, so we encourage faith leaders to read the following recommendations and begin at the point that feels most immediately doable to you, committing to addressing additional suggestions gradually, ultimately leading to a safer environment for youth in your community.

Perhaps most broadly, faith communities must address and implement theological reform. Many faith communities overlook the significance of texts pertaining to children in each of the world's major religions (57). Equally important, faith leaders must analyze and apply these texts to instances of child maltreatment. Although there is some movement among theologians in this regard (58, 59), more can be done. A focus on the obligations towards children contained in sacred texts brings child protection to the forefront of the community's attention, making it an ongoing priority. Such analysis can also prove critical in addressing the spiritual needs of children and adult survivors, many of whom have profound questions about these writings.

Faith communities should create faith-specific initiatives to robustly support their institutions in safeguarding initiatives. The initiatives detailed above have begun to address abuse that may have seemed intractable at one time and can serve as inspiration to a wide range of traditions. Some faith structures include hierarchies, like the Catholic Church, through which large-scale change can be enacted. Less hierarchical systems may leave the protection of children and adolescents dependent on individual institutions, but programs like Aleinu can provide a manageable roadmap and critically needed support and fellowship for such communities.

Faith leaders can work across faith communities to learn from one another's efforts, building on successes and adapting to fit the unique culture, needs, and risks of each tradition. While significant theological differences exist between faith traditions, we also recognize many similarities in how faith communities discuss and respond to child maltreatment. The authors of this chapter have collaborated on such efforts, which can be replicated more broadly. In addition, houses of worship are implicitly YSOs, so innovations that emerge from YSO prevention work are likely applicable in faith-based environments.

Faith communities should be proactive in addressing the spiritual needs of maltreated children and adult survivors. Healing is a fundamental core value among most faith traditions. Prioritizing survivors means not only educating faith leaders about the spiritual impact of trauma, but teaching them how to deliver a trauma-informed sermon or Bible study as well as how to coordinate spiritual care with medical and mental health care (60, 61).

Child protection policies and safe environment training programs should focus on two areas: the risk of and harm from maltreatment within the faith-based environment AND the risk and harm related to maltreatment outside of the house of worship in the home, school, and community. An emphasis on protecting children only within the house of worship may have been a useful first step decades ago, but faith leaders and researchers in the field of abuse prevention now know more about maltreatment risk and harm. Simply stated, faith communities, which necessarily address the well-being of the whole person or family, should seek to address abuse in the home in all its forms, including sexual abuse, physical abuse, emotional abuse, neglect and witnessing domestic violence.

Faith-related institutions that prepare future spiritual leaders should implement undergraduate and graduate training that enables developing faith leaders to respond to all forms of victimization and to serve as community leaders in prevention. The national movement "Child Advocacy Studies" (CAST) has implemented intensive courses in 85 institutions of higher education (62). As of this writing, eight peer-reviewed studies have found that these courses dramatically improve the skills of professionals in responding to abuse (63). However, few faith-based institutions have implemented this reform and, as of this writing, only one seminary. The faith-based community is poised to lead others on this issue, and education of faith-based professionals as well as parishioners is a crucial step in this direction.

Faith communities can develop effective partnerships with child protection professionals, including Children's Advocacy Centers (CAC). Many abused children raise spiritual questions during the course of a child abuse investigation, and many CACs have developed loose connections with some faith leaders (64). Some CACs even partner with a full-time trauma-informed chaplain who advises child protection professionals in addressing the spiritual needs of abused children and their families (28). Joining this network and having partners on whom to call can advance faith-based organizations' prevention and response efforts.

Finally, faith leaders should improve their skills in ministering to sex offenders or other people who have harmed youth. Drawing on their belief in every individual's potential for repentance, many faith leaders have made harmful errors by permitting access to individuals with a known history of offending into their communities. Knowing more about sexual offending and risk, as well as coordinating spiritual care with a seasoned sex offender treatment provider, can play an important role in reducing the risk of re-offense and protecting and supporting all members of the community (65, 66).

In summary, this chapter calls for action to avoid the tendency to avert our gaze from the reality of child maltreatment in the faith-based setting. Such action requires an effective response to victims and survivors as well as prevention efforts to eliminate the harm before it ever happens.

In order to achieve both prevention and response, we must view the world through the lens of those who are hurting. Lutheran minister Dietrich Bonhoeffer, who was executed by the Nazis because of his opposition to the government, called on the faith community to see the world "from below, from the perspective of the outcasts, the suspects, the maltreated, the powerless, the oppressed, the reviled, in short, from the perspective of the suffering" (67). Rabbi Avi Weiss writes, "The test of spirituality … is not how the community receives the most powerful, but how it welcomes the most vulnerable" (68). Faith leaders, regardless of faith tradition, are best poised to witness suffering and commit to reforms, engaging in the hard work necessary to make all houses of worship, and the communities that surround them, places of safety and healing for the children entrusted to their care. A path to this goal exists, as this chapter has demonstrated, and we encourage all faith leaders to begin walking that path in fellowship with one another and with their communities.

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Chapter 17

ADOLESCENT ABUSE: SELECTIVE ISSUES INCLUDING PREVENTION

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ABSTRACT

Abuse (physical, sexual, neglect) of adolescents is a serious phenomenon in society that has been present since the dawn of human civilization. This discussion considers certain perspectives in this area, specifically incest, sibling to sibling abuse and the adolescent sexual predator. The psychological effects of such abuse are cataclysmic for these persons with lifelong as well as generation to generation impacts for these persons, their families and for society in general. Concepts of management and prevention are considered.

INTRODUCTION

The abuse of and by adolescents remains a sorrowful story in all societies in the past and the present; without appropriate preventive measures, it will continue unchecked in the future of *Homo sapiens* (1). In this disquisition, we look at specific aspects of this complex topic: incest, sibling to sibling abuse, and one potential result of childhood abuse---the adolescent sexual predator. It is humbling as well as terrifying to see that such abuse has been recorded in accounts

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of human beings dating back to the dawn of human life. For example, the story of incest is found in the archetypical Old Testament figure, Lot, over 4,000 years ago.

> "Lot and his two daughters left Zoar and settled in the mountains, for he was afraid to stay in Zoar. He and his two daughters lived in a cave. One day the older daughter said to the younger, "Our father is old, and there is no man around here to give us children—as is the custom all over the earth. Let's get our father to drink wine and then sleep with him and preserve our family line through our father." That night they got their father to drink wine, and the older daughter went in and slept with him. He was not aware of it when she lay down or when she got up. The next day the older daughter said to the younger, "Last night I slept with my father. Let's get him to drink wine again tonight, and you go in and sleep with him so we can preserve our family line through our father." So they got their father to drink wine that night also, and the younger daughter went in and slept with him. Again he was not aware of it when she lay down or when she got up. So both of Lot's daughters became pregnant by their father. The older daughter had a son, and she named him Moab; he is the father of the Moabites of today. The younger daughter also had a son, and she named him Ben-Ammi; he is the father of the Ammonites of today." (Genesis 19: 30-38)

Theologians, philosophers, psychologists and other scholars provide various interpretations of this story that include the common theme of ancient and not-so-ancient human history about the need to continue the human race no matter the obstacles. If appropriate or suitable mates are not found for females of child-bearing age, then father-daughter incest becomes a method of continuing the family lines. Indeed, brother-sister incest is seen even earlier in the Old Testament, as Cain, son of the first *Homo sapiens sapiens* (Adam and Eve), married his sister Awan (2).

Royal families, such as seen in the ancient dynasties of Egypt, utilized brother-sister incest to provide the "proper" protection of "appropriate" blood lines who could remain in power and authority (2, 3). The overt abuse of such arrangements can be identified in the Old Testament account dating back to 1,000 B.C., describing the actions of Amnon, son of the ancient King David; in this account from 2 Samuel 13: 9-14, Amnon rapes his half-sister, Tamar:

> "Send everyone out of here," Amnon said. So everyone left him. Then Amnon said to Tamar, "Bring the food here into my bedroom so I may eat from your hand." And Tamar took the bread she had prepared and brought it to her brother Amnon in his bedroom. But when she took it to him to eat, he grabbed her and said, "Come to bed with me, my sister.""No, my brother!" she said to him. "Don't force me! Such a thing should not be done in Israel! Don't do this wicked thing. What about me? Where could I get rid of my disgrace? And what about you? You would be like one of the wicked fools in Israel. Please speak to the king; he will not keep me from being married to you." But he refused to listen to her, and since he was stronger than she, he raped her."

The tragedies and trials of human life were as also depicted by ancient Greek writers, as illustrated by Sophocles (497-405 BCE), whose classic play, Oedipus Rex (429 BCE), immortalizes incest (4). Oedipus murders his father (Laius), becomes king of Thebes, and then marries Jocasta—his mother. According to Sophocles, the result of such horror was terrifying

tragedy: Jocasta hangs herself, Oedipus gouges out his eyes and provides this classic lament analyzed for over 2½ millennia by countless humans of various education:

> "….that I was fated to lie with my mother,
> And show daylight an accursed breed
> Which men would not endure, and I was doomed
> To be murderer of the father that begot me." (4)

Sexual abuse of children and adolescents was an accepted aspect of family life, and the first law in Western civilization that was against incest of children and adolescents was in 1280 AD in England, though it was not called a crime until 1908 in England (1). Sigmund Freud (1856-1939) theorized about the conceptualization of the Oedipus complex and its effects on human mental health (5, 6). In this still controversial concept, the son develops a desire for sexual behavior with the mother that is usually unresolved and leads to extreme negative feelings for the father as the rival sexual person; similar feelings in the daughter for the father is termed the Electra complex, as theorized particularly by Carl Gustav Jung (1875-1961). Freud had originally thought his patients were sexually abused by their parents, but abandoned this 'seduction hypothesis' when he did not want to believe that such abuse occurred so frequently (and some say he sought favor among his professional colleagues).

Despite the long historical context of such incest, scholars of the 19th and 20th centuries have explored the natural aversion that children typically have for intra-sibling incest (7). The Finnish sociologist/philosopher, Edward Alexander Westermarck (1862-1939), noted that the incest avoidance concept (incest taboo) was a normal concept for children in the same family (7). Conclusions in this regard by Charles Darwin (1809-1882), the English naturalist as well as geologist scientist, were that incest aversion was based on a nonconscious practice rooted in concerns over genetic kinship or congruence (**7**).

Research over the past two centuries has supported this concern by noting the potential increased risks for the offspring of incest that includes recessive genetic disorders, congenital defects, preterm birth, and neonatal mortality (8-10). The reality and effects of incest continue to be debated in current society that involves the under-pinnings of biology, theology, philosophy, and history (11-14).

INCEST

Sexual contact within a family up to the 5th degree of blood relationship (consanguinity) defines the term *incest* (1, 2). *Sexual exploitation* is defined by non-sexual contact of a minor in which s/he is engaged in pornography, observes sexual behavior of others that includes watching adult (s) exposing him/her/them to the minor, and other activities done for the pleasure of the adult that is not appropriate for minors. The victim of *sexual abuse* can be a child or adolescent who can be abused by a family member and/or non-family member for the pleasure of the abuser; these activities can include penetration, sodomy, rape, incest, genital fondling and indecent exposure (15-18).

A classic study alerting 20th century society to the reality of incest was the work of Samuel Kirson Weinberg (1912-2001); his 1963 publication looked at 103 cases of incest that was classified as father-daughter incest (78%), brother-sister incest (18%), mother-son incest (1%),

and multiple incestuous behavior (3%) (19). Such work was part of other researchers' conclusions that incest is one piece of a larger puzzle of sexual abuse that involves children and adolescents. For example, one study noted that 30% of adult females report being sexually abused as minors (20).

An important influence in the sexual abuse of minors is the strong prevalence of paraphilic disorders in the adult population; this involves 3-5% of adult men having pedophilic disorder, up to 30% of men with frotteuristic disorder, 12% of men (plus 4% of women) having voyeuristic disorder, 2-4% of men having exhibitionistic disorder, 2-3% of men having sexual sadism disorder, and 2.2% of men (1.3% of women) having sexual masochism disorder (15). Minors can become targets of such paraphilic disorders, and this overall cataclysmic reality is complicated by family dysfunction, substance use disorders, and other problems; also, much effort is spent by the perpetrator to keep the victim(s) silent about this behavior (21-25).

Children and adolescents can be exposed to offending parents as well as offending stepfathers, stepmothers, parents' boyfriends/girlfriends and others. Clinicians need to be vigilant to such events in the lives of their pediatric patients (children and adolescents) that can involve incest or broader issues of sexual abuse that need comprehensive evaluation and management (26-28). Comments regarding different types of incest are now provided.

(Step)father-daughter incest

As noted by Weinberg's 1963 report, (step)father-daughter incest appears to be the most common form of overall incest (19). Another well-known researcher, David Finkelhor, noted that 5 of every 1,000 college females identified as being victims of father-daughter incest (29-31). Research around the world confirms this reality (32-35). This includes a 2014 study from Turkey detailing 43 cases of incest involving 36 females and 7 males; father-daughter incest was found in 34.9% (32).

The sexual abuse of daughters by fathers and step-fathers can involve children and adolescents as well as extending the abuse in the same person from childhood into adolescence. As with abuse in general, psychological effects in the victim can be severe as well as lifelong, and includes chronic depression, anger, low self-esteem, anxiety, risk-taking behaviors, problems being a parent later in life, psychosis or psychotic-like behavior, and others (1, 33-38). The abuse can be both sexual as well as physical while contact between abuser and victim may last for many years. A key factor in treatment is to intervene as soon as possible and prevent contact between the abuser and incest victim as early as possible (36).

A historical illustration of the complex and devastating relationship that may arise in such incest cases is found in writings of Theodosia Burr Alston (1783-1813); she was the daugher of Aaron Burr (1756-1836) who became a vice-president of the United States. She wrote:

> "You appear to me so superior, so elevated above other men. I contemplate you with such a strange mixture of humility, admiration, reverence, love, and pride, that very little superstition would be necessary to make me worship you as a superior being…I had rather not live than not be the daughter of such a man. (39)"

Brother-sister incest

As noted, such incest has long historical and Biblical dimensions in human cultures involving families of kings, pharoahs, and other leaders (1, 2, 19, 32, 40). Family dysfunction can be so rampant that such behavior can be considered acceptable in families and even involve the abuse of females by multiple brothers on their sister or sisters (41). Its presence can hidden in the family or involve substance use disorder by the abuser, multiple forms of abuse, and a severe destructon of otherwise assumed trust within families (42, 43). The impact on the victim is chronic, devastating, and lifelong—requiring comprehensive therapy (44).

Other examples of incest

Unfortunately, many other types of incest can be found in such reports, such as *mother-son incest*. Indeed, this is a difficult type to understand and even identify as it seem to be rare and can be subtle and difficulties arise in separating out actions of a normal loving mother from a mother who overtly sexually abuses her son (45-47). Tender caressing can become sexual penetration with the son and more rarely with a daughter (48, 49).

The victim can be a child or adolescent while identified mothers can have severe psychiatric and sexual disorders (50). The victim, as with other sexual assault, can develop severe psychiatric and behavioral symptomatology/disorders including depression, post-traumatic stress disorder (PTDS), anxiety, anger, suicidality, substance use disorders, identity problems, difficulties in forming normal adolescent or adult relationships, sexual dysfunction and others (47, 51-53). Less recognized and appreciated is that sexual abuse of the child or teenager can be by uncles, cousins, grandparents and others in which the victim can be abused by various and multiple intrafamilial members; grandparents may abuse family members across generations (41, 54-58).

The results of such sexual assault, often combined with various degrees of neglect and physical assault and threats, are considerable emotional sequelae for the child and adolescent victim lasting a lifetime (1, 16). Research findings from the Adverse Childhood Experiences (ACE) studies for pediatric persons of all ages reveal horrific impacts leading to major psychiatric sequelae impacting all areas of life in childhood, adolescence and adulthood (23, 27, 59-78). The reality and impact of incest also arise out of the larger phenomenon of sibling abuse that is considered now.

SIBLING ABUSE

A key part of abuse of children and adolescents is sibling abuse, the most common form of abuse that members of families must endure in their various trials and tribulations. Such abuse has been covered over the eons of human civilizations in its writings. For example, the first murder noted in antiquity was Cain killing his brother, Abel, over perceived favoritism:

> Now Cain said to his brother Abel, “Let’s go out to the field.” While they were in the field, Cain attacked his brother Abel and killed him. (Genesis 4:8)

Sometimes sibling to sibling abuse can be by multiple siblings on a younger one as seen in the Old Testament story of Joseph because it was concluded by Joseph's brothers that he was loved by the father (Jacob) the most of all the brothers:

> Genesis 37:3
> Jacob loved Joseph more than any of his other children because Joseph had been born to him in his old age. So one day Jacob had a special gift made for Joseph—a beautiful robe.
>
> Genesis: 37:17-20, 26-28: So Joseph went after his brothers and found them near Dothan. But they saw him in the distance, and before he reached them, they plotted to kill him. "Here comes that dreamer!" they said to each other. "Come now, let's kill him and throw him into one of these cisterns and say that a ferocious animal devoured him. Then we'll see what comes of his dreams."
>
> Judah said to his brothers, "What will we gain if we kill our brother and cover up his blood? Come, let's sell him to the Ishmaelites and not lay our hands on him; after all, he is our brother, our own flesh and blood." His brothers agreed. So when the Midianite merchants came by, his brothers pulled Joseph up out of the cistern and sold him for twenty shekels[a] of silver to the Ishmaelites, who took him to Egypt.

FREQUENCY OF SIBLING ABUSE

Research from the 20th and now 21st centuries have revealed that stories from religious and fictional authors (including classic childhood fables) reflect the sad truth that siblings often do abuse young siblings in a variety of ways that include physical and sexual abuse (79-83). Hotaling and colleagues published on intra-family violence noting that 37% of 498 children from "non-pervasively" abusive families admitted to performing one or more "serious" aggressive actions on one or more of their siblings; in so-called "pervasively abusive" families, 100% revealed sibling to sibling abuse (79). Other 20th century research concludes that 3 in 100 siblings are "dangerously violent" toward a sibling—typically an adolescent or older child to a younger child (80, 81).

An early 21st century publication reported on a 10 year female killing her 6 months old sister (also female) by throwing her out of a window (82). Etiologic aspects of this killing included diagnosis of autism spectrum disorder and epilepsy with the aggressive sibling and severe dysfunction noted in the family (83).

Though death is typically not the outcome of such abuse, the abuse results in considerable psychological injury to the victim(s) (84-90). One study of sibling to sibling abuse noted that there was pushing or shoving in 74% of siblings, biting/punching in 42%, and regular verbal abuse in 85% (84). Other research reports over half of older siblings are severely aggressive to younger ones and that such abuse is more common than abuse from spouse-to-spouse or parent to child (81). David Finkelhor has reported his work with college students in which 15% of the college females and 10% of the college males noted they had been raped by a sibling (86). Sexual and physical abuse from sibling to sibling abuse can be repeated over many years with resultant major psychogical damage to the victim (s) (87-90).

ETIOLOGIC FACTORS BEHIND SIBLING ABUSE

The reasons that adolescents or older children abuse their younger siblings are many and often reflect underlying family dysfunction (85). The Old Testament stories of Cain murdering Abel or Joseph being almost killed and then traded into slavery were due to feelings of jealousy that are typical is many families—siblings feeling that some are loved more or treated better by parents than others. The well-known French writer, Charles Perrault (1628-1703), penned the classic childhood fable, Cinderella, who suffered at the hands of a jealous step-mother (91). Such stories reflect family violence seen in the media (i.e., television, movies, internet) and in research (85). There may be a spouse abusing another spouse and turning to a younger child or teen in the family.

Siblings can observe such abuse or be victims of such violence and then abuse other siblings in a "second-hand" abuse pattern (92). Families may have absent parents, step-parents who do not bond with their step-children, step-siblings who do not bond with step-siblings, and many other relationship complexities (85). Few parents receive comprehensive parental skills training and may deny such abuse in their families or choose to ignore it in order to keep their current abusive spouse. Family violence is also a mirror for the violence found in all societies that may have helped humans survive over the past millennia in a savage world (85, 93). The damage to the abused can be severe and require intensive therapy over much time to improve (85, 89, 90).

> [Jack] tried to convey the compulsion to track down and kill that was swallowing him up.
>
> "I went on. I thought, by myself—"
>
> The madness came into his eyes again.
>
> "I thought I might kill"
>
> Lord of the Flies (William Golding, 1954)

> All at once, Robert was screaming and struggling with the strength of frenzy. Jack had him by the hair and was brandishing his knife.
>
> Behind him was Roger, fighting to get close. The chant rose ritually, as at the last moment of a dance or a hunt. "Kill the pig! Cut his throat!
>
> Kill the pig! Bash him in!" Ralph too was fighting to get near, to get a handful of that brown, vulnerable flesh. The desire to squeeze and hurt was over-mastering
>
> Lord of the Flies (William Golding, 1954)

It is important to note, however, that sibling rivalry is different from sibling abuse. Jealousy, squabbling and competition are normal sibling behaviors. Fighting between equals is common. A sibling rivalry is reciprocal and typically motivated by parental attention. Sibling abuse takes place when one sibing is bullying a weaker, usually younger sibling more than occasionally, so that the bullying forms a pattern. This bullying causes harm to the other sibling, disempowers them and incites fear or distress. Sibling abuse can be physical, sexual or emotional.

Children who are victims of sibling abuse may complain of headaches, stomachaches, sleep and eating disorders. They experience nightmares and phobias. Adult survivors of sibling abuse may have "survivor trauma," struggling into adulthood with feelings of shame, depression,

unhealthy boundries, somatic complaints and fear of the dark. Sibling abuse is linked to codependency as well, as survivors demonstrate "pleasing behaviors," lack assertiveness and are without the skills to protect themselves from dangerous relationships (94).

ADOLESCENT ABUSE: CONCEPTS OF MANAGEMENT

Clinicians who care for adolescents should be involved and emersed in the extraordinary effort to identify teens who have been abused (physical, sexual, neglect) and help get them into treatment for physical ailments and psychological-psychiatric-behavioral management of mental health problems/disorders that are found (95-97). One should avoid blaming the parent who did not abuse versus the parent who was the perpetrator (96, 97). Clinicians and therapists should seek to intervene to stop intergenerational abuse, get the offender to take responsibility for his/her actions, manage all victims (female and male), and encourage further research in this complex and confusing area (98-103). Trust has been broken, and therapy seeks to repair this betrayal of trust and looks for ways of abuse prevention (85, 103-107).

Clinicians must also be *trauma-informed*. Many medical exams, by necessity, are invasive. They involve asking sensitive questions, examining intimate body parts and delivering uncomfortable treatments. Clinicians may encounter resistance to medical treatment by trauma survivors for these reasons, or trauma survivors may withhold important information.

Because trauma is so common, clinicians should assume their patients have experienced trauma and deliver care by three trauma-informed principles: *safety, empowerment and healing*. Trauma-informed care includes: a) always asking for permission (*safety*); b) offering control to the patient (*empowerment*); and c) finding support for survivors of trauma (*healing*) (108).

Clinicians should also be aware that the treatment for traumatic stress goes beyond cognitively-oriented therapies ("talk therapy"). Because traumatic experiences are stored in the brain stem, therapies that create mind-body integration may offer more relief to patients than traditional talk therapy. Eye Movement Desensitization and Reprocessing (EMDR), Theraplay, Sensorimotor Training, and Trauma-Sensitive Yoga have proven effective in calming unbearable body sensations experienced and often described by trauma survivors (109, 110). In one study, just five days of EMDR and Trauma-Sensitive Yoga reduced symptoms in 9 of 12 patients (111).

ADOLESCENT SEXUAL PERPETRATOR

One of the aspects of management considered now is the adolescent who has a history of physical or sexual abuse and becomes an adolescent sexual perpetrator (112-114). The data on youth sexual perpetrators is limited and includes that from the Juvenile Justice Delinquency and Prevention division of the National Center on Sexual Behavior of Youth (NCSBY) and a few other sources (115-118). Primary care clinicians may see these youth because of reports by parents of such sexual abuse, admission by the adolescent offender, and/or because of a legal referal for evaluation.

Adolescent sex offenders refers to those between 13 and 17 years of age who perform sexual behavior that is considered illegal sex crimes based on crime statutes in their area; exact

definitions of sexual crimes or offenses can vary from state to state (119). Most youth are not sexual predators and do not meet official definitions for pedophilia (15). However, children and adolescents under the age of 18 years are identified in one-fifth of arrests for all sexual offenses (that do not include prostitution) (112). Youth do commit over one-third (35.6%) of the sexual victimization of children, though under 1% of arrests of those 17 years of age and younger are for sexual offenses (112-114). Annually, there are about 2,200 arrests of youth for committing forcible rape; approximately 9,200 arrests of youth (mostly males) occur each year for various sex offenses (115-118).

Evaluations of these adolescent sexual predators reveal many complex, underlying factors that include being victims of abuse themselves; however, there are also many features of family dysfunction, cognitive limitations, impulse control behavior, access to children to abuse, exposure to pornography (erotica), psychiatric co-morbidity and others (15, 27, 112-114, 120). Such co-morbidity includes conduct disorder, substance use disorders, mood disorders, attention-deficit/hyperactivity disorder, specific phobias, and adjustment disorders (112).

Most of the sexual crimes (offenses) are done by a relatively small number of adolescent perpetrators who become repeat offenders and come from all socio-economic backgrounds (112-114). Psychiatric evaluation typically diagnoses the male offender with antisocial behavior and paraphilias while the less frequent female offenders are typically diagnosed with mood disorders and involvement with self-mutilation (112-114, 117, 121).

MANAGEMENT OF SEXUAL OFFENDERS

Treatment of adolescent sexual predators is difficult and in need of further research to established evidence-based guidelines (112). Management typically occurs in community-based programs, and these youth often re-offend despite treatment (112-114). Multisystemic therapy (MST) appears to offer the best currently available treatment program for youth involved in antisocial and sexual predator actions; however, recidivism remains high, though not as high as seen with *adult* sexual predators (122). Trauma assessments should be completed on all sex offenders to gain context in the patient's trauma history, accurately diagnose the patient, and prescribe treatment approaches likely to be successful (123).

Parents of these youth may not be able to differentiate normal from abnormal "sex play" or sexual activity, and clinicians who work with these youth and/or are involved in juvenile or adult court evaluations should have specific training in this area. Clinicians must have clear understanding of concepts of confidentiality versus mandatory reporting laws in their area.

Protection of younger children from adolescent or adult sex predators should be paramount in the minds of involved clinicians and parents. Adequate supervision of young children in this regard is always important, and youth should be advised to avoid contact with younger children as necessary (57). Such youth should not be involved in "baby-sitting" activities, should not be involved in viewing pornography sites, and should take part in therapy as available.

States vary with regard to juvenile versus adult court involvement, though certain events (i.e, rape, sodomy, sexual homicide) lead to adult court involvement where penalities for conviction can be harsh and not involve treatment for the sexual offender (112-114). Thus, the best option for these youth is early identification with comprehesive management to reduce repeat offending with potential severe consequences for both victims and predators.

PRINCIPLES OF PREVENTION

Abuse of children and adolescents remains a global affliction that has caused immeasurable physical and mental damage to human beings since the dawn of human civilization. Principles of *prevention* begin with the realization that such behavior is never acceptable (i.e., incest taboo), that such abuse must be brought out of the shadows, that abuse should not occur in childhood or adolescence, that abuse should be stopped in childhood if present, and that negative effects last a lifetime as well as reach across the generations (32, 85, 107, 124-128). If we allow the abuse of children, or even allow children to observe abuse, an adolescent may emerge who abuses his/her siblings and others.

Principles of prevention begin with establishing ways to educate parents and society about causes of abuse in children and continue such vigilance into the adolescent years and beyond. Programs, for example, to teach adolescent mothers about caring for their children can lower abuse that children of teen mothers face (129). A key aspect of prevention is to lower abuse in children and lower psychopathology in the adolescents who emerge from childhood and have an increased risk to be abused or to cause abuse—depending on their earlier experiences (130-134).

Clinicians and society must seek to break the cycle of abuse soon as possible (134). Sexual violence by adolescents can be evaluated, and various methods of intervention can be implemented by clinicians, therapists, and others in society (135, 136). We should talk to, work with, and encourage these youth at whatever stage they are in—being abused, abusing, both—preventing more damage and more abuse remains an important goal of clinicians (137, 138). Etiologic factors behind the adolescent abuser and adolescent sexual perpetrator are complex; however, important aspects of health care in the 21st century include stopping this behavior as soon as possible, preventing its onset, and preventing further abuse such as seen in violent dating practices (139, 140).

Victims of emotional trauma should receive trauma-informed health care and should not be re-traumatized by insensitive or poorly trained health care personnel (141, 142). The present and future of child and adolescent abuse prevention is comprehensive application of measures at all levels: primary, secondary, and tertiary strategies (143). This includes attention to drug use by adolescents, why they use them (i.e., to avoid emotional pain from trauma), and ways to stop dangerous drug use/abuse (144, 145). More research is needed to determine the potential benefit of various pharmacologic agents for management of sexual predator problems; these drugs include testosterone-suppressing agents (i.e., gonadotropin-releasing hormone [GnRH] analogues, antiandrogens, progestogens), selective serotonin reuptake inhibitors [SSRIs] and antipsychotics) (146).

One arena that can serve in the *prevention* approach can be found in the juvenile courts of the United States. Traumatic experiences are common in those being seen in these courts as noted by research concluding that 90% of these youth have had at least one major traumatic event in their lives (147). Adolescents who are in the juvenile and adult courts of law are at risk of developing a dangerous and violent pattern of recidivism with potential harm to themselves and society (147, 148). Finding a youth in such a system is the time for intense psychological evaluation and management; it should occur early in this person's juvenile court appearance to prevent a long-lasting pattern of violence and crime (147, 148).

Consultants in Kalamazoo, Michigan have developed the Nation's first Trauma and Resiliency Court for youth in the juvenile court experience with the goal of recidivism prevention (148). This court program assesses all youth in the juvenile justice system for trauma history (using the ACEs questionnaire and a more comprehensive trauma assessment tool based on the Theraplay model), refers at-risk youth to a court-supervised program, and offers trauma-based treatment services in the community for young trauma victims and their families. Kalamazoo County's Trauma and Resiliency Court program endeavors to go beyond being "trauma-informed" in its interactions with young people and their families. The Trauma Court is treating trauma as a root cause of crime and delinquency in the community by offering supportive services to trauma survivors that teach resiliency skills, much in the way that Drug Court programs treat addiction as a root cause of crime and Mental Health Court programs treat mental illness to reduce crime and delinquency.

CONCLUSION

Abuse (physical, sexual, neglect) involves large numbers of children and adolescents in the world including those with disabilities (1, 29-31, 86, 118, 149, 150). Abuse of children and adolescents is a complex conundrum for contemporary society with most cases not discovered and with negative psychological effects on these persons that last a lifetime (1, 149, 150). This discussion looks at adolescent abuse in a historical context as reflected by classic children's stories and religious writings in addition to research data (151). Specific perspectives on abuse in adolescence that are discussed include incest, sibling abuse, and the adolescent sexual perpetrator (1, 81, 85, 114, 118, 152).

> If you want your children to be intelligent, read them fairy tales. If you want them to be more intelligent, read them more fairy tales.
>
> Albert Einstein (1879-1955)

It is concluded that important aspects of abuse done to adolescents and done by adolescents reflect many difficult factors including family dysfunction and societal chaos as well as societal indifference (1, 81, 85, 153). Comprehensive therapy is needed for adolescents and others found to have become victims of abuse, though it is often not an easy task to accomplish (154). At the time of this writing, the world is suffering through the COVID-19 pandemic of 2020-2021, and it is urged that management of abuse not be ignored because of on-going chaos including pandemics, war and other threats to world stability (22, 151, 155).

A major conclusion to this discussion is the need to establish means of *prevention* for our adolescents who are being abused and who are abusing others. One method is to teach adolescent mothers about proper parenting techniques and tools (129). Another is to provide comprehensive therapy to adolescents as soon as they are identified in the juvenile court system as being involved in crime (147, 148). The development of a trauma-informed juvenile justice system has been recommended by the United States Department of Justice and includes children having various Neurodisability (156, 157). The establishment of a Trauma Court is recommended by the authors to work with youth early and reduce the recidivism that leads to so much abuse and injury (148).

Since most sexual abuse begins well before puberty, preventive education, if it is to have any effect at all, should begin early in grade school.

Judith Lewis Herman (Father-daughter incest: With a new afterword, 1981)

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Chapter 18

PREVENTING ATHLETE HARM IN YOUTH SPORTS

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ABSTRACT

Children and youth participating in sport activities is pervasive in the United States, and increasingly professionals and parents are recognizing both positive and negative aspects associated with participation in sports. Among the positives, associated with wellbeing, are "lasting lessons on personal responsibility, sportsmanship, goal setting and emotional control" along with improved sense of well-being and improved mental health. Along with these positive aspects, there are potential risks for negative experiences that may affect some children and youth during their sport participation as well. Among these are the risks for overtraining, injury, peer abuse (bullying) and hazing as well as various forms of maltreatment and exploitation. This chapter explores the potential risk for youth harm in sports related to maltreatment and injury, with an eye towards prevention efforts that may mitigate these risks. The chapter aims to provide a framework of prevention strategies to effectively manage the elements of the sports environment to decrease the risk for harm and maltreatment and that highlights the potential for positive experiences so valued and highly associated with sports participation.

INTRODUCTION

Children and youth participating in sport activities is pervasive in the United States, and increasingly professionals and parents are recognizing both positive and negative aspects associated with participation in sports. In 2017, of the more than 73 million children and youth in the U.S. under 18 years of age, 58% of those between the ages of 6 and 17 years of age

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participated in either an individual or team sport (1). The American Academy of Pediatrics (AAP) in its clinical report on organized sport highlighted the many positives that may promote the wellbeing of children who participate in sport activities (2). Among the positives associated with wellbeing are "lasting lessons on personal responsibility, sportsmanship, goal setting and emotional control" along with improved sense of well-being and improved mental health (3 p2). In addition, the American Academy of Child and Adolescent Psychiatry (4) also highlighted positives that may be seen from sports participation for children and youth which included the development of physical skills, increased exercise, friendships, recreation, learning teamwork, developing a sense of fairness and improved self-esteem.

Along with these positive aspects, both the AAP and AACAP draw attention to the potential risks for negative experiences that may affect some children and youth during their sport participation (2). Among these negative experiences are risk for overtraining, injury, peer abuse (bullying) and hazing as well as various forms of maltreatment and exploitation (5-7). This chapter explores the potential risk for youth harm in sports related to maltreatment and injury, with an eye towards prevention efforts that may mitigate these risks. The chapter aims to provide a framework of prevention strategies to effectively manage the elements of the sports environment to decrease the risk for harm and maltreatment. This framework also highlights the potential for positive experiences so valued and highly associated with sports participation.

TYPES AND PREVALENCE OF YOUTH HARM IN SPORTS

Enhancing the safety and wellbeing of youth in sports settings begins with a clear understanding of the types of harm that can befall an athlete, from maltreatment to unintentional mental or physical health problems. While definitions vary, The US Center for SafeSport ascribes to a high standard and defines maltreatment in sport as including various forms of physical abuse, emotional abuse, sexual abuse, bullying, harassment, hazing and a number of related violations (e.g., aiding and abetting a form of maltreatment, other inappropriate conduct) (8). Evidence suggests that a broad range of individuals can be responsible for youth maltreatment in sports contexts. However, parents, peers, and coaches are the most likely perpetrators of abuse, with the majority being adult male offenders (9, 10).

Prior research has shown that emotional abuse is the most common type of maltreatment against youth in sports. Emotional abuse is defined as including excessive criticism about athletic performance, being shouted or sworn at, being embarrassed or humiliated, and teasing or bullying (11). In a UK sample, 75% of participants had experienced emotional harm while participating in youth sports (12). The most frequent perpetrators of emotional abuse were peers. However, emotional abuse perpetrated by coaches was more common in elite sports teams.

Evidence suggests that 19-31% of youth playing sports have experienced sexual harassment or sexual abuse in sports contexts (10, 12, 13). Coaches were the most common perpetrator of this type of abuse, which is attributed to the power differential between the coach and youth athletes. As with most sexual violence, male perpetrators were more common than female perpetrators (14).

Physical abuse was reported by 6.2-24% of youth involved in sports (10, 12, 15). As with emotional abuse, physical abuse was primarily perpetrated by peers, with increases in

perpetration by coaches as athletes' level of competition increased. Examples of physical abuse include being forced to train when injured or exhausted, as well as experiencing aggressive and violent behavior (e.g., being hit, grabbed around the neck, beaten up) (11).

Other risks to youth athletes' safety and wellbeing, outside of formal maltreatment definitions, include the risk of unintentional injury and concerns related to physical and mental health. For example, body image is a concern for many youth athletes, which has the potential to negatively impact mental and/or physical health. While 52% of children and teens like the way sports participation makes their body look, girls are more likely to report a negative impact on their body image, particularly if they are involved in a sport that requires wearing a revealing uniform. (11) Self-harm is another concern for some youth athletes. In fact, 10% of youth athletes reported committing some form of self-harm, and 39% of those athletes described cutting themselves. For these participants, self-harm was either directly or indirectly associated with their involvement in sports (11).

Physical injury is a common occurrence for youth who participate in sports. Approximately 37 children are treated for a sport- or recreation-related injury every hour in the US (16). However, there are forms of unintentional injury that pose both immediate and long-term risks to the health of youth athletes. For example, concussions are a concern for many parents of youth athletes, and with good cause. Youth are six times more likely to have a severe concussion from participating in an organized sport than other recreation activities, and such an injury can have an adverse effect on memory and academic performance (17-19). Less common but riskier is cardiac arrest due to a sports injury, such as receiving a blunt force trauma to the chest. Sport-related cardiac arrest is more likely to occur in youth with anatomical heart defects and is the most common cause of sudden athlete death (20). Young athletes are also at risk of experiencing heat-related illnesses during sports participation. One study found an average of 29.5 cases of heat illness per school year across 100 schools (21). Heat illness is particularly prevalent in the U.S. during the month of August and is experienced more frequently by football players as compared to other sports (22).

SPECIAL CONSIDERATIONS FOR UNDERSERVED POPULATIONS

LGBTQA+ individuals, people of color, and individuals with disabilities are frequently excluded from research in general, and this is particularly evident in research related to youth maltreatment in sports. Unfortunately, this means that there is a paucity of information on maltreatment experienced by children and teens from these underserved groups. When this topic surfaces, it most often points to the need for more investigations into sports-related maltreatment to fill this significant gap in the literature (23, 24).

Evidence does suggest that sport is often rooted in aggressive masculinity, which fosters a culture of sexism, homophobia, and transphobia (25). This culture can discourage sports participation by LGBTQA+ members of the community (26). LGBTQA+ athletes may avoid disclosing this aspect of their identity due to fear of emotional or physical harm. Still, 6% of athletes report being LGBTQA+, and these athletes have created safe spaces, such as The Gay Games and The Out Games as a response to the more negative overall culture of sports (23).

While under-researched, there is some evidence to suggest that athletes with disabilities experience a variety of maltreatment related to their sports participation. Kirby and her

colleagues (23) report that disabled athletes experience a number of unique risks for maltreatment related to power imbalances with caregivers, medication administration, assistance with personal hygiene, and physical handling (e.g., transfers). Further research is needed to provide more nuanced information on the particular risks associated with individuals who have different types of disabilities. Information of this nature would help foster the development of more tailored prevention efforts that can be instituted by organizations, coaches, parents, and athletes themselves to enhance safety in sports for all (27).

Maltreatment due to racial inequity in sports at the collegiate and elite levels is discussed sparingly in the literature, but even less is known about the specific maltreatment of youth of color in community-level sports. At the collegiate level, racial bias has been noted in healthcare workers who have treated Black athletes, perceiving them to have a higher pain tolerance than white athletes (28). One study found that Black collegiate athletes felt socially segregated from their white teammates and had experienced racial bias from fans both on and off the field (29). While these athletes gain power through celebrity, with few exceptions, they still exist within a predominantly white power structure that does not prioritize their role as students. Moreover, Black male college athletes are less likely to graduate college than their white teammates (29, 30). Independent of their school performance, many young Black students see success in sport as the primary way to climb the socio-economic ladder, despite the narrow odds of achieving a career as a professional athlete (31). Unfortunately, college athletics is not necessarily a reliable path to financial achievement, since athletes' academic success is rarely prioritized in these systems. Additional research is needed to examine racial inequity experienced by youth participating in school, community, and leisure sport and the effects on their wellbeing.

OVERVIEW OF STRATEGIES TO PREVENT HARM IN YOUTH SPORTS

No single strategy will guarantee youth protection in sports. Sports organizations can use a variety of approaches to reduce the likelihood of abuse and other athlete harms. The remainder of this chapter highlights these strategies both through an illustrative overview of key approaches presented in Table 1 as well as a more in-depth examination of three important areas: 1) coach training and education; 2) the role of parents in youth sports safety and 3) situational prevention strategies for youth sports.

Key sports prevention approaches and illustrative strategies

Some critics have pointed to the inadequacy of existing policies and practices designed to foster youth sports safety, while others have suggested that the real concern lies in the lack of implementation of available safety guidelines (32, 33). In fact, a variety of major sports organizations provide a wide range of safety resources including training materials, sample policies, checklists, and guidelines on their websites (e.g., National Alliance for Youth Sports, US Center for SafeSport, Canadian Centre for Child Protection, and the National Council of Youth Sports). The Organizational Prevention Approaches presented at the top of Table 1 illustrate a number of key safety strategies that foster youth protection and contribute to the development of a team's safety culture (34, 35). Table 1 identifies key prevention areas, the

strategies that underlie each area, as well as illustrative topics covered. While a detailed discussion is beyond the scope of this chapter, the interested reader is referred to the US Center for SafeSport's Minor Athlete Abuse Prevention Policies or Wurtele for more on safety strategies for youth serving organizations in general (36, 37).

Table 2 identifies a number of promising and evidence-based safety and prevention programs that have been utilized in sports to enhance youth safety. These programs provide prevention approaches focused in three areas: 1) bystander intervention; 2) social marketing and 3) general prevention and education curricula. The list of programs in each of these three areas provide an excellent starting point for teams and sports organizations interested in adding components of this nature to their existing safety efforts. Finally, Table 2 briefly defines coach and parent education and skills training approaches as well as situational prevention strategies as available components to complete a comprehensive approach to creating a child-safe sports organization.

Coach training and education

One of the most important, yet underdeveloped, components of youth protection in sports is the delivery of comprehensive and theory-driven education and training programs for coaches—at every level. The critical nature of this training gap is reflected in coaches' unique role in young athletes' lives. Coaches have considerable authority over the youth on their teams, access afforded to few others in children's lives, and they provide supervision across a broad spectrum of contexts depending on the sport and the level of competition (e.g., intensive individual training to elite athletes; regional, national, and international team travel for competition; a car pool ride home for athletes provided by parent-coaches). Moreover, these behaviors are not only sanctioned by children's parents, they are a normalized aspect of current youth sports.

At the same time, coaches serve as significant positive and supportive figures and important safety gatekeepers for youth participating in sports. Coaches dedicate a great deal of time to their youth athletes, which makes them well positioned to respond quickly to athletic injury, notice signs of abuse, and provide positive adult mentorship. Proponents for the advancement of coach training point to its value in promoting a variety of desirable outcomes associated with youth safety and wellbeing. Some of the training areas often cited as among the most critical for coaches include, but are not limited to: 1) preventing and addressing sports-related injury (e.g., through first aid, cardiopulmonary resuscitation [CPR], concussion education and more); 2) understanding and responding to child sexual abuse and other forms of maltreatment and 3) general skill-building related to the use of positive and appropriate coaching and mentoring techniques (38,39). While options for coach training in these and other areas have increasingly become available, major inconsistencies remain in terms of what is required of and delivered to coaches across the youth sports movement (40). The following sections explore these three training areas for coaches in greater detail.

Table 1. Key organization prevention approaches and illustrative strategies

Organizational Prevention Strategies* **Team or sports organization-specific policies and practices intended to prevent athlete harm**		
Prevention Area	**Key Strategies (Target)****	**Illustrative Topics Covered**
Hiring/Recruiting Practices for Employees & Volunteers	Background Checks[1,3]; Reference Checks[1,3]; Team Safety Policy Clarifying Active Prevention Efforts[1,3]	Past criminal charges; History of working/volunteering with children/adolescents; Past coaching experience; Any history of concerns working with children/adolescents; Team/organization commitment & strategies for ensuring safety
Code of Conduct (CoC)	Coach CoC[1]; Athlete CoC[2]; Parent CoC[4]; Administrator/Other Staff CoC[5]	Expectations for appropriate behaviors; Appropriate relationship boundaries; Appropriate sideline behavior; Prohibition on romantic and intimate relationships with athletes; Prohibition on all forms of maltreatment
Safety Policies	Limitations/prohibitions on 1:1 coach-athlete time alone[1-3,5]; Acceptable & unacceptable contact/touch between coach and athlete[1-3,5]; Carpool and transportation guidelines[1-5]; Restrictions on out-of-program contacts & relationships[1-2]; Prohibitions on all forms of maltreatment, bullying, hazing[1-3,5]; Guidelines for reporting maltreatment[1-5]	Any restrictions on out-of-program contacts or relationships; Guidelines/restrictions on transporting youth to and from practices/competitions; Guidelines for athlete hotel arrangements; Expectations for the reporting of child sexual abuse and other forms of maltreatment
Athlete Education & Training	Orientation to policies & CoC[2]; Sexual abuse prevention education[2]; Reporting procedures for all forms of maltreatment[2]	Review, clarification, & sign-off on safety policies & CoC; Identifying sexual harassment, abuse, and other forms of maltreatment, bullying, and hazing; Maltreatment reporting requirements and procedures (All developmentally appropriate)

*Note – In some cases "coach" is intended to also represent team staff, administrators, and volunteers. This is clarified by the policy targets in parentheses.

**1 = Coaches; 2 = Athletes; 3 = Volunteers; 4 = Parents; 5 = Other Team Staff/Administrators.

Table 2. Coach, parent and team programs

Coach & Parent Education & Skills Training* **Team or sports organization specific policies and practices intended to prevent athlete harm**		
Prevention Area	**Training Areas** (Target)**	
Coach Education & Training	Orientation to policies & CoC[1]; Sexual abuse prevention[1]; Reporting procedures for all forms of maltreatment[1]; Concussion, heatstroke & injury prevention[1]; Positive coaching approaches[1]; Positive youth development[1]	Review, clarification, & sign-off on safety policies & CoC; Identifying sexual harassment, abuse, and other forms of maltreatment, bullying, and hazing; Maltreatment reporting requirements and procedures; Identification and response to concussion and heatstroke; Positive motivational strategies in sport
Parent Education & Training	Orientation to policies & CoC[4]; Sexual abuse prevention[4]; Reporting procedures for all forms of maltreatment[4]	Review, clarification, & sign-off on safety policies & CoC; Identifying sexual harassment, abuse, and other forms of maltreatment, bullying, and hazing; Maltreatment reporting requirements and procedures; Selecting sports programs that prioritize safety; Actively monitoring youth involvement in sport
Safety & Prevention Programs These represent independently developed safety and prevention programs that can be adopted by teams to enhance athlete safety.		
Prevention Area	Prevention Program (Target, Source)**	
Bystander intervention	Step Up![2] (NCAA); Mentors in Violence Prevention (MVP) Strategies[2] (MVP Organization); Fair Play[2] (Oterbein University); Green Dot[2] (Alteristic)	
Social Marketing	White Ribbon Campaign[1](Dean College)	
Prevention & Education Curricula	My Playbook[5] (NCAA); Sexual Assault Prevention Suite[2] (EVERFI); Real Consent[2] (Emory University); Coaching Boys into Men[1] (Futures Without Violence)	
Identifying & Addressing Organization/Team-Specific Safety Risk Factors These strategies allow sports organizations/teams to identify the safety risk factors unique to their athletes/organization/team and develop tailored prevention and risk reduction strategies to address their specific concerns		
Strategy	Illustrative Safety Risks	
Situational Prevention Approach	Too few coaches for the size of the team; 1:1 coaching instruction in sports that require "hands on" instruction and spotting (e.g., gymnastics); Field trips; Challenges in monitoring organization bathrooms	

*Note – In some cases "coach" is intended to also represent team staff, administrators, and volunteers. This is clarified by the policy targets in parentheses.

**1 = Coaches; 2 = Athletes; 3 = Volunteers; 4 = Parents; 5 = Other Team Staff/Administrators

Training on sports-related injury

Preventing and addressing athletic injuries is perhaps the most common focus of required and voluntary training for coaches in youth sports, although the breadth and depth of such training varies widely, and a large number of coaches continue to go untrained (40). Many organizations require, at a minimum, first aid and CPR training for head coaches, and to a lesser extent, for volunteers who take on assistant coaching roles. In their 2019 report, the Aspen Institute's Project Play reported that less than 30% of youth sports coaches had been trained within the past year in first aid/CPR, injury prevention, or concussion management, and about four in 10 coaches had never received training in these areas (41). Both the merits of receiving a basic level of training, as well as the need for better and more frequent training, have been documented in the literature. For instance, one study found that youth soccer coaches who were certified in first aid and CPR were more likely to score higher than un-certified coaches on an online first aid assessment (FAA) test (42). At the same time, Chin and colleagues (2015) noted considerable room for improvement on scores across the board; indeed, only 23% of the first aid and CPR certified coaches in their study achieved a FAA score of 80% or higher.

A growing training emphasis for coaches has been on concussion prevention and response. The National Federation of State High School Athletics Associations (NFSH) released a free online course on concussion in sports in 2010 targeting coach, administrator, and parent audiences (43). These efforts are encouraging, and preliminary findings show positive knowledge-related outcomes for coaches who received NFSH's concussion training (44). However, even coaches who have satisfied their state's high school training certification requirements appear to lack the skills needed to deal with athlete injuries as they arise. For example, recent research has highlighted inadequacies in high school coaches' knowledge of the use of Automated External Defibrillators (AED), which improves survival rates for those who suffer sudden cardiac arrest (45). This is an especially crucial finding given that sudden cardiac arrest is the leading cause of abrupt death for youth in the sports context (46), and many school and organizational youth athletics programs provide AEDs on-site in case of emergency (47).

Taken together, this research suggests that many coaches lack the knowledge necessary to prevent and address both common and severe injuries in youth sports. It is also clear that sports-related injury training is available (e.g., see NFHS courses [2019]), although not universally required of or accessed by coaches (43). More research is needed to determine what content, delivery mechanism, and frequency of training for coaches will produce the best outcomes for youth athletes related to both safety and wellbeing.

Preventing and responding to abuse

Another critical area for coach education is how to prevent and respond to abuse in sports. While sexual abuse in sports has received the most media and research attention, emotional and physical abuse also appear to be prevalent and to have significant impacts on affected athletes (48). A study by Noble and Vermillion shed light on the need for more and better abuse prevention training for coaches involved in youth sports. Specifically, they found that of 155 surveyed sports administrators, 37% were unsure if their organization provided adequate training on how to identify and report child abuse, while 26% felt their organization did not provide enough training in this area (49).

Increasingly, experts have called for abuse prevention training to be a mandatory part of the coach accreditation process (50). Encouragingly, this recommendation has gained some

traction in recent years. For example, the Protecting Young Victims from Sexual Abuse and SafeSport Authorization Act of 2017 requires that all amateur sport organizations in the U.S. provide abuse prevention training to all adult members who are in regular contact with youth amateur athletes (51). To help meet this requirement, the US Center for SafeSport has developed a suite of courses, including a 90-minute online core training on mandatory reporting, sexual misconduct awareness, and emotional and physical misconduct in sports (39). The SafeSport core training is mandatory for coaches and other adult members within the US Olympic and Paralympic Movement, as are annual refresher courses that build on one another to increase trainee knowledge from one year to the next. Another popular course developed in collaboration with the US Center for SafeSport and covering a similar set of topics is freely available through the NFHS Learning Center, although it is currently listed as an elective rather than a requirement of the National Standards for Sport Coaches (43).

Positive youth development training

The literature has long suggested that the presence of caring adults is a vital condition for positive youth development, and that coaches have great potential to impart transferable skills that will benefit youth beyond the context of their sports participation (52). Indeed, multiple studies have reported better self-esteem and other personal and social benefits for athletes whose coaches received training on positive youth development compared to athletes whose coaches did not (53, 54). Despite this potential, research findings have been inconsistent regarding the broader association between youth sports participation and the development of desirable skills and positive characteristics. As Petitpas and colleagues suggested (52), this inconsistency may be largely driven by the fact that the vast majority of coaches receive no formal training in either coach education or youth development. Many coaches bring with them the experience of having been an athlete themselves; it is commonly assumed that former players are well-equipped to take on the role of coach without formal training or coach education (52). According a recent study by McMahon and colleagues (55), many former athletes are "fast-tracked" into coaching under this very assumption. Further, research suggests that the primary source of coach knowledge comes from experience and observation in the sport (56). This informal system for coach development may be one of the reasons why many coaches do not receive the education and training that would help them better support athlete safety and wellbeing.

One example of a training program focused on helping coaches to promote positive youth development is *Coaching with Courage,* a recent initiative of Futures Without Violence (57). Coaching with courage consists of four learning modules that include videos and activities aimed at enhancing social-emotional learning, creating equitable sporting environments, and teaching trauma responsive coaching practices. Another example is *Project SCORE (Sport COnnect and REspect),* which provides activities and exercises for coaches and parents to help them support youth athletes' confidence, character development, and build positive relationships (58). More research and evaluation are needed to assess the effectiveness of positive youth development training programs. Findings do indicate, however, that coaches perceive training in this area to be valuable, yet generally lacking within mainstream coach education courses (59).

The role of parents in youth sport safety

The following section describes three strategies that parents can utilize to help protect their children in the sports context. Similar to the discussion on coach training above, these strategies are not comprehensive in nature, but rather, should be understood as key components of broader parental practices for safeguarding sports-involved youth.

Understanding and recognizing abuse in sport

Some of the most significant ways that parents can prepare to keep their youth athletes safe are by understanding the various forms of maltreatment (emotional, physical, and sexual), how these harms can manifest in athletic environments, and what to do if concerns arise. There is a noted gap in the research literature related to parents' knowledge of maltreatment in sport (60). However, the few studies that have addressed this topic have revealed important educational needs for parents of athletes. For instance, McMahon and colleagues (61) conducted an educational intervention using a narrative pedagogy with 14 parents of children involved in gymnastics and swimming. Their results suggest that parents may perceive potentially harmful coaching practices as acceptable and resist questioning the behaviors of coaches (i.e., harboring a "coach knows best" attitude) (61). This finding indicates that education and training aimed at empowering parents to reflect and act on coaching practices may be particularly valuable (61) and is consistent with the International Olympic Committee's recommendation for parent education as an important facet of abuse prevention in sport (9).

There are several empirically based options for parent education, including a free online course and a toolkit for parents offered by the US Center for SafeSport (39). However, there remains a need for more sports-specific parent education options in this area and rigorous evaluation of the resources that do exist (39).

Parents as gatekeepers

Parents have the authority to act as gatekeepers by making decisions about who is allowed access to their children. Parents can exercise this authority in impactful ways, such as by intentionally choosing sport organizations that have strong youth protection policies and practices in place and that demonstrate a commitment to prioritizing safety. A useful resource that parents can refer to when vetting sport organizations is the Safe Stars Initiative of the Tennessee Department of Health (62). Parents can reference the Safe Stars' list of recommended safety policies, plans, and practices when asking sport organizations about the protections they have in place.

Even after parents enroll their child in a sport organization, they should monitor the organization to ensure that it lives up to high child protection standards. In one study examining emotional abuse in youth sports, Kerr and Stirling (63) found that parents were often expected, or even required, to relinquish a large degree of control and supervision of their child to coaches. Closed practices, for example, often require that parents not stay and observe practice or training so as not to "distract" the athletes. Closed practice policies are not uncommon, despite experts having issued warnings about their potential risks for decades (64-66).

Of course, it may not be feasible for most parents to regularly attend their child's practice. A good alternative is for the team to designate a parent to stay through each practice, and have parents rotate in this role as their schedules allow (67). This parent's job is to monitor team

interactions during practice and keep an eye out for any concerning behaviors. Having a parent in this role may also represent an acceptable alternative to the "closed practice" that satisfies parents as well as coaches. A team's unwillingness to allow a single parent to be present for practices should be a warning sign to parents and prompt action on their part.

Situational prevention strategies for youth sports

The prevention of child abuse has been predominated by a focus on individual victim and perpetrator dynamics (37, 68, 69). While these represent critically important perspectives, this emphasis has neglected a host of significant underlying situational risks as well as the situational prevention strategies designed to address this type of safety concern (70). Situational prevention approaches target factors contributing to abuse and other forms of harm. In youth serving organization (YSO) settings, this can include environmental safety concerns; unsafe daily and routine activities on the part of youth and YSO staff; and YSO policies that are missing, in need of updating, or not sufficiently communicated or implemented (71). Situational prevention approaches are a long-standing part of the criminal justice field. They have a strong empirical foundation rooted in more than 35 years of creating safe housing around the world and more than 25 years of successful application in community-based crime prevention (72). However, situational prevention strategies have only been applied to the prevention of child sexual abuse over the past 15 years, and rarely to the prevention of other forms of youth harm, despite their promising potential.

The situational prevention approach

Kaufman developed the Situational Prevention Approach (SPA) as a strategy designed primarily to prevent child sexual abuse (73, 74). The approach was later expanded for general use in YSOs and to address a much broader array of youth safety concerns (e.g., physical and emotional abuse, neglect, accidental injury) (71, 75). YSOs represent a significant vehicle for the prevention of child maltreatment with most U.S. children and teens involved in one or more programs (i.e., estimates suggest that 58% of all U.S. youth participate regularly in youth sports) (1). The SPA was conceptualized based on Clarke's previous work on situational prevention. It also drew from routine activity theory, defensible space theory, and rational choice theory (71, 76-78). The SPA has been utilized successfully over the past dozen years in a variety of organizations that serve youth and young adults including Boys and Girls Clubs of America (BGCA) settings in multiple states, children's hospitals, and seven different colleges and universities as part of a large project funded by the Department of Justice's SMART office.

Applying the situational prevention approach with elite sports organizations

The SPA is currently being utilized with Olympic, Paralympic, and younger elite athletes as part of a three-year project funded through the US Center for SafeSport in cooperation with teams from the US Olympic and Paralympic Committee. This project is designed to develop the "Sport Situational Prevention Approach" (SSPA), a tailored version of SPA, to help prevent harm to elite athletes. To date, the project has included more than a dozen Olympic, Paralympic, and younger elite teams from across the country with very promising results. Preliminary evidence reflects very high satisfaction with the SSPA and promising findings with regard to

teams' ability to identify critical safety risks and develop tailored solutions to address these concerns. These findings are consistent with past results for the SPA in the BGCA project, which demonstrated that clubs using the SPA were able to identify 7-10 times more safety risks than clubs in the same city doing "business as usual." Clubs using the SPA were also able to identify and implement safety solutions for most risks in a timely and effective manner. Additional evaluation studies are necessary to confirm the SPA's effectiveness with various YSOs including sport organizations.

The sport situational prevention approach (SSPA) details

The SSPA's goal is to assist sports teams in identifying and addressing safety risks when they are small and manageable, and prior to them causing harm to youth athletes. The SSPA is a four-step prevention process that involves: 1) Brainstorming safety risks, 2) Prioritizing risks for taking action, 3) Developing solutions to address high priority safety risks and 4) Creating implementation plans that guide taking action. Risk brainstorming meetings are scheduled with key stakeholder groups (e.g., team coaches and staff, parents, and athletes) with the goal of identifying as many safety risks as possible. Using a series of risk prompts helps participants generate a broad range of pertinent safety concerns. Risk identification prompts can be tailored to the type and developmental level of the team and should reflect key aspects of the youth's sports experience (e.g., high risk locations, policy related concerns, team climate and norms, concerns specific to hazing or other forms of maltreatment). Once safety risks are identified, the prioritization process helps determine those concerns that require the most immediate attention. Preference is given to prevention-oriented safety solutions, since they are more likely to ensure that safety risks will be more permanently resolved. That said, there are some risks that cannot be prevented and will require a risk reduction strategy instead. Finally, developing implementation plans to guide taking action on solutions helps clarify key solution tasks, identifies which staff members are responsible for each task, clarifies who is supervising the solution process, provides due dates for tasks, and indicates whether there are any conflicts between solutions and existing organizational policies. Since youth sports teams represent dynamic settings (e.g., changing coaches/staff, athletes), maintaining a safe environment requires repeating the four-step process on a regular basis (e.g., annually). This offers an opportunity to identify new safety concerns as well as obtain feedback that may suggest the need to rethink a previous solution that has not fully resolved the safety risk.

CONCLUSION

Despite the potential for positive experiences and enhanced wellbeing resulting from participation in sport activities, some children and youth have negative experiences such as injury and various forms of maltreatment that intrude into their lives and cause harm. This chapter dispels the myth that a so-called magic bullet might exist that if uniformly embraced would make the sports environment completely safe and risk free. Instead, prevention efforts must be multi-faceted and address the many individuals, groups, and organizations that form the complex environment that characterizes the youth sport endeavor. Adults in this environment such as parents, coaches, volunteers and organized sport leadership need training as a foundational element upon which to create a culture focused on the wellbeing of the

children and youth participating in the sports activities. In the U.S. context, this culture will best be reflected in a comprehensive set of policies and procedures that codify what safe practice looks like; what responsibilities each parent, coach and sports organization need to play in this culture; and which practices are most effective to increase public and professional awareness of the risks that children and youth may regretfully confront during their participation in sport. From a practical perspective, a model that coherently pulls from these many components of a comprehensive prevention strategy is necessary and when adopted can provide a clear roadmap for what needs to be done and by whom. The Situational Prevention Approach (SPA) is offered as one such cohesive model that is, as described above, well tested in other contexts, and which appears to be ideally suited for adoption in the sports realm. With the increased professional and societal awareness that participation in sport activities may pose a risk for maltreatment, and further, recognizing the sheer numbers of children who participate in sports who may be at risk, the prevention imperative could not be more clear. Our collective challenge will be to pursue viable prevention strategies in sports so that safety and promotion of wellbeing remain front and center on the field of play. Children and youth who participate in sport activities deserve no less from the adults and organizations associated with sport than to be protected from the negative, harmful experiences and instead to be engaged in an environment that is positive and growth oriented.

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Chapter 19

PREVENTION OF HUMAN TRAFFICKING IN CHILDREN

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ABSTRACT

Human trafficking is a violent crime and a global public health crisis with victims identified in every region of the world. Similar to other violent crimes, human trafficking affects individuals, families, communities, and societies with adverse consequences identified at each of these levels. Human trafficking is preventable and can be eradicated by addressing the different risk factors that increase the child's vulnerability to being trafficked. This chapter utilizes the US Centers for Disease Control and Prevention's ecological model as a guiding framework for the multilevel interactions of the social determinants of vulnerability. It is the combination of individual, relationship, community, and societal factors that increases the risk of a child being trafficked. Understanding these factors that make some populations more vulnerable to victimization and perpetration helps us work on mitigating these risk factors. Understanding which children are most at risk for trafficking is also integral to a public health response to trafficking, including the design of prevention interventions. This chapter provides an overview of these risk factors to help identify strategies for prevention and provide guidance for professionals who have various roles in the lives of children.

INTRODUCTION

Human trafficking is a violent crime that involves the exploitation of others for the purpose of forced labor or commercial sex (1, 2). Human trafficking is defined by the US Trafficking Victims Protection Act of 2000 as "(a) the recruitment, harboring, transporting, supplying, or obtaining a person for labor or services through the use of force, fraud, or coercion for the purpose of involuntary servitude or slavery; or (b) sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform sex acts

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is under 18 years of age." The International Labour Organization includes labor trafficking in its definition of the 'worst forms of child labour' (3).

Using a more global definition, the United Nations defines "trafficking in persons" as "the recruitment, transportation, transfer, harboring or receipt of persons by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability, or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person for the purpose of exploitation" (4). When children (<18 years) are involved, force, deception, or other means need not be present.

Human trafficking is also a major public health issue and is a growing problem in both the United States and the larger global community (5, 6). The eradication of human trafficking and forced labor are included in the United Nations' Sustainable Development Goals for 2030 (SDG 8.7) (4). The goals include elimination of all forms of violence against women and girls in the public and private spheres, including trafficking and sexual exploitation, and all forms of violence against and torture of children (4). It urges the global community to take immediate and effective measures to end human trafficking, eradicate forced labor and secure the prohibition and elimination of the worst forms of child labor, including recruitment and use of child soldiers, and by 2025, end child labor in all its forms (4).

The report on violence and health developed by the World Health Organization (WHO) incorporated an ecological model to understand the nature and influences of violence (7). The ecological environment consists of four different levels of systems arranged as a nested structure (i.e., individual, relationship, community, and societal) (7). These four levels interact to increase a child's likelihood of becoming a victim of exploitation:

1) The first level, *individual level*, is the child's own biology and personal history factors that increase a child's risk;
2) The second level, *relationship level*, looks at the individual's close relationships such as family, friends, teachers, intimate partners, and peers, and explores how these relationships increase the risk of being a victim;
3) The third level, *community level*, considers social relationships embedded in neighborhoods and schools, and explores the characteristics of these settings that increase the risk for violence and victimization;
4) The fourth level, *societal level*, looks at the broader social and cultural contexts that affect social identities and relationships among individuals, families and communities such as socioeconomic opportunities, racial and ethnic differences and public policies (7).

Therefore, a public health approach to combating human trafficking using the US Centers for Disease Control and Prevention's (CDC) four-level social ecological model has been proposed. (8, 9) The CDC uses this model to better understand violence and the effect of potential prevention strategies (10). These four levels will be discussed in detail with various methods and prevention strategies within each level that may be implemented by professionals and societies as a whole.

TARGETING PREVENTION AT THE INDIVIDUAL AND RELATIONSHIP LEVELS

Human trafficking affects people from all demographic, ethnic, and social groups. It is a crime based on exploitation of the most vulnerable of the population. Children in general tend to be more vulnerable due to their age and lack of physical and mental strength to fight traffickers (11). Gender and minority ethnicity increase the risk for victimization. Girls are more likely to be victims than boys and being African American further increases the risk (12, 13).

Studies have shown that certain personal factors and exposure to adverse experiences further increase the risk of a child being exploited. Victims of commercial sexual exploitation are commonly identified as having psychosocial risk factors, including a history of maltreatment (including sexual, psychological, and physical abuse), involvement in foster care, criminal history, involvement with child protective services, substance use or abuse, and a history of homelessness or running away (6, 14-16). Even when compared to children who are victims of child sexual abuse, children who are victims of child sexual exploitation are more likely to have had experiences with substance abuse, violence, running away from home, and involvement with child protective services and/or law enforcement (15). Domestic child sex trafficking victims were also significantly more likely to have ever run away and were more likely to be from racial/ethnic minorities than were non-trafficked adults engaged in the commercial sex industry (16, 17). Also significantly associated with being a victim of domestic child sex trafficking was having family members in sex work and having friends who purchased sex (17). In general, childhood maltreatment trauma and running away from home were the most important risk factors for trafficking victimization (16). Lesbian, gay, bisexual, and transgender (LGBT) youths are also at risk for exploitation, partially due to the increased risk of homelessness and/or running away (18). Having an Individualized Education Program/504 plan developed for school-aged children whose ability to succeed in traditional educational formats is challenged by learning, social, or functional problems was also found to be associated with a higher risk of being trafficked (19).

The risk of victimization further increases in adolescents who tend to be more independent, with less parental supervision and accompanied occasionally by a desire to challenge the authorities and break the rules (20, 21). The time of adolescence is also associated with inner developmental struggles with issues of independence, identity, sexuality, and relationships (15). In addition, the use of web-based communications including Myspace®, Facebook® and chat rooms increases their vulnerability and makes them easier targets for traffickers who recognize their weaknesses and use emotional strategies to meet their needs for attention and love (11). Youth engaging in runaway behaviors are at greater risk for further exposure to a variety of harms while on the street or away from home, including substance abuse, violence, and exploitation for forced labor and/or commercial sex (22). Many runaways and homeless adolescents are at risk for "survival sex" as a means to obtain money for food, shelter, and drugs (15).

Adding to the individual vulnerability, risk factors at the relationship level further contribute to an increased risk of victimization (11). Children growing in abusive, troubled and dysfunctional families lack a safe and supportive environment. Those insecure family attachments and feeling marginalized may result in children running away, further increasing their risk of being lured by a trafficker in the hopes of fulfilling their emotional needs for

belonging and acceptance within a family unit (17). Children and adolescents are influenced by surrounding peers and family members (23). Having family members involved in sex work is a significant risk factor. Familial trafficking also further increases the risk with parents trafficking their own children. Familial risk factors may include domestic or intimate partner violence and parental substance abuse. Youth may attempt to escape this environment, further increasing their risk of being trafficked.

INTERVENTIONS AT THE INDIVIDUAL AND RELATIONSHIP LEVELS

At the individual level, prevention should aim at addressing individual risk factors and taking steps to modify service programs and promote awareness. Health care providers have a major role in addressing these factors and creating programs that increase awareness amongst others (9). However, extensive research surveying health care providers on the warning signs of human trafficking, identifying victims, and their knowledge on human trafficking has shown medical providers lack the knowledge in screening for and identifying victims of human trafficking. This results in the inability to identify the physical and mental health needs of victims and inadequate health care. Screening tools for use in healthcare settings are still in the process of being validated. However, they are extremely helpful in identifying and assessing the individual risk factors (24). The effects of trauma are unique to each individual. Thus, the care of victims needs to include trauma-informed care principles that acknowledge the uniqueness of each child and experience (6, 11, 25-28). This includes providing an individualized medical assessment and treatment including both physical and mental health services (29). More importantly, health care providers need to promote evidence-based, trauma-informed programs to prevent child maltreatment, address prior abuse/ neglect and promote positive parenting (30, 31).

Level of education was linked to cessation of commercial sexual exploitation by adulthood (32). Exploitation had ceased by adulthood among over two-thirds of women who completed at least high school education, but only 13% of those exploited into adult life had finished high school (32). Educational support, including individualized education plans, needs to be offered for all children especially for vulnerable girls to complete education at least to high school level. Additionally, educators need to be aware of local food banks to address food insecurities. They may also help in encouraging peer support and mentoring of children especially during adolescence when many high risk behaviors are initiated (e.g., substance abuse).

At the relationship level, health care providers should focus on developing positive family connections and peer networks for children to encourage safer behaviors and protection against human trafficking. A detailed social history obtained as part of the medical evaluation may reveal relationship level risk factors present in the child's family unit. Despite the adverse life experiences, homeless youth who had a supportive adult in their life had lower odds of being trafficked compared to those with no support (33). Families, schools and communities may benefit from supportive educational programs focusing on nourishing these family relationships and bringing awareness of the need of strong relationships. Supportive networks especially in high risk crime areas offer further protection for children and adolescents. Connections with service providers are important as well to help support dysfunctional families and assist in needed resources such as stable housing.

TARGETING PREVENTION AT THE COMMUNITY AND THE SOCIETAL LEVELS

Although victimization occurs across all socioeconomic backgrounds, human trafficking occurs often in the context of other community problems and pre-existing adversities. Traffickers tend to specifically target poor and marginalized communities. These vulnerable families are more likely to take greater risks in order to provide for themselves and more likely to fall victim to the false opportunities and promises of money, food, shelter, and love (34). Poor communities also lack sufficient police presence and lack the ability to optimally respond to crimes. The presence of transient adult males (tourists, military, or conventioneers) and gangs in the community also increase a child's risk of being trafficked.

Sex trafficking in particular is described as a form of gender inequality and gender-based discrimination. It has also been described as a contemporary form of female slavery (35). Although victims of sex trafficking can be of any age and of either sex, the majority are women and adolescent girls (36). Women and girls in the society are devalued and sexualized by the media. A culture that accepts prostitution and normalizes the sexualization of girls as a form of cuteness further increases the risk for sexual exploitation. Verbal and physical violence against females in video games sold to teenagers also potentiates gender discrimination (9). Women living in poverty and those that runaway are forced to perform sex for survival to meet their basic needs for food and shelter.

As a society we need to mitigate the risk factors that lead to human trafficking. Globally, many countries have focused on adopting anti-trafficking legislations and laws to criminalise traffickers. More effort needs to be focused on prevention programs and support for female victims in addition to therapeutic services for pornography addicts (35). Victims of human trafficking, especially children may experience considerable physical and mental health consequences as a result of being trafficked (37). Therefore, health care providers play an essential role in identifying, treating, and providing for the complex health care needs of victims of human trafficking and should be knowledgeable in the signs of possible sexual exploitation. Research has shown that the majority of victims seek health care during the time of their victimization, with the emergency department being the most frequent setting. Sadly, research has also shown the inability to properly identify victims of human trafficking in health care settings, medical clinics, and emergency departments. There is a lack of awareness of the magnitude of the problem in addition to the absence of validated screening tools. Victims may also not self-identify for fear of biased treatment or being judged by the health care provider (26). There is also a lack of collaboration among agencies in addition to a lack of referral services.

Policy development and legislative efforts are still evolving at both the federal and state levels (38). Federal laws including the *Trafficking Victims Protection Act (TVPA) (2000)* are essential. According to the TVPA, any person under age 18 years who performs a commercial sex act is considered a victim of human trafficking, regardless of whether force, fraud, or coercion was present. Therefore, force, fraud, and coercion does not need to be proven when children under 18 years of age perform a commercial sex act; as victims of human trafficking, they must be protected. At the state level, safe harbor laws were enacted by several states to redirect child victims of commercial sexual exploitation and child sex trafficking from the criminal justice system and into the child welfare system (39). Children who have been

trafficked and exploited need to be treated and thought of as vulnerable children in need of services rather than perpetrators of sex crimes. They also need to be protected from prosecution for offences such as prostitution and charges need to be dropped (40). Safe harbor policies also include law enforcement training, and increased penalties for adults seeking sexual contact with minors (39, 40). Research showed that law enforcement responses to juvenile prostitution are influential in determining whether such youth are viewed as victims of commercial sexual exploitation or as delinquents (11).

However, laws without funding for services are insufficient. The laws are also implemented differently from state to state, impacting the way children are cared for and treated. In addition, the implementation of these laws requires more collaboration amongst the state and local responders to ensure children are not criminalized and are referred to appropriate services. States are graded based on the strength of their laws related to commercial sexual exploitation of children based on an annual review of state laws as analyzed under the *Protected Innocence Challenge Legislative Framework*. All professionals working with high risk children or victims of human trafficking need to be familiar with the state law where they practise and work with state lawmakers and partners to introduce or strengthen safe harbor laws. Furthermore, states need to work on preventing human trafficking through reducing demand and improving training on identification of victims and how to appropriately respond. Laws need to mandate appropriate services and shelter for victims and incorporate trauma-reducing mechanisms into the justice system.

Social media networking, virtual worlds, and gaming sites have grown exponentially in recent years. These sites offer children opportunities for communication and socialization, enhanced learning experiences, and the ability to access information including health information (41). However, the internet has many risks, with children and adolescents being most vulnerable. Risks include inappropriate content; lack of understanding of online privacy issues; and outside influences of third-party advertising group. The widespread access to the internet and the increase in online advertising for sexual services has led to an increase in sexual exploitation amongst adolescents (11, 42).

INTERVENTIONS AT THE COMMUNITY AND THE SOCIETAL LEVELS

Prevention is a community effort, and awareness and education on human trafficking needs to spread to all community members, neighborhoods and organizations, including schools and municipal and county stakeholders. This will assist each community in developing protocols to monitor the extent of the problem and community related risk factors and take steps to address these problems. Despite the internet having a role in facilitating the commercial sexual exploitation of children, it may also have a role in educating community members and high-risk youth and children on the dangers of exploitation and how to be safe on the internet (43). This makes the role of educators, health care providers and especially pediatricians essential in educating the youth and their families on the dangers of the internet. The American Academy of Pediatrics encourages pediatricians to increase their knowledge of digital technology so that they can have a more educated frame of reference for the tools their patients and families are using. This will aid in providing timely anticipatory media guidance as well as diagnosing media-related issues when they arise (41, 44). In addition, parents need to discuss with their

children their online use, become better educated on the technologies their children are using, and supervise their online activities.

One of the leading indicators of vulnerability to human trafficking is housing insecurity. Homelessness is a huge problem in many communities forcing adolescents to engage in sexual activity in return for a place to stay. There is a shortage in numbers of crisis shelters, residential treatment centers, child protective services-funded group homes and foster care placements. Access to a list of supporters of the anti-trafficking efforts and those that offer services within each community (e.g., shelters, churches, and non-profit organizations) would facilitate referrals to these providers. More advocacy needs to focus on additional resources at the federal, state, and local level for service providers that are critical including emergency shelter, food, transportation, medical and behavioral health treatment and medication. Prevention needs to focus on increasing awareness of these supportive services according to the specific needs of victims that are trauma informed and victim centered to help reintegrate children in the community. Governments need to develop policies that help those in housing pay their rent, help cover utilities and prevent eviction. They also need to facilitate access to housing and offer temporary housing and shelter to those that are homeless or on the verge of becoming homeless including youth aging out of the foster care or child welfare systems.

Victims of human trafficking may continue to attend schools and may even be trafficked on school grounds by peers who are viewed to be 'popular' and more mature looking. These children may have academic and behavioral challenges that need to be addressed. However, the lack of awareness of the signs in this high-risk group may result in many of these students being unrecognized (11). School teachers, staff, nurses, and social workers are well positioned to recognize these children and need additional education and increased awareness in order to do so whether they are located in urban, rural, or suburban communities (11). Educators and school officials also need to know how to detect victims of human trafficking when they encounter them in the classroom. School boards are in need of education as well so that policies protecting children are implemented in schools. Education of children at schools and in the classroom is also essential. Children need to know what to do if they find themselves in a high-risk situation.

Educational programs targeting all stakeholders involved in caring for victims, including law enforcement, medical providers, and social services, are needed. These programs need to take into consideration the complexity of the multiple risk factors increasing a child's vulnerability for being trafficked, including the individual risk factors and influences of the family, community, and society. There has been a focus on educating health care providers on detection of victims of human trafficking and high-risk youth. Healthcare providers are uniquely poised to identify victims due to their close interactions with victims who suffer the mental, physical and sexual health consequences (45). Heath care providers need to be involved in detecting risk factors prior to the child being trafficked in order to prevent trafficking from occurring. It is imperative that healthcare providers also contact law enforcement and child protective services or the equivalent agency according to the local laws in the area where they practice (46). Table 1 shows different organizations and websites that may help in obtaining education and guidance in addition to services for victims. The websites include access to assessment tools, interactive training modules, and pre-recorded webinars in order to increase awareness among all community stakeholders. Healthcare providers can influence policies and advocate for high risk and vulnerable youth to prevent trafficking from occurring. Health care providers can lead the global efforts through education, advocacy, prevention and further

research to end human trafficking and promote the health of the vulnerable children. All health care providers working with children need to come together in a unified force to increase awareness of human trafficking. This can be done through educating other health care professionals and advocating for changes in policies. They also need to address contributing risk factors to create a strong human trafficking prevention program.

Table 1. Helpful resources and organizations for human trafficking education, prevention, and internet safety

Organization	Website
Futures without violence	A health and social justice non-profit with a simple mission: to heal those among us who are traumatized by violence today—and to create healthy families and communities free of violence tomorrow. https://www.futureswithoutviolence.org/
HEAL trafficking	HEAL is a united group of over 3,100 survivors and multidisciplinary professionals in 35 countries dedicated to ending human trafficking and supporting its survivors, from a public health perspective. https://healtrafficking.org/
Office on trafficking in persons SOAR to health and wellness training	SOAR applies a public health approach to build the capacity of communities to identify and respond to the complex needs of individuals who have experienced trafficking and understand the root causes that make individuals, families, and communities vulnerable to trafficking. https://www.acf.hhs.gov/otip/training/soar-to-health-and-wellness-training
Physicians Against the Trafficking of Humans (PATH)	PATH was founded by the American Medical Women's Association in order to educate physicians, residents, and medical students about issues. The website is interactive and contains a series of educational videos to educate the medical providers. http://www.doc-path.org/
National Human Trafficking Resource Center	The National Human Trafficking Hotline connects victims and survivors of sex and labor trafficking with services and supports to get help and stay safe. The Trafficking Hotline also receives tips about potential situations of sex and labor trafficking and facilitates reporting that information to the appropriate authorities in certain cases. In the USA the hotline can be accessed by calling 1-888-373-7888. https://humantraffickinghotline.org/resources
Shared Hope International	Shared Hope International proactively supports the legislative, law enforcement, and social services communities with timely and effective reports, studies, surveys and legislation aimed at eradicating human trafficking. https://sharedhope.org
United Nations Office on Drugs and Crime Human Trafficking Knowledge portal	An initiative to facilitate the dissemination of information regarding the implementation of the UN Convention against Transnational Organized Crime and specifically the Protocol *to Prevent, Suppress and Punish Trafficking in Persons*, Especially Women and Children. https://sherloc.unodc.org/cld/en/v3/htms/index.html

At the societal level, multiple sectors serving potential human trafficking victims and high-risk youth also need to collaborate to develop a comprehensive supportive infrastructure to address local and state policies. Law variations across states may lead to inconsistent and inadequate protection of victims. Professionals also need to be more aware of local and state policies that address human trafficking in their state and country of practice. This awareness will result in professionals being more vocal in supporting their congressional representative in developing antitrafficking bills and efforts. Children need to be offered medical and psychological treatment, emergency and long-term housing, education assistance, job training, language assistance and legal services (6, 29). These services are critical, especially with most of these children experiencing previous abuse, neglect and other forms of trauma.

On an academic level, research collaboration across disciplines would enhance the development of national antitrafficking polices and promote interprofessional collaboration. It will also assist in developing educational programs targeting professionals from law enforcement, health care, and social services. Findings from studies looking into risk factors that increase the vulnerability of children and the victimization can inform state-level policies on human trafficking and assist juvenile justice and child protection agencies in developing prevention responses to commercial sexual exploitation (17, 47).

CONCLUSION

Human trafficking is a violent crime and a public health crisis with consequences affecting individuals, families, communities, and societies around the world. Efforts have focused on increasing awareness of human trafficking and addressing exploitation after it occurs. However human trafficking is preventable, and more efforts need to focus on preventing it before it occurs. Using a system-based social-ecological model helps stakeholders in understanding the social determinants of vulnerability of trafficked children. Through this understanding, a framework can be established to address the root causes that increase a child's risk of being victimized. There is no single factor that increases a child's risk for being trafficked. It is the interaction of factors from the four different social levels surrounding the child. Thus, our focus needs to address this multilevel interaction of risk factors. Combatting human trafficking and, more importantly, prioritizing prevention have become a shared responsibility for everyone; each in their own unique role in caring for children, whether at the individual, relationship, community or societal level.

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Chapter 20

CHILD FATALITY REVIEW AND PROGRAMS TO PREVENT CHILD MALTREATMENT DEATHS

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ABSTRACT

The death of a child is a sentinel event for a community, prompting a need to understand the cause and to prevent additional deaths. A substantial number of children who die as a result of maltreatment were previously known to children's protective services. Child fatality review (CFR) is one means of understanding child maltreatment deaths and developing efforts to prevent them. CFR teams are made up of community members from various disciplines who convene in an effort to recommend prevention efforts. A number of prevention programs have been developed in the United States and Canada that show meaningful promise for reducing the number of child fatalities. These include *Choose Your Partner Carefully* programs and *Period Of Purple Crying*, both of which have

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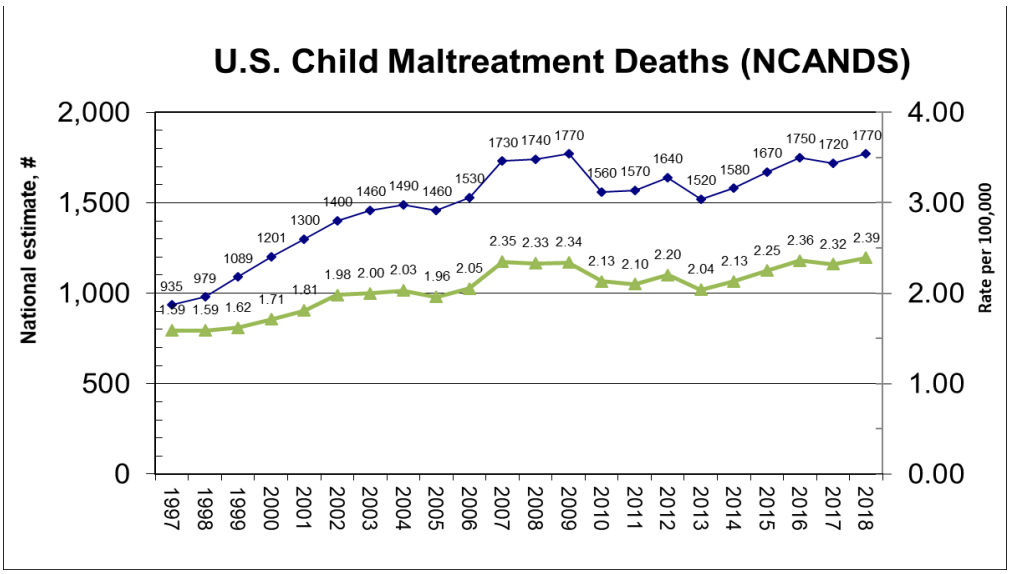
demonstrated empirical support. Working with immigrant and refugee families is also crucial to reducing child fatalities. Among the strategies that CFR teams should utilize to spread the prevention message is to develop a mass media campaign.

INTRODUCTION

The death of a child is a sentinel event for a community, prompting a need to understand the cause and to prevent additional deaths. When the death is caused by child abuse or neglect, the cause is preventable and reflects modifiable psychosocial factors rather than biologic causes (1). An estimated 1,770 children died as the result of maltreatment in the United States in 2018, a rate of 2.4 per 100,000 children (2). This number has increased in recent years (see Figure 1). Most (>70%) were under the age of three years, and most occurred as the result of neglect alone (73% in 2018) or in combination with abuse. This number is thought to be an undercount and the actual number may be two or three times larger than reported in official statistics (3).



Source: US DHHS, Child Maltreatment 2018.

Figure 1. Maltreatment deaths and rates recorded in the US in NCANDS, 1997-2018.

We do know that there are a number of factors that raise the odds for child abuse fatalities, and these factors vary depending on the population studied (emergency departments, inpatients, medical examiners) and certain child, family and community factors (4-8). Infants and toddlers have the highest risk for an abuse or neglect fatality compared to other age groups and require special attention. Schnitzer and Ewigman (4) found that children under five years of age who lived in households with male adults who were not biologically related to them were 50 times more likely to die from inflicted injury compared to children residing in households with two biological parents. Substance abuse as well as access to and use of drugs and alcohol were also risk factors (2). Using child abuse report data, Douglas and Mohn (9) found that children who

were fatally maltreated lived in families that experienced more financial and housing instability compared to non-fatally maltreated children and used/received fewer social services.

Although certain causes of death have been identified medically (e.g., abusive head trauma, blunt trauma, asphyxiation, poisoning, neglect) (10), child maltreatment (CM) fatalities are not solely a medical problem. While we know that more fatalities are caused or contributed to by neglect, it is not clear how or whether prevention should target specific causes even when a case has previously been reported to children's protective services (CPS) (11). In 2016, 29.7% had at least one prior CPS contact in the three years prior to death. Similarly, in 2018, 20.3% of cases with deaths had received family preservation services within five years (2). It turns out that a prior call to a child protection hotline, regardless of the disposition, is the best predictor of a later child abuse or neglect fatality (4). This demonstrates a need for a policy discussion about CPS's role and how it responds to calls, as well as a discussion about whether an initial decision to "screen out" certain calls leaves children unseen who may be at a high risk for later death (12).

It will be impossible to appropriately respond and know if we are making improvements without an accurate national count of CM fatalities (3). Despite more than 25 years of administrative data, child fatality review (CFR) teams and a national CFR case collection system (13), only limited research into CM prevention has been conducted and it is difficult to measure whether there has been a reduction in child maltreatment fatalities (3, 14). It has been suggested that we need to dramatically redesign our approach to helping families and children—with a stronger focus on prevention—in order to eliminate child abuse and neglect fatalities. However, any response is limited by our lack of understanding of the effectiveness of any specific prevention strategies. Low incidence rates, the myriad of potential causes, and our inability to predict accurately CM fatality in infants and young children have made prevention problematic (3).

Unfortunately, the current array of services and supports in the US does not adequately ensure safety for children at increased risk for fatality. These services fail to sufficiently strengthen and support these children's caregivers and do not achieve the US Commission to Eliminate Child Abuse and Neglect Fatalities's goal "of eliminating child abuse and neglect fatalities" (3). Professionals in health, education, criminal justice, and child welfare have increasingly important roles to play in identifying, reporting, investigating, responding to, and preventing CM fatalities (14-17). Child fatality review (CFR) teams, fetal-infant mortality review teams and CPS citizens review panels can only respond after the death of a child, but they can play an important role in accurately identifying these deaths as well as in the development of prevention strategies in the community (10,19-21). As noted, many children who subsequently die from maltreatment are known to CPS or have been receiving services (2, 5). However, the current approach waits until a child is severely injured before intervening with vital supports and relies primarily on a single government agency (CPS) to intervene with families that face complex and intersecting challenges. Too often, the current approach inflicts significant additional trauma on the very children and families it seeks to protect (17).

This chapter reviews CM fatality prevention efforts taken to date as well as the national recommendations for responding to child maltreatment fatalities, including legislative and policy issues designed to address needs in the current systems. It begins with a brief overview and history of child fatality review, including the legislative context creating a national center and data collection system to support state efforts. While the term *child fatality review* will be used throughout, the term *child death review* has been used synonymously. Our current

understanding of the child fatality review process, data collection and synthesis will be considered, including the composition of teams, the process itself, current best practices and experience in the states. Benefits and weaknesses will be explored. Most importantly, the impact of teams, the prevention strategies developed, and the effects on child deaths will be discussed. Training for team members and all the professionals involved in the response will be discussed, as well as potential strategies involving media and public health interventions that target risk factors such as parental practices in corporal punishment and infant shaking. While it will become clear that it is difficult to measure the impact of these activities, if we are able to prevent even a few child maltreatment fatalities, the effort will be worth it.

OVERVIEW OF CHILD FATALITY REVIEW

Child fatality review (CFR) is a multidisciplinary examination of individual child deaths to gain an understanding of the risk factors and circumstances surrounding the death of a child. Death certificates and vital records provide basic information about how children die but lack the detailed information about why or what risk factors existed in the child, family, community and/or environment. The role of CFR teams is not to place blame on individuals or agencies. Instead, the role of CFR is to identify and address system gaps (22).

The membership of CFR teams varies depending on state and/or local laws, jurisdictional needs, and type of death under review. At a minimum, it is recommended that CFR teams be composed of law enforcement, death certifier (medical examiner/coroner), public health, pediatrician, child welfare and prosecuting attorney. Many teams include members from emergency medical services, schools, hospitals, community mental health, fire departments, healthy start and birth to three. Team members come to each meeting with case information regarding specific children and share what is known with the team. CFR teams are tasked with catalyzing prevention based on the review meeting and data collected (13).

History of CFR

While the exact origin of CFR is difficult to trace, it is believed that the first review teams originated in the late 1970s. During the 1980s, CFR teams began to expand due to grassroots efforts. In 1993, CFR was established in the literature by a landmark study in the journal *Pediatrics* that demonstrated the underreporting of child abuse deaths based on CFR conducted in Missouri (23).

During the 1990s, CFR expanded, and several pieces of federal legislation were passed to support it. Most notably, the Child Abuse Prevention and Treatment Act (CAPTA) required states to include fatality data in their program plans. CAPTA not only requires states to review fatalities, it requires that states have a comprehensive plan to engage a broad group of stakeholders, including law enforcement, private agencies, and public health. CAPTA also requires that data be made available to the public (24). Given the similarities between CAPTA reviews and CFR teams, many states worked to build collaboration between the two systems. In fact, some states use CFR teams to fulfill their CAPTA requirements.

The first national convening on CFR took place in 1994; representatives from 43 states attended. By the end of 1995, the US Advisory Board on Child Abuse and Neglect reported that 45 states were reviewing child deaths (1, 26). Through the late 1990s and early 2000s, CFR continued to grow based on grassroots efforts focused on reducing child abuse and neglect fatalities (23). In 2002, the US Health Resources and Services Administration funded the first national resource center for CFR. Since then, there has been federal support for this national resource center. Currently, CFR program exist in all 50 states, the District of Columbia, and on many tribal reservations.

Reviewing deaths

Today, CFR programs exist in three ways (26). The first is a state level program where case review, data collection and written recommendations are done statewide. This process is common in geographically small states or those with low population density. The second structure is that reviews are done by local teams, typically county-based. Local teams review deaths and collect data. The third structure is a hybrid, with a state team that writes recommendations based on data gathered from reviews conducted by local teams.

The hybrid state/local structure is the most common structure within the US. This is effective because it maximizes local access to records while leveraging state relationships to make policy changes (26). By having reviews at the local level, the team has access not only to the records and to the professionals who responded to the death. This allows the team to deepen its understanding of what happened beyond case notes and official reports. Often, the information that fatality review teams are seeking related to risk factors, adverse experiences and disparities is not captured in official reports, and local reviews provide the opportunity for professionals to share their observations. By sharing data collected by local reviews with state fatality review teams, data trends are identified and action can be taken across jurisdictions. Additionally, state fatality review teams can recommend changes and shifts in agency policy and practices.

Data collection

CFR programs have a unique opportunity to collect data from a variety of sources, including law enforcement, death scene investigators, health records, child welfare, schools and more. Given this unique set of data, a national CFR data system was developed in 2005 that is now used by 45 US states. This National Fatality Review-Case Reporting System (NFR-CRS) is a web-based system that allows users real time access to their data (27). Additionally, NFR-CRS allows states to compare data across local teams, while restricting local team access to their own jurisdiction. Currently, there are more than 2,800 variables in NFR-CRS.

Data are collected regarding numerous domains. This includes information about: the child; the biological parents; the caregivers (if different than biological parents); the supervisor at the time of the incident; the incident; the cause and manner of death; risk factor data specific to the cause of death; the sleep environment (if relevant); suicide risk factors (if relevant); detailed health history (if relevant); any acts of omission or commission; prevention strategies

recommended; team members present at the review; barriers that impacted the review; and a narrative.

NFR-CRS is revised every 18-24 months. The latest revision (May 2020) included a section titled "life stressors." This section seeks to provide a space for communities to collect data that speaks to the circumstances in which children and families live. Some of the variables in this section ask if the child and/or family had ever experienced: racism, food insecurity, poverty, lack of technology, or housing insecurity. The goal of this section is not only to expand the conversation about these topics during the review meeting, but also to document the circumstances in which the child and family live.

One of the benefits of the NFR-CRS is that the variety of data collected can be analyzed in multiple ways to look at circumstances and risk factors about the child, family, community or environment in which the death occurred. NFR-CRS provides users with the ability to download their data as well as run more than 30 preprogrammed reports. These reports are used at the local, state and national level to help understand how and why children die.

CFR TEAMS AND PROCESS

CFR is a community response to a child dying. Each CFR team is comprised of members who seek to improve the health and safety of their community. In order to understand the complex factors surrounding the death of a child, it is recommended that CFR teams use a process called "share, question and clarify" (26). This process allows team members to share information fully about the case. Typically, this is done by allowing team members sharing everything relevant to the death to do so without being interrupted. The team member with the most information shares first; this is typically the medical examiner or law enforcement. The team member who has the next most information shares next. The team moves around the circle calling on each team member to ensure that all the information is shared. Once all of the information is shared, the team can move on to asking questions about how systems responded to the family before the death-causing event, during the event and after. The goal of asking questions is to uncover systems gaps. The final step is to clarify all the case information with the systems responses. It is important to clarify information to ensure that as complete a picture as possible is created (26).

It is vital that team membership be broad and that key disciplines are represented. Additionally, it is important to ensure that the team resembles the community it serves. It is important to consider race, gender, socioeconomic status, geography, literacy, sexual orientation and gender identity when evaluating the composition of the team. It is vital to include members that represent the most disadvantaged parts of the community. In order to authentically shape the work, these members should be given leadership roles. Ideally, prevention partners from the community are on the team as well, to help implement some of the strategies that the team identifies.

CFR teams do not seek to point fingers or place blame on any individual or agency (16, 26). Instead, CFR teams seek to understand how systems worked or failed to work together. By compiling records from many disciplines, CFR teams can examine a death through a new lens. Often, individual agencies are unaware of how other agencies respond to a death. CFR reviews

allow communities to understand how agencies could improve collaboration and services to families.

Benefits of CFR process

The topic of a child death is a difficult one to discuss. When a child dies from abuse or neglect, we as a society need to do everything within our power to learn why that death occurred, and what can be done to prevent future deaths. There exist many layers of protection and investigation in most jurisdictions. The police investigate crimes, the district attorneys prosecute crimes, and the child welfare system seeks to protect vulnerable children and help strengthen vulnerable families. However, in many locales, the coordination between these different systems is suboptimal. There is not always good communication.

Increased collaboration among agencies is one benefit that the CFR process brings to a community (26, 27). A well-run CFR team will bring together members of a community who are involved with dealing with a child's well-being. Ideally, members come to meetings prepared with the appropriate documents from their jurisdiction and share that information with the entire team. CFR teams improve communication among agencies by the mere fact of coming together on a periodic basis to review deaths and prevention strategies. In today's siloed world, there is a benefit of bringing people face to face to improve relationships for future collaboration. In addition, Schnitzer et al. (20) found that no single source of data was adequate for surveillance of fatal CM, but by combining multiple sources, case ascertainment was substantially increased. Among them, child fatality review team data was the key source, and identification was further improved when combined with child welfare data.

Many communities rely on death certificate data when counting the number of child deaths and their causes. The complete facts of a case may not come to light until after a period of time, and sometimes this will change the determination of a manner and cause of death. Thus, the death certificates are often an undercount of true CM (23, 30). Also, not all children who die get the full investigation that they deserve (23). For example, investigators must consider whether child maltreatment is the cause of death in order to ensure a comprehensive scene investigation. If you do not look for something, you will not find it. CFR team meetings often occur months after the death of the child. One benefit of this delay is that most investigations have been completed. By coming together with this information, teams can build a story of why and how that child died that is more complete than it would be in the immediate aftermath of the death.

A mature CFR team has the ability to review difficult cases, such as child abuse, and ask the hard questions that need to be asked of the community and specific agencies. Sometimes, when the history of a child is presented from multiple angles, it becomes clear that a pattern of abuse or a high-risk situation was missed and may have been prevented. While the goal of CFR is not to assign blame, unless there is a thorough review of the role that each agency or system played in a child's life, or lack thereof, a community is not going to learn how to prevent future deaths. Thus, CFR teams can help hold agencies accountable and spur them to change their policies or procedures based on what is learned through the CFR process.

Implementing prevention strategies at the local or state level is another benefit of CFR (30). Part of the review process is to discuss improving the delivery of services to children and families, advocate for prevention strategies, and influence policy or legislation when

appropriate. While the initial review might focus on the why and how a child died, a review is not complete until a discussion ensues on how to prevent these poor outcomes from reoccurring. Closing the circle from evaluating the root cause of a death, to working as a community to prevent future ones, is the ultimate goal and benefit of CFR. It is therefore helpful when teams have prevention partners as part of their membership.

Weaknesses of CFR

CFR can impact children's lives. It is important, though, to look at the weaknesses of the CFR process, and at possible improvements. One area of concern is that there is no single model across the US. CFR varies widely in the composition of teams and the execution of reviews. According the National Center for Child Fatality and Review's 2017 report (31), the following vary among states: lead state agency, permissive versus mandated legislation, local versus state review, types of deaths reviewed, maximum age of deaths reviewed, and time between death and review. Only 15 US states review 100% of child deaths.

Inconsistent legislation across jurisdictions makes it challenging to create uniformity for teams. Also, having legislation in place does not always mean that all the required elements are being followed. Funding for teams varies widely (from zero to over $1 million). All this creates uncertainty as to how teams are performing their roles.

CFR teams consist primarily of volunteers who are not compensated for their participation in team reviews. There is neither required standard training nor ongoing certification for members nor is attendance at team meetings compulsory. And even if a team member attends the meeting, there is no guarantee that he/she will bring all the appropriate documents or divulge all that is known about a case. This can lead to incomplete reviews.

The fact that not all deaths are reviewed introduces potential bias into the results of the US national case reporting system. Although not intended to be a surveillance tool, a weakness of the combined data is the varied approach that different states have for CFR. Also, there are elements of the dataset that are subjective, such as: "could this death have been prevented?" Many jurisdictions will interpret this differently based on experience and who is present at the meeting. It is important to note that while this might be considered a weakness, it is the process of the review and discussion that adds meaning to the review. While there might be disagreement among team members about whether a death was "preventable," what is learned from that discussion and what is done with that information is where the value of CFR lies.

One goal of a successful team is to present recommendations for policymakers to implement with the goal of preventing future child death. Teams often struggle with writing effective recommendations that can be translated into action (34). When teams do make recommendations, there may be an inability to follow through, often leading to grand ideas that are never implemented as policy or practice.

Despite these limitations, it is worth remembering that an overarching goal for any CFR team is to bring people together to look at systematic changes that can reduce child death and morbidity. This process is ideally done at the local level and will be different among teams, reflecting the diversity of our country.

Effectiveness for prevention

CFR teams are charged with identifying opportunities for prevention. Long-standing, successful CFR teams focus on prevention. These teams have made significant contributions to reducing future child deaths. Professionals want to do "something" when a child dies, and CFR can be that something if the team moves beyond the review into prevention.

One of the unique ways CFR teams contribute to preventing future deaths is by offering a real-time, continuous feedback loop. CFR teams examine system policies and their implementation. Sometimes, professionals follow an agency policy but there was an unexpected result. A prompt CFR review can help agencies identify and address these systems gaps. By participating in CFRs, agencies may change and shift their policies and procedures to address emerging trends.

Although much has been written and discussed about the difficulties of accurately measuring the effectiveness of CM fatality prevention, the plain fact will always remain that it is virtually impossible to count things that did not occur. A reduction in the numbers of such child fatalities may be revealing, but it does not itself establish a causal relationship between prevention efforts and the actual reduction in numbers. Similarly, an increase in the numbers of identified child fatalities resulting from abuse or neglect does not mean a particular prevention program was a failure, especially since there remain significant concerns about under-ascertainment of child maltreatment fatalities. For example, in a study comparing medical examiner records to vital statistics, Herman-Giddens and colleagues found that 61.6% of child abuse fatalities were under-ascertained in vital statistics (32).

Undercounting CM fatalities is a concern dramatically illustrated by a CDC-commissioned study of three states' reporting systems that concluded that there is no consistent method of accurately counting how many such deaths occur each year (20). The study illustrated that, when an intensive effort was undertaken in three states to combine child maltreatment fatality data from more than one source, the actual number of cases identified dramatically increased. This study provided empirical support for what professionals had been saying for decades, that "official" counts of CM deaths were likely underestimates. In that study, case counts were collected from child welfare agencies, death certificates, and criminal justice data for California, Michigan and Rhode Island. The authors note:

> Our results confirm existing literature that documents the underascertainment of child maltreatment deaths by state child welfare agency and death certificate data. When compared with the total number of cases identified by multiple sources and alternative approaches to surveillance in these 3 states, state child welfare agency data underascertained child maltreatment deaths by 55% to 76%, and death certificates underascertained deaths by 80% to 90%, a range that is consistent with the literature. ... The results further demonstrate the value of using multiple existing data sources to improve child maltreatment surveillance. In each state, the use of 2 data sources resulted in ascertainment of more than 90% of unique cases identified from all 4 sources. Although the 2 data sources were not consistent across the states, child fatality review team data were a key source. Combining child fatality review team data with child welfare data in Michigan and Rhode Island resulted in 98% (108 of 110) and 100% (60 of 60) ascertainment, respectively, whereas combining child fatality review team and UCR data in California identified 93% (214 of 230) of cases ascertained by all sources (20 p 300).

It is troubling that child welfare data and death certificate reports undercounted actual child maltreatment related deaths at such alarmingly high rates, indicating the need for systemic changes in the way child maltreatment deaths are reported nationwide in the US. This is important because until there is an accurate count of how many child maltreatment deaths are occurring, determining which prevention efforts may be most effective, especially if the measure is reduction in numbers of such deaths, will remain elusive. We suggest that pure numbers of child maltreatment deaths and whether a decrease in such numbers has occurred after a particular prevention effort is implemented will never actually capture whether the program had an impact. Given that fact, the discussion should be informed by what types of prevention efforts are likely to prevent even one child caretaker from losing impulse control and causing permanent harm or death to a child in their care. What programs may result in a child's parent being more discerning when choosing alternate care for the child or gaining an affirmative commitment from the babysitter that he/she will ask for assistance before harming the child? The answers to these questions cannot be tied directly to decreases in overall numbers, especially as the numbers may not be accurate without more intensive surveillance. Rather, the measure of "effectiveness" should be focused on what collective professional experience tells us about the triggers of fatal child maltreatment and specifically what messages might get through to those caregivers who find themselves in a moment of crisis that precedes an act or acts of fatal maltreatment.

Beyond effectiveness, the benefit of a multidisciplinary group reviewing child maltreatment fatalities has been demonstrated (33). Each professional who participates in such reviews, whether the meeting is convened by the child welfare agency, a state health department, or another source, brings different experiences and skills to the discussion. And, as Dr. David Sanders, the Chair of the US Commission to End Child Abuse and Neglect Fatalities said:

> "Our commission found the review process, as it currently stands, to be generally ineffective. Reviews tend to focus on details of individual cases rather than systemic issues that allow these tragedies to occur. The fatality review process should focus on change at the systems level, be comprised of a multi-disciplinary team, coordinate with other review processes, and include an accountability mechanism to ensure that public agencies are following through to change the conditions that result in child deaths." (33)

Although child fatality review teams continue to play a very important role in identifying and learning about precursors to individual child maltreatment deaths, this recommendation is important and should be followed throughout the country by reforming child fatality review to focus not just on individual cases, but on systemic changes that would contribute to prevention of future deaths. Many teams already provide such recommendations for policy and procedure changes, but at least in some situations the recommendations could be improved by focusing the message to those who can achieve the desired changes (34). Successful prevention efforts and programs will likely take several forms, from public and media messaging to home visitation to general parenting training and community support. Virtually anything that will decrease the stress on child caretakers, especially for those caregivers who for whatever reason are isolated from family or community supports, should be considered when the goal is to prevent so many children from being killed by preventable child maltreatment.

OTHER FATALITY PREVENTION PROGRAMS THAT HAVE SHOWN PROMISE

Criminal justice professionals who work in the field of child maltreatment and child welfare attorneys who engage in child protection efforts have reached the conclusion that what we learn from handling case after case can be translated into effective prevention strategies. Prosecutors and law enforcement officers are frustrated when they see the same patterns repeated in multiple cases involving the fatal abuse of very young children. These professionals often discuss the answer to one question: "What might enter the mind of the overstressed caregiver to avoid a fatal act of abuse?" Some of the most commonly offered answers are: "Just put the baby down in a safe place and walk away" or "You don't have to stop a baby from crying; babies cry to communicate, not always because something is wrong that you can fix" or "Why don't these mothers realize that just because their boyfriend is someone they love that doesn't mean he is a safe babysitter?"

Choose Your Partner Carefully campaigns

One of the primary CM prevention campaigns showing some promise of success is Ohio's *Choose Your Partner Carefully* Campaign (CYPC). First launched in 2008 in Lorain County, and designed by a caseworker in that county, the program was adapted to 17 other counties in Ohio and is now used as a model in Nevada. The State of Texas has adapted the program to its prevention program efforts through the *Think before you trust* Program.

Following a spate of child deaths at the hands of their mother's paramours, the Ohio Child Fatality Review Board recommended teaching parents to identify responsible adults as caregivers for children. The Ohio experience was, of course, not isolated, as virtually every jurisdiction in the country has identified at least some child abuse or neglect related fatalities resulting from action or inaction by a paramour of the child's parent. This was the first program designed specifically to attempt to prevent those child maltreatment fatalities. The goals of the program are to: 1) increase awareness among women of the risk their children face when a non-related male (or female) is entrusted with their care; 2) provide tools to help women better evaluate the likelihood that their paramour could become a perpetrator of abuse; 3) educate women to recognize potential signs of abuse to their children; 4) increase community awareness of the problem and its overall impact on the community and 5) provide local resource information to the child's parent.

The program's message is "choose your partner carefully, your child's life depends upon it." *Choose Your Partner Carefully*'s public information campaign uses social media, brochures and public service announcements. It explains the risk parents take when they trust their paramour to be a competent and safe caregiver for the children just because the parent loves him or her. Toolkits for single parents often feature the following list of "warning signs," each of which should result in the parent not leaving their children alone with their partner:

- Does he/she get angry when you spend time with your child?
- Does he/she get angry or impatient when your child cries or has a tantrum?
- Does he/she call your child bad names or put them down?

- Does he/she think it is funny to scare your child?
- Does he/she make all the decisions for you and your child?
- Does he/she put you down or tell you that you are a bad parent or that you should not have your kids?
- Does he/she pretend when he/she hurts your child that you are to blame or that it is no big deal?
- Does he/she tell you that your child is a nuisance or annoying?
- Does he/she scare your child by using guns, knives, or other weapons? (35)

The Nevada version of *Choose Your Partner Carefully* has been evaluated and the original version has been changed to adapt to the recommendations emerging from that evaluation process (36). Although the message in Nevada's program is the same as in Ohio, Nevada has added a parenting training course after their evaluation and has improved the materials based on feedback from parents surveyed. The evaluation in Nevada did not attempt to determine whether implementation of CYPC had reduced the number of paramour-caused maltreatment fatalities in Nevada, nor has Ohio conducted that type of evaluation. Prevent Child Abuse Nevada's CYPC) program's webpage suggests several questions to ask caretakers and institutional day care centers before trusting a child's care to them and includes links to the brochures and posters used in the Nevada CYPC Campaign (37).

While it has long been known that parents who live with a partner who is unrelated to their children may be putting their children in harm's way by leaving the children to be cared for by such a person, until fairly recently prevention programs did not focus directly on this risk (38, 39). Jenny and Isaac found that "children living in a household with an unrelated adult were 27 times more likely to die of an inflicted injury than children living with one or two biological parents" (39). It is recommended that all jurisdictions consider implementing some version of the *Choose Your Partner Carefully* campaign, since the problem of unrelated paramours of the natural parent being left to care for children and causing serious abuse or death of a child is universal. Recently, the State of Texas has adapted the CYPC concept in its program *Think before you trust* (39). The introduction to the program explains: "It's a common mistake to think that just because someone loves you, he or she will be able to safely care for your child. It's important to understand that not everyone has the parenting skills and patience necessary to provide care for a child." The program materials point out that sometimes parents leave their children in the care of an individual who has a known criminal record or a violent past, sometimes resulting in serious injury or death to the child.

Hospital-based prevention programs

Dr. Marc Dias pioneered one of the most innovative Shaken Baby Syndrome prevention programs in several hospitals in Western New York in the late 1990s/early 2000s. The program lasted for six years and provided information to all parents (mothers and fathers or father figures) after the birth of their baby. This included material about the dangers of shaking and alternatives to soothe a crying baby. One of the innovative aspects of the program was the use of commitment statements that the parents signed before leaving the hospital, acknowledging they understood the information and would pass it on to others who cared for their baby.

Participants were surveyed after 10 months to determine if they remembered the information. The researchers found an overall incidence rate decrease of 47% of inflicted head injuries over the 6-year control period from 1998 to 2004 (40). This type of hospital-based parent education program was replicated or modified and applied in several other locations throughout the United States, with varying levels of measured "success." The Centers for Disease Control published "Preventing Shaken Baby Syndrome: A guide for health departments and community-based organizations" (41). Appendix A of the guide describes all of the different hospital-based prevention efforts and all of the State initiatives relating to legislation mandating training on Shaken Baby Syndrome's dangers and ways for parents to cope. It has often been suggested that educating parents about the dangers of inflicted head trauma is insufficient alone to effectively prevent such injuries and that prevention efforts should focus on getting them to make a plan for what to do when they are overstressed while caring for an infant or toddler and cannot stop the child from crying. Of course, crying behavior is only one "trigger" of abusive or violent reactions, and any source of stress may have dire results for a child when the frustration of their caretaker boils over.

Another promising hospital-based and research-supported abusive head trauma prevention program was developed by Dr. Ronald Barr in conjunction with the National Center on Shaken Baby Syndrome. Dr. Barr's research over many years established that infant crying is a normal method for communication and that there are times in an infant's development where he/she will cry even though apparently all the baby's needs have been provided for. This research is the basis for the *Period of PURPLE Crying* prevention effort, targeted at stressed infant caretakers who may believe they should always be able to stop a baby from crying and that failure to do so means they are failing in their parental duties. In a 2018 study conducted in British Columbia, the authors determined there was a 35% reduction in AHT cases following implementation of the purple crying program in hospitals compared to the period prior to use of the program (42-44).

There are dozens of similar hospital-based prevention programs in use across the United States. It is clear from all of them that education of parents and caregivers is only the first step to prevention of abuse and child fatalities and that more needs to be done in terms of innovating new methods to teach caregivers how to cope in that moment of crisis right before they might lose impulse control and harm a child. Clearly, other aspects of engaging community support for young or inexperienced child caregivers is also key to prevention. Many communities are making efforts to expand the availability of respite care for stressed caregivers, provide advice and financial assistance to parents to minimize levels of stress, and activate faith-based communities to both educate and provide support to their congregations.

Immigrant families

According to the Child Welfare League of America's 2018 Legislative Agenda, approximately 9 million children under 8-years-of-age live in a family that includes at least one immigrant to the United States. Almost half a million of these children experienced the deportation of a parent or caregiver (46). Much has been written for professionals in the child welfare system about working with immigrant and refugee families. While there are several local efforts to provide child maltreatment prevention services to these families, there is little in the literature analyzing the success of these prevention efforts.

Despite these efforts, there remains an urgent need to recognize and provide supportive information and services to immigrant and refugee families coming into the United States. Multiple researchers have pointed out the difficulty of determining the true incidence of child maltreatment among these families for a wide variety of systemic and record-keeping reasons. However, the best suggestions for prevention of future maltreatment of children in immigrant and refugee families seem to agree that meeting the many needs of such families, especially in the early stages of their resettlement, may be the most important method for prevention of overly harsh discipline which may lead to fatal abuse (47-49). LeBrun and her colleagues (47) attempted to determine whether children of immigrant and refugee families are at higher risk for child maltreatment, whether there are risk and protective factors that should be recognized among such families, and what future research should be conducted. They concluded that because of the differing ways that data is collected in different countries and jurisdictions, often not separating or taking into account whether the CM occurred in an immigrant or refugee family, and because 'unofficial' studies were inconsistent in their analysis, there is no reliable indication that immigrant or refugee children are at a higher risk than the general population for child maltreatment. They did, however, provide a list of risk factors that may be enhanced among this population of families especially in the early stages of their resettlement, but which are for the most part the same risks for child maltreatment seen in all families. These include:

- High degree of family stress
- Step-parenthood or single-parent home
- Low education level
- Large families
- Witnessing domestic violence in the home.

To this list, they added these factors unique to the 'challenges of resettlement':

- Short time in the new country
- Lack of familiarity with the new country's cultural norms and expectations, laws, and expectations for parental behavior
- Use of excessive physical discipline, often because that was tolerated in country of origin
- Low to no social support in the new country
- Stress caused by changes in gender and other family roles.

As with other authors, LeBrun and colleagues (47) focus on the importance of providing immigrant and refugee families with the resources and information they need to adjust to their new environment in as safe and non-threatening an environment as is possible. They suggest future research should focus specifically on this category of families and that prevention efforts should be both culturally sensitive and tailored to the particular challenges based on each family's country of origin and their own experiences getting to the new country.

The reason the need is so urgent to provide tailored child maltreatment prevention efforts directed to immigrant and refugee families is that the parenting and disciplinary practices in the family's country of origin may well be substantially different from the cultural norms and laws in the new country. Yet these differences may be something of which newly arriving families

are unaware. Unfortunately, in the United States, if such a family member is convicted of any crime of violence, which includes any crime involving child abuse, deportation is almost a certainty even if the family member came here on a visa or was awaiting refugee status. Additionally, many newly-arrived families are unaware that there is a variety of social and economic services available to them even if they are undocumented, which often results in the family being further socially isolated. Many such families have come from countries where social welfare agencies don't exist, where their country may have been at war or affected by other forms of daily violence, and where the police are not trusted to be a source of protection, but rather are seen as a danger. When the family's daily survival was the primary focus of their former lives, child maltreatment or neglect may not have been something they thought about, and is likely to have never been the focus of supportive government services. Immigration policy and practice in the US is still in a state of chaos as we enter the third decade of the new century. The country continues to lack consensus about whether to help immigrant and refugee families, which, though their numbers have been greatly reduced recently, continues to increase the risk of family stress and thus the risk of intra-family abuse.

There are now numerous resources for professionals working with immigrant and refugee families (49-52). Each contains helpful information about the need to become not only culturally informed and sensitive while working with immigrant and refugee families, but even more importantly, the significance of getting to know and building trust with each family. Prevention of child maltreatment among immigrant and refugee families should start with educating professionals to appreciate both the differences between ethnic cultures and the uniqueness of each individual family within a group of those migrating to the United States. There will never be a "one size fits all" prevention strategy. The prior experience of each immigrant or refugee family will have been different; their prior parenting practices, religious beliefs, and beliefs about physical discipline will vary. Some families may distrust someone associated with the government to tell them the truth about their new country's norms and laws.

Lisa Aronson Fontes has provided one of the most helpful guides to working with immigrant families (46). After thoroughly discussing the challenges faced by immigrant and refugee families, the author makes sound recommendations about tailoring wrap-around services, not just for all coming from a particular ethnic region or country but also for each individual family that recognizes both their strengths and weaknesses. She points out that most such families will experience culture shock in a very real way and need to experience warmth and support through many different sources. As for child maltreatment prevention, Dr. Fontes recommends much more than just giving families a list of things which they can't do and instead providing supportive and positive parenting training for each family to meet their needs. No single local, state or federal agency can provide all of these individualized services, so the recommendation is to team prevention professionals with faith-based and other community leaders to tailor education and support to each family within the community. She concludes by noting that the focus of prevention should be on lessening the stress on newly arrived parents and families through wrap-around supportive services: "When working with immigrant families we should try to address the family's welfare in general rather than just the narrowest questions of child abuse" (46).

With these suggestions in mind, the authors of this chapter suggest that child maltreatment prevention efforts for immigrant and refugee families should include at a minimum the following elements:

- Adequate and competent interpreters in the family's native language–including documents translated into that language–children in the family should not become the default translators;
- Assessing each family's strengths and needs and either providing for those needs or referring the family to others who can meet those needs;
- Non-threatening information about acceptable parenting methods in the new country, including positive methods of discipline without harsh physical punishment which may have been common in the country of origin;
- Specific information about topics covered in this chapter, for example, information relating to the dangers of inflicted head trauma in infants and toddlers, avoiding adverse childhood experiences, and the benefits of cultivating nurturing parent-child or caregiver-child interactions;
- General overview of the child welfare and other laws in the new country that affect them–including putting them in touch with legal assistance as to their status in the country and to meet other needs;
- If at all possible, prevention efforts should be provided to all immigrant and refugee families, not just a targeted few that are considered at "high risk" for child maltreatment–this will avoid stigmatization and isolation of the family;
- Emphasize the importance of faith-based and other community leaders among the immigrant or refugee community to provide ongoing support to the members of their community, including respite care, referral to government support services, and financial and other sources to assist them in meeting their needs;
- Work toward connecting each resettling family with others in similar situations as well as others in the new country to minimize social isolation, one of the most common causes of child maltreatment and neglect; and
- Policy changes at all levels of government to recognize that those who come to a new country need help and understanding, not discrimination and distrust, since almost all have come to the new country seeking to contribute and make a better life for themselves and their family.

With these and other supportive services, most immigrant and refugee families should at least have an easier time adjusting to the cultural norms and expectations of their new country, realizing that there are many avenues of support to help them in their transition. With the appropriate mix of support and information, it is hoped that the risks of serious child maltreatment among immigrant and refugee families will be lessened. It is certainly time to focus more attention on this particular need for child maltreatment prevention efforts.

The mass media

As this discussion seeks to make clear, the prevention of child maltreatment fatalities is a community-wide problem that calls for a community-wide solution. Unfortunately, too often the community beyond professionals directly involved in responding to such maltreatment are unaware of the nature and extent of the child fatality problem. Nor are they aware of how they might help to address it. This is where professionals should consider engaging the media. Recent changes in the media landscape have resulted in major changes in local media (53). Some local media has disappeared while much has moved to online and digital formats. Many of those outlets that have survived have struggled to make the transition from more traditional print, television and radio formats to electronic formats (54). The good news is that they are indeed making the transition and there is reason to believe that local media will once again thrive (46).

This provides an opportunity for CFR programs at the state and local level. Professionals working to learn about the causes of child death and preventive measures that might be taken at the national, state and local level to address child maltreatment deaths should seek out ways to access the media to advance the cause of prevention.

There are several ways of doing this. First, CFR teams could seek out and engage public relations firms or individual professionals to assist with disseminating their findings and about prevention-oriented programming in the relevant community. This, of course, might include the need for expanded prevention programs aimed at addressing the needs of marginalized families and communities.

CFR teams should seek out ways of engaging all forms of media, both traditional (newspapers, television and radio) and digital and online news sources. Each community will have a unique array of digital and traditional outlets, and CFR teams would benefit from understanding their local or statewide outlets. Issuing press releases, holding news conferences or engaging individual journalists known to have interest in issues affecting children and families, child well-being or child maltreatment are strategies that should be explored. Posting reports on local websites and on social media sites is also a dissemination method that may get information to a broader cross-section of the community. Writing Op/Ed pieces for local newspapers or websites, making appearances on local radio and television public interest shows may help to disseminate the team's findings and educate the public about gaps in resources and needs.

Mass messaging through both general and social media addressing a single topic can be effective. For example, a post that addresses, say, corporeal punishment or 'Don't Shake the Baby' or that there is no shame in asking for help—may be effective at raising awareness. Such campaigns may include public service announcements on local radio and television. Similarly, posters or messages on electronic billboards in high traffic areas can get the prevention message out. Cultivating a relationship with a local celebrity—a newscaster, professional, college athlete or similar persons—can be effective in attracting attention to the message you are trying to convey.

While it is helpful to be proactive—including educating local journalists—about the issue of child maltreatment and its prevention, it is also important to respond when misinformation appears in the media. When an online newspaper or blog post contains inaccurate or outright false information, it is important to counter-message with accurate, scientifically validated information. It will often be helpful in such responses to provide information about where

readers or listeners can learn more and get help. These are but a few steps that CFR teams can take to help educate members of their community about the causes of child maltreatment deaths, the efforts being made to understand why children die and implement programs aimed at preventing these deaths.

CONCLUSION

Child fatality review is a method of analyzing CM deaths that holds promise for reducing the number of children who die because of child abuse and neglect. Through constant feedback loops such as those that CFR provides, professionals are learning more about the causes of child maltreatment deaths and are developing new and promising programs to address the main causes of child deaths that result from maltreatment. Other programs such as those described in this chapter—*Choose Your Partner Carefully*, *Period of PURPLE Crying*—have demonstrated promise in reducing child maltreatment deaths. It will be helpful if CFR teams find ways to disseminate their finding through the mass media in order disseminate information and program awareness beyond the professional communities actively involved in conducting reviews.

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SECTION IV: PROFESSIONAL ISSUES

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Chapter 21

HEALTH-BASED INTERVENTIONS

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ABSTRACT

The prevention of child maltreatment (CM) fits well within the pediatric scope of practice, as child primary care professionals (PCPs) have long focused on prevention and management of behavioral and social issues. This chapter will review the many ways that child PCPs can help prevent CM. Multiple evidence-based models have been developed to screen for and manage risk factors, either independently or in conjunction with other programs. PCPs can also refer caregivers and children to evidence-based services located elsewhere within their community. Anticipatory guidance on infant crying may be effective in preventing abusive head trauma, while counseling about personal space and privacy, open communication, and safer childcare may help prevent sexual abuse. Finally, PCPs can advocate in multiple ways to prevent CM. They can assist families in accessing services, help to develop community-based services, and advocate for government policies that benefit children and their families.

INTRODUCTION

Preventing child abuse and neglect (i.e., maltreatment) fits well with the goals and scope of pediatrics, as expressed by the American Academy of Pediatrics' (AAP) commitment to prevention, early detection, and management of behavioral, developmental, and social problems as a focus in pediatric practice. The prevention of child maltreatment (CM) has benefits at the level of the individual child, the family, the community, and society at large. Preventing the physical, cognitive, behavioral, emotional and social problems associated with CM is intuitively and morally preferable to intervening *after the fact*.

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Beyond the individual child, the prevention of CM has at its heart the goal of supporting parents and parenting, strengthening families, and promoting children's health, development, and safety. Effective interventions should thus achieve much more than the narrow goal of preventing CM, such as enhancing children's cognitive, emotional and social development, guiding their behavior, improving maternal health and relationships with their children, as well as decreasing involvement in public assistance and the criminal justice system. CM has significant costs, human and economic, that need to be weighed against the cost of prevention. A few studies have demonstrated the costs saved by specific preventive strategies. Finally, the moral imperative to protect children and prevent CM is compelling (1).

Knowledge about preventing CM has advanced considerably. There are an array of evidence-based approaches and practices that are mostly implemented outside the healthcare system. Child health professionals need at a minimum to be aware of such resources in their community in order to facilitate referrals. This chapter focuses on what reasonably can be done in pediatric and family medicine settings; some interventions such as preventing abusive head trauma are described elsewhere in this volume. While it is inevitable that much remains to be learned regarding the prevention of CM, it behooves us to implement that which has been found to be effective or quite promising, while continuing to evaluate such interventions.

ROLES OF PEDIATRIC PROFESSIONALS

Pediatric practice has focused primarily on the important issues of identifying abuse and neglect, providing medical care, reporting to public agencies, and facilitating referrals for assessment and treatment. In order to fulfill their responsibility to promote children's health and wellbeing, child health professionals should also prioritize preventing CM (2). They can do so by identifying and helping address child and family risk and protective factors, referring families to effective community-based services, and advocating for policies and programs that promote child and family wellbeing.

Primary care offers an excellent opportunity to play this role. It is well institutionalized in the US; most parents accept the need to bring their children in for well child visits. There is no need to build a new infrastructure. There are many visits especially in the first few years of life and primary care professionals (PCPs) generally enjoy excellent relationships with children and families. PCPs are usually perceived as credible, supportive and caring, without facing the stigma often attached to behavioral health and child welfare professionals. This rapport offers a remarkable entry into families' lives, enabling the sharing of sensitive information and an opportunity to intervene.

RISK FACTORS FOR MALTREATMENT

The ecological framework posits that contributors to CM involve interactions among individual child, parent and family factors as well as others at the community and societal levels. Child characteristics, such as a difficult temperament or chronic physical or mental health problems may challenge parents, heighten parental stress, and increase the risk of CM. Specific patterns of behavior within the parent-child dyad, such as harsh, inattentive or inconsistent parenting,

illustrate a risk factor or, may reflect CM. Maltreating parents, particularly physically abusive ones, have reported feeling "out of control" as parents.

Parental problems are strongly linked to CM. For example, maternal depression has been associated with both neglect and abuse (3-5); one study demonstrated that treating depressed mothers improved maternal and child outcomes (6). Substance abuse, including alcoholism, impedes parenting and has been clearly associated with CM (7-9). Approximately 15.5 million children are estimated to live in two-parent households in which at least one instance of intimate partner (or domestic) violence (IPV) occurred in the previous year (10), and about 16% were exposed to IPV at some time (11). Substantial evidence links children's exposure to IPV with many serious consequences, including emotional, behavioral, physical, social and academic problems (12). A review of 31 studies found co-occurrence rates of IPV and CM between 30% and 60% (13). Given the strong association between these parental problems and CM, identifying and addressing them should help prevent child abuse and neglect as well as other problems.

Family and community contexts, although less immediately observable to PCPs, also contribute to CM. Family stressors such as poverty, unemployment, negative life events or geographic mobility heighten the risk of CM. Families referred to Child Protective Services (CPS) are more likely to have single mothers, unemployed fathers, and to receive public assistance (14). Food insecurity, too, is closely associated with poverty and may be linked directly and indirectly to CM; it can be considered a form of societal neglect in a wealthy country. Severe child hunger has been linked directly to overall poor health in school-age children, even after controlling for low birthweight, housing status, maternal distress and stressful life events (15). It is not difficult to understand how the burdens associated with poverty may compromise parents' abilities to adequately care for their children. At the same time, it is important to highlight that most impoverished families do not abuse or neglect their children, and, CM certainly also occurs in middle and high-income families. Another contributor to CM is limited social support to families. Compared with non-maltreating families, maltreating ones have smaller social networks with which they have less contact. Cultural influences may also be a factor in CM. Wide variation has been noted across cultural contexts regarding, for example, the nature of child supervision, the belief in corporal punishment, and acceptance of mental health care. Finally, societal influences such as the availability and affordability of childcare and healthcare may contribute to CM.

While the factors described above may increase the risk of CM, families usually also have protective factors that help buffer the impact of stressors and lower their risk. These may be internal characteristics (e.g., parental caring for the child) or external (e.g., a pediatrician's support). A strong social network can also serve as a buffer. Good social support is associated with lower rates of physical neglect and increased use of non-physical disciplinary methods. Identifying and building upon families' strengths and resources is critical in intervening optimally. Research has shown that protective factors help explain why some maltreated children have positive outcomes (16).

IDENTIFICATION OF FAMILIES AT RISK

Screening

High-risk families often lack insight into their problems and may not know how to access help, thus they underutilize both formal and informal helping systems. These families are, however, still likely to seek medical care for their children. Pediatric primary care provides a critical, near-universal access point for identifying and helping address psychosocial problems facing many families, such as parental depression, a valuable opportunity to help prevent CM.

When considering what problems to target, practitioners need to feel competent and comfortable to efficiently address problems and to be familiar with community resources for further evaluation and services. It is axiomatic that screening is justified if the screenee stands to benefit. There are, however, many forms of potential benefit, including mental health care, access to a food pantry, and also a PCP's reassurance and emotional support.

Many risk factors are unlikely to be detected unless specific screening efforts are made. Relying on clinical judgment as to who, for example, appears depressed will result in many problems remaining hidden; parental depression is often well masked. IPV is usually a well-kept, dark family secret. For these reasons, the AAP (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/Screening-Tools.aspx) has specifically recommended that pediatricians screen for IPV, parental depression, food insecurity, substance abuse, and other family risk factors. An approach to identify these possible problems is to periodically screen all families at selected well child visits with a brief questionnaire, which can be completed before the visit or incorporated into the interview during the visit.

Several screening questionnaires have been developed to identify psychosocial factors such as depression, substance abuse, food insecurity and IPV, which can also be viewed as social determinants of health. Recent reviews of such tools provide useful guidance to practitioners, including the evidence supporting a tool, the targeted problems and the possible cost (17, 18). Given the range of issues to be covered in a pediatric visit and the limited time available, brief tools are critical. Introducing questions in a sensitive manner may help parents feel comfortable disclosing potentially sensitive information. For example, the Safe Environment for Every Kid (SEEK) Parent Questionnaire-R (PQ-R) begins with: "Being a parent is not always easy. We want to help families have a safe environment for kids. So, we're asking everyone these questions. They are about problems that affect many families. If there's a problem, we'll try to help… . This is voluntary. You don't have to answer any question you prefer not to" (https://seekwellbeing.org/) (see appendix 1). It is useful to begin with some well-accepted less sensitive issues such as smoke alarms. Building on PCPs' (and parents') longstanding interest in children's safety is a logical transition to more personal areas such as corporal punishment, parental depression, substance abuse, IPV and other environmental hazards. The SEEK PQ-R offers a useful example; it is part of the model developed for pediatric primary care, in which PCPs are trained to screen, briefly assess, and initially help address CM-related risk factors.

In addition to questions directed to parents, valuable information can be obtained directly from children and teenagers. It is now customary for clinicians to spend time alone with adolescents and to obtain a medical history independently; this practice can be extended to younger children as well. It is generally a good principle to talk to children alone if possible. Establishing rapport first is important, beginning with general open-ended questions such as,

"What are you doing this summer? What's school like? What kind of things do you like to do?" One can then ask how family members get along and what kinds of things the child likes to do with each of them. More sensitive issues can then be raised, such as "all kids sometimes behave badly. What happens when you behave badly?" "Is there anyone at home who gives you a hard time?" and "Who do you tell when you've got a problem?"

The Adverse Childhood Experiences (ACE) studies have generated much interest. Research has shown the link between early exposure to adversities, such as CM, parental divorce, household members with mental illness or who are incarcerated can lead to physical and mental health problems later in life. Although not developed for clinical purposes, ACE questionnaires have been developed for parents and children, and by summing the number of adversities, one obtains an ACE score. Those with a score higher than three are designated as "very high risk". An important question is what follows. Practitioners could, for example, decide to monitor such children more closely or refer for an evaluation by a behavioral health professional. Concern has been raised, however, about the application of the ACE research to clinical settings (19, 20). It is also unclear how often parents may engage in addressing problems that occurred in the distant past. While these problems may pose risks for parents and their children, it is likely more practical to prioritize recent and current functioning. In addition, helping individual families involves tailoring services to their specific needs; a summary score is less useful. A related effort involves ACE screening tools developed to capture the experiences of children and youth; these remain to be evaluated.

Assessment

If screening identifies risk factors, there is a need for further brief assessment to clarify whether the parent's response is a 'true positive'; this can be done by child health professionals, behavioral health professionals, social workers or case managers. (see appendices 2, 3). For example, the screen may identify a parent with depressive symptoms. A brief assessment should focus on prioritized concerns such as how the parent thinks the problem is affecting the family, whether the parent is receiving treatment, what's been tried with what results, and possible interest in obtaining (more) help. Incorporating principles of motivational interviewing helps to understand the parent's perception of the problem and informs the PCP's response (21). By jointly developing a plan based on the parent's ideas and the parent "owning" it, there is a greater likelihood of recommendations being implemented.

The traditional biomedical model focuses on the pathology, or what's wrong. As discussed earlier, however, there are invariably protective factors that help offset the impact of problems. The assessment should therefore identify families' internal and external protective factors. Building on strengths is critical to intervening effectively.

Confidentiality

Screening raises issues pertaining to confidentiality. If information is gathered on sensitive problems, particularly IPV, it is prudent to assess the problem privately, without the child or partner present. Women may be understandably reluctant to disclose violence in the presence of others, and there may be a risk of aggravating the situation. Children may be later coerced

to report on what was said during the visit. A child who is present when a parent denies ongoing violence may learn to keep all maltreatment secret. If a child or youth reports a problem, there may be a need to inform the parent(s) if there is concern about safety. This limit to confidentiality should be raised early in the interview. There may also be a need to refer a family to a child welfare agency; in some states a child's exposure to IPV is grounds for CPS referral. Practitioners need to know the local laws and policies and may choose to apprise parents in advance. There is also an issue of documentation, given that the partner often has access to the child's medical record. One approach is to place sensitive information in a separate section of the chart or to use code terms, such as "family conflict discussed."

PREVENTIVE INTERVENTIONS

A critical criterion for screening is that the recipient benefits from having a problem recognized. Following screening and a brief assessment, there may be a need for further evaluation and intervention. In some instances, PCPs can provide education and guidance, such as helping a parent to address a child's challenging behaviors or supporting a parent suffering a loss. Alternatively, a behavioral health professional or another staff member may play this role. In other instances, such as IPV or substance abuse, PCPs serve primarily as "gate keepers," facilitating referrals—a potentially pivotal role that with knowledge and skill may make a valuable difference in only a few strategic minutes.

To provide a child with adequate or excellent health care and to prevent CM, PCPs need to be familiar with a family's structure; child rearing practices; stresses and strengths; and barriers to care. Rooted in a trusting relationship, this understanding builds over time and is dynamic as circumstances change. While it is often difficult to change others' behavior, the approach used in the SEEK model, including empathy, support and motivation, conveys an important message that the PCP cares about the parent; this may facilitate a later disclosure of a problem and a willingness to engage in help.

The following are general principles concerning prevention efforts:

- *The needs of parents, children, and families should be considered*, following the vision of Bright Futures. Effective interventions focus on basic problem-solving skills and concrete family needs, provide behavior management strategies, *and* help address environmental factors. Parents often require attention to their own needs in order to nurture their children.
- Identification of a family's *strengths and resources* is key to comprehending the situation and to intervening. Strengths may include coping abilities, intelligence, determination, and/or religious faith. Resources may include *informal supports* (i.e., family, friends), as well as *formal community resources*. Informal support may be especially useful for families who are resistant to interventions from public agencies or behavioral health professionals. Formal support through a *religious affiliation* may be valuable, and professionals too often overlook this important source of support and guidance. However, some fundamentalist religious groups may encourage corporal punishment, exacerbating the risk for physical abuse. It is, therefore, important to have a sense of the nature of support that is likely from such resources before simply

recommending them. Incorporating strengths into one's approach helps address problems more constructively (e.g., "I can see how much you love your child. How can we make sure she stays healthy?"). By explicitly conveying caring, a PCP can be a valuable resource to parents.

- *Risk factors for maltreatment* need to be identified and addressed. Appendix 2 offers an approach to assessing and addressing one of these as an example, IPV. More information on other risk factors is available at https://www.SEEKwellbeing.org.
- Be knowledgeable about *community resources* and facilitate referrals. PCPs serve as an important conduit to community services and are in a good position to encourage reluctant or ambivalent families to accept or try services. Alternatively, this role may be played by a behavioral health colleague or other staff. Office staff can also help with referrals, the way they do for many issues.

HEALTH-BASED INTERVENTIONS TO IDENTIFY AND ADDRESS CM RISK FACTORS

A number of interventions have been developed to identify CM risk factors in the health care setting and provide assessment and referral. All include screening questionnaires; some incorporate brief counseling and behavioral change strategies; and most provide referrals to other professionals and/or community-based agencies. Several interventions that have been well evaluated are described below.

The Safe Environment for Every Kid (SEEK) Model

(www.SEEKwellbeing.org)

The SEEK model offers a practical, evidence-based approach to help PCPs address targeted psychosocial risk factors for CM in families with children aged 0-5 years (22). The targeted problems are parental depression, major stress, substance abuse, domestic violence, food insecurity and harsh punishment. See appendix 3 for the "Algorithm for Approaching Possible Partner Conflict". By helping address these problems, SEEK aims to strengthen families, support parents and parenting, and thereby promote children's health, development and safety, and help prevent child abuse and neglect. Core components of the SEEK model are: 1) t*raining PCPs* to help address the targeted risk factors; 2) the *SEEK Parent Questionnaire –R* (PQ-R) to screen for the problems at selected well child visits; 3) the *Reflect–Empathize –Assess–Plan (REAP)* approach to help PCPs briefly assess and initially address positive screens; 4) principles of *Motivational Interviewing*; 5) facilitating *referrals* to in-house or community resources for identified problems; 6) *SEEK Parent Handouts* for the targeted problems, customized with information on local resources; and 7) ideally, a social worker or behavioral health professional, partnering with PCPs and parents.

Evidence Supporting the SEEK Model. Two randomized controlled trials have been conducted. The first was in pediatric residency primary care ("continuity") clinics serving a very low-income urban population (23, 24). The second was in 18 suburban private pediatric practices serving a mostly middle-income and relatively low risk population (25, 26). In both

trials, medical professionals significantly improved in their level of comfort, perceived competence and practice behavior with regard to addressing the targeted problems. Some of these improvements were sustained for 18-36 months beyond the initial training. In the first study, SEEK families benefited by having significantly less child abuse and neglect—assessed three ways: by parental report of how they handled conflict with their child, by review of medical records for instances of abuse or neglect, and by CPS reports. In the second study, SEEK mothers reported less harsh physical punishment and psychological aggression, reasonably considered as CM, compared to controls. SEEK did not require additional time on average for medical professionals to address psychosocial problems. In the second study, SEEK cost $3.59 per child per year and $305.58 per case of psychological aggression or physical assault averted (27).

Health Leads/WE CARE (Well-childcare visit, Evaluation, Community Resources, Advocacy, Referral, Education)

Health Leads is a nonprofit organization that trains undergraduate students to volunteer in urban health clinics helping families meet their social needs. Developed at Boston Medical Center, it has since expanded to 19 healthcare centers across the United States. Families seeking pediatric primary care complete a pre-visit screening form, and PCPs conduct an initial needs assessment and make referrals to Health Leads staff. The Health Leads volunteer conducts an in-depth assessment, provides information on resources and phone follow-up to families, and updates the PCP as needed (https://healthleadsusa.org/). The program website includes a toolkit for practices to create their own screening questionnaire, as well as webinars and additional resources.

The *WE CARE* model developed out of the Health Leads program (https://www.bmc.org/pediatrics-primary-care/we-care/we-care-model). It consists of a 10-item screening questionnaire, brief provider education, and a Family Resource Book, developed with social work and legal colleagues. Targeted psychosocial issues include education and employment status, food insecurity, homelessness risk, parental depression, parental smoking, household drug use or problem alcohol use, IPV and childcare needs. Families complete the questionnaire; pediatric residents then review it during the visit and make referrals to needed resources. In a randomized, controlled evaluation of WE CARE, parents in the intervention group discussed more family psychosocial topics, were more likely to receive referrals for services, and were more likely to have contacted a community resource compared to control group parents. A subsequent cluster randomized trial also found increased use of community resources (28, 29, 30). In addition, participants in the intervention group were more likely to be employed and to have childcare, and less likely to be living in a homeless shelter.

Social Needs Screening and In-Person Service Navigation–iScreen/FIND

The iScreen/FIND intervention also was developed through Health Leads. It was implemented in both primary and urgent care settings at safety-net hospitals in San Francisco (31). Trained, volunteer patient navigators conduct risk factor screening, and provide in-person or telephone follow-up. When compared to a control group that received handouts with a resource list,

intervention families had fewer social needs and better health status at four-month follow-up (32). While there were no differences in emergency department visits between the groups at 12 months, children in the in-person navigator group were 69% less likely to have been hospitalized (33).

Medical-Legal Partnerships

Medical legal partnerships (MLPs) place lawyers within healthcare settings to address social determinants of health, including risk factors for CM. Services are typically provided by civil legal aid organizations or law schools. Common issues that are addressed include access to health insurance and public benefits, poor housing conditions, and educational services and accommodations for children with special needs. The program began in 1993 at Boston Medical Center, when the chief of pediatrics hired a part-time attorney to address pediatric patients' basic needs, including food, housing, and safety. It has expanded to nearly 300 sites, as well as the National Center for Medical-Legal Partnership at George Washington University. Each health center focuses on risk factors most relevant to their patients. Some focus solely on legal needs, while others address additional issues via center-based social workers or financial counselors. This is discussed in more detail in another chapter.

After criticism regarding the absence of a formal screening protocol (34), MLP collaborated with the National Association of Community Health Centers and several other agencies to develop a formal screener. PRAPARE (The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences) includes questions related to housing, financial stability, stress, employment and insurance status, as well as risk factors such as IPV and incarceration, which are optional. Screening questions have been incorporated into electronic medical record systems at Community Health Centers participating in the MLP. Several studies have demonstrated MLP benefits, including improved health of asthma patients due to improved housing, and better access to services and fewer barriers to care in children with sickle cell anemia (35-37).

Project DULCE (Developmental Understanding and Legal Collaboration for Everyone) (38-40)

Project DULCE is a primary care-based intervention for infants from birth to 6 months of age. Based on a Strengthening Families protective factors approach (41), the program is built upon two existing interventions, Healthy Steps (described below) (42) and Medical-Legal Partnerships. DULCE Family Specialists (FSs) have postgraduate training in child development as well as from both Healthy Steps and MLP. They conduct child developmental and parental mental health screening, offer support, and facilitate referrals to help meet basic needs. FSs consult with the MLP as needed. Decisions about needed services are jointly made by parents and FSs.

A randomized trial of Project DULCE demonstrated better immunization rates and fewer ED visits for intervention families compared to control families. Intervention families were also more successful in accessing resources, including food, energy, telephone, and emergency cash

assistance (38). Project DULCE has expanded to 4 counties in California and one in Vermont (https://dulcenational.org/).

FORMALIZED PROGRAMS INTEGRATING PEDIATRIC CARE AND PARENTAL SUPPORT

Parent support programs typically aim to improve parents' level of comfort and sense of competence with parenting. Approaches vary among these programs; some models such as Triple P and Healthy Steps work directly with pediatric practices to align services, while others function independently. Program components may include psychoeducation regarding child development, promoting positive parent-child relationships, and teaching effective emotional communication and disciplinary approaches. Some programs have shown improvements in behavioral and depressive symptoms as well as enhanced parental self-esteem and attitudes toward child rearing.

Integration of behavioral health in primary care

While not specifically focused on preventing CM, integration of behavioral health services into primary care may well impact this problem by improving parent-child relationships, reducing child behavior problems, and facilitating treatment for mental health problems. Services may be provided by a psychiatrist or another licensed mental health professional, by phone or in-person, at the primary care practice or offsite. Some programs address specific behavioral or mental health concerns such as ADHD or substance abuse; others serve a broader range of problems. Some programs incorporate behavioral health screening while others do not systematically do so (43). The National Network of Child Psychiatry Access Programs supports programs and provides a listing by state. (http://web.jhu.edu/pedmentalhealth/nncpap_members.html)

Several programs have demonstrated positive outcomes. In the Doctor Office Collaborative Care (DOCC) program, Kolko et al. enrolled children with behavior disorders, anxiety, or ADHD (44, 45). An on-site care manager provided assessment, psychoeducation, consultation and collaboration with the primary care provider, and linkages with specialty services. Those enrolled in DOCC had higher rates of treatment, improved child behavior, and less parental stress compared to those receiving enhanced usual pediatric care with psychoeducation and specialist referral. The Reaching out to Adolescents in Distress (ROAD) program provides Cognitive Behavior Therapy for youth with depression (46). At 12-month follow-up, enrolled teens had higher rates of remission than controls.

Triple P

(https://www.triplep.net/glo-en/getting-started-with-triple-p/)

Triple P addresses children's behavioral, emotional and developmental problems, enhances protective factors, and reduces CM risk factors. Five tiers of services enable tailoring to an

individual family's needs. An evaluation in South Carolina demonstrated lower rates of substantiated CM, fewer CM-related injuries and fewer out of home placements in counties that implemented the model compared to those providing usual care (47, 48).

HealthySteps

(https://www.healthysteps.org/the-model)

HealthySteps is an evidence-based program that enhances pediatric primary care with a child development specialist who interacts with families through pediatric and home visits, by telephone, e-mail and text, to educate, support and refer (41, 42). A program now led by the Zero to Three Foundation, it coordinates the work of healthcare professionals, community and family members to support parents of young children. HealthySteps counselors work in pediatric practices and serve as integral members of the care team, providing help with parental adjustment to parenthood, support during pediatric visits, and developmental and behavioral evaluations. The counselor screens to identify a family's needs and helps address these through referrals to community resources. Parents enrolled in HealthySteps are more likely to adhere to child safety guidelines and use positive parenting and discipline strategies rather than harsh punishment.

Help Me Grow

(https://helpmegrownational.org/)

Help Me Grow is a community-based model that provides care coordination and collaboration among child health care providers and community-based resources to improve screening, assessment and management of children's developmental and behavioral problems. The goal is to build effective early childhood systems that support family protective factors and decrease the impact of adversity. Its four key components include a centralized access point, family and community outreach, child health care provider outreach, and data collection and analysis to identify gaps, improve advocacy, and conduct quality improvement. The model is in 29 states and appears to improve communication among community agencies, but no program evaluations have been published.

COMMUNITY-BASED PREVENTION PROGRAMS THAT PARTNER WITH HEALTH CARE SERVICES

PCPs alone cannot address many of the social determinants of health facing families. They therefore need to be familiar with local resources and periodically update this information. Such information may be available from a local or state health department, United Way agency or through an internet search and confirmed via phone calls. Ideally, PCPs should work collaboratively with community agencies including two-way communication, without disclosing unnecessary personal information.

It is also optimal for PCPs to be knowledgeable about the quality and effectiveness of the available programs, prioritizing evidence-based interventions. Several on-line resources provide information about the quality of community-based prevention programs. These include the Home Visiting Evidence of Effectiveness website (https://homvee.acf.hhs.gov/), the California Evidence-Based Clearinghouse for Child Welfare (https://www.cebc4cw.org/), the Centers for Disease Control and Prevention's Child Maltreatment Prevention Strategies (https://www.cdc.gov/violenceprevention/childabuseandneglect/index.html), and the Guide to Community Preventive Services (https://www.thecommunityguide.org/). See elsewhere in this book for a chapter specifically devoted to home visiting.

IMPORTANT TOPICS FOR ANTICIPATORY GUIDANCE

Prevention of abusive head trauma

Several programs have been developed to help prevent abusive head trauma with the goal of educating parents about normal crying patterns and how to respond appropriately. One program focuses on educating parents of newborns during their post-partum hospital stay via a brochure and video as well as a signed commitment statement indicating their understanding that shaking is harmful. An evaluation showed a decrease in the rate of AHT, while AHT rates in a neighboring state without the intervention were unchanged (49). A more recent evaluation comparing one state with mandated implementation to five other states did not show any reduction in AHT but did show improvements in parental knowledge (50). The National Center for Shaken Baby's *Period of PURPLE Crying* intervention led to fewer nurse advice line calls for crying but also did not decrease the rate of AHT (51).

Prevention of child sexual abuse

While there has been no formal evaluation of health care-based interventions to prevent child sexual abuse, PCPs can provide children and parents with basic information about privacy and genitals. Some examples are described below:

- During the genital exam of young children, the PCPs can point out that only a doctor and specific adult caregivers should be allowed to see their "private parts." Parents can clarify to which caregivers this applies.
- Children should be encouraged to tell a parent or someone they trust if anyone tries to see or touch their genital area. This can be introduced to parents and children in terms of "personal space and privacy" rather than explaining sexual abuse (52).
- PCPs can encourage parents to use and to teach children to use anatomically correct words for their genitals so that disclosures of sexual abuse or other genital issues can be understood and addressed by non-parental caregivers.
- PCPs can encourage parents and children to maintain open channels of communication, such as letting a child know that it's good to tell a parent if anyone makes them feel bad. Because those perpetrating abuse may discourage disclosure by

framing abuse as a secret, parents can let children know that secrets can be shared with them. Distinguishing secrets from surprises may also be helpful.

- Parents can be given information on how to minimize the opportunity for perpetrators to access children (e.g., limiting one-adult/one-child situations), how to discuss issues of sexual abuse with children, and how to recognize potential behavioral and medical signs of sexual abuse. The "Stewards of Children" program, developed by the Darkness to Light Foundation has developed educational materials on these topics (https://www.d2l.org/).

ADVOCACY

PCPs can be advocates for the prevention of CM at different levels, including that of the individual child, parent, family, community, and society. Helping parents meet their children's needs is advocacy on behalf of children unable to express or meet their own needs. Acknowledging the stress a parent may feel and facilitating help is also advocacy. PCPs can work with other professionals to establish prevention programs that coordinate with primary care such as Triple P or HealthySteps. While most PCPs do not have direct involvement in community-based prevention programs such as home visiting or family support centers, they can volunteer with these programs and can advocate for financial and institutional support.

PCPs can advocate either individually or through local or national organizations for adoption of public policies and programs that benefit children and families. Because of the strong link between nutrition and health, for example, the American Academy of Pediatrics (AAP) (www.aap.org) works at the federal level to increase access to nutrition programs such as the Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Zero to Three, a national organization that supports child wellbeing during the first three years (https://www.zerotothree.org/), advocates for quality childcare, home visiting, and paid family leave. At the state and national level, health care professionals can help prevent maltreatment by communicating with their legislators and encouraging them to support laws that reduce family stress. In particular, access to subsidized childcare and paid family leave have shown to reduce rates of child maltreatment (53, 54).

PREVENTION AFTER CM HAS BEEN IDENTIFIED (I.E., TERTIARY PREVENTION)

Child health professionals can play an important role after identifying a child as likely to have been maltreated and having referred the family to a child welfare agency or law enforcement. Such ongoing efforts should help mitigate the likelihood of continuing abuse or neglect and increase the likelihood of positive outcomes despite the child's experiences. Primary care practitioners are especially well positioned to be helpful given their usually positive relationships with families and their credibility. In this context, it is advisable that parents be apprised of the referral (not report, with its negative connotations) to the child welfare agency, ideally before it is made. If the practitioner is not forthright, there is a risk of destroying trust

should the parent suspect a surreptitious referral. Ideally, the basis for the referral should be kindly conveyed, without blame, and can be framed as an effort to clarify the child's and family's circumstances, and to help. Alternatively, some practitioners present this as a legal obligation.

Practitioners, perhaps with the assistance of behavioral health professionals, social workers, case managers or patient navigators serve a valuable role in facilitating referrals for services, in-house or in the community. Integrating behavioral health into primary care is being increasingly embraced as an optimal model for addressing families' varied needs. As suggested earlier, planning the intervention is best done with the parent (and older child) via motivational interviewing, rather than simply indicating what should be done. This process should help prioritize the most important problems to tackle, rather than overwhelming a family with multiple services. Addressing some problems can have a ripple effect yielding many benefits. Helping a depressed father get counseling, for example, may help him find work and a better place to live. Efforts to fix every problem may overwhelm a parent and the practitioner and may actually be counterproductive. Clearly, practitioners need to know the array of services available to families.

CM can be understood as a symptom of underlying family dysfunction. The related problems may be multiple, complex and run deep. In many instances, quick fixes are unlikely to work, and there may be an ongoing need for support and monitoring. This role fits well with primary care, often requiring more involvement than that indicated by the AAP periodicity schedule.

CHALLENGES

Addressing risk factors for CM within primary care medicine may be novel to many child health professionals. Some PCPs may raise concerns about the feasibility of implementing systematic screening, assessment and referral for psychosocial problems in the family. Below are responses to commonly cited concerns:

- *"There's not enough time to delve into psychosocial problems, such as a mother who seems depressed."* It may add time, but there are ways to briefly assess and address these problems, playing a valuable gatekeeper role. It is also a matter of setting priorities. If there are serious and prevalent problems affecting children, they deserve attention; other issues may be given less time (e.g., listening to the lungs in an asymptomatic child). Knowledge, practice and skills enhance efficiency in addressing these problems. Having parents complete a screening questionnaire before the visit, obviates the need to ask these questions during the visit, and saves time.
- "*What will this cost me?"* When efficiently incorporated into practice, the financial costs should be minimal, and there is possibly increased reimbursement through CPT code 96161, covering care provided to caregivers during a child's well child visit. Access to behavioral health is helpful, and, costs are saved when families function better and child abuse and neglect are prevented; admittedly, these savings are not accrued directly by PCPs.

- *"I'm not sure how to handle problems, like IPV."* It is clear that most PCPs have had little training in some of these problems. There is a need to obtain some training and to identify local resources for referrals. There is online training that is readily available. As with a worrisome peripheral blood smear, it may amount to simply knowing whom to call. Office staff should be able to readily identify a few key local resources; apps such as *Aunt Bertha* facilitate this.
- *"These problems are very sensitive. I don't feel comfortable raising them."* The issues are sensitive, but important. If framed carefully (e.g., "Lots of families have these problems, so I'm asking everyone…"), most families will not be offended, and some will be grateful. Discomfort is also related to not knowing what to do; knowledge and skill help, and these build with experience. As an analogy, asking adults about sexual practices was awkward for many, but the prevalence of HIV disease warranted overcoming that discomfort.
- *"What if the screen is incorrect? There's the problem of false positives and false negatives."* First, it is important to recognize that a screen is just a screen. A brief assessment should clarify whether the problem exists. Screening questionnaires will miss some at-risk parents. These false negatives may occur when a parent is in denial about a problem or is not ready to acknowledge it to others or to engage in help. An ongoing, supportive relationship with families and periodic repetition of screening may increase a parent's comfort in disclosing sensitive information and in accepting help. It is also important to remember that while screening misses some at-risk parents, many others will be identified who would have otherwise gone undetected.
- *"Appropriate services are often not available to address the family's needs*." This issue naturally varies in different regions. However, a little scouting on the internet often identifies local resources. Even when less than ideal, there are often some services, and practitioners need to be careful not to be overly nihilistic.
- *"We don't really know that these approaches work."* There is mounting evidence supporting preventive strategies. For example, the U.S Preventive Services Task Force recommended screening for IPV during primary care in their most recent statement (55). Evaluations of the SEEK model in two randomized controlled trials yielded promising findings (56, 57). Motivational interviewing has increased the effectiveness in engaging those with a substance abuse problem in seeking treatment. There is also considerable clinical experience indicating that healthcare professionals can successfully facilitate referrals for mental health, social and other services. Their positive relationships with families enable them to be trusted confidants and to offer valuable support and guidance.

CONCLUSION

There are clearly many ways that PCPs can play a role in the prevention of child maltreatment. Screening for child maltreatment risk factors, followed by brief assessment, counseling and referral is very feasible with validated screening tools, education in motivational interviewing, and knowledge of community resources for referral. PCPs can refer families to existing community programs, develop partnerships with programs to better coordinate services for

families, or establish in-house services, e.g., with mental health providers. Health visits should include prevention messages as part of anticipatory guidance, providing parents with tools to protect their children. Finally, PCPs can use their position of authority and respect in the community to advocate for policies and programs that support families, making it easier to meet children's needs, which include protection from abuse and neglect.

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APPENDIX 1: PARENT QUESTIONNAIRE - R

Dear Parent or Caregiver: Being a parent is not always easy. We want to help families have a safe environment for kids. So, we're asking everyone these questions about problems that affect many families. If there's a problem, we'll try to help.

Please answer the questions about your child being seen today for a checkup. If there's more than one child, please answer "yes" if it applies to any one of them. This is voluntary. You don't have to answer any question you prefer not to. This information will be kept private, unless we're worried about your child's safety.

Today's Date: ___/___/____ Child's Name: _____

Child's Date of Birth: ___/___/____ Relationship to Child: _____

Please Check

□ Yes	□ No	Would you like us to give you the phone number for Poison Control?
□ Yes	□ No	Do you need to get a smoke alarm for your home?
□ Yes	□ No	Does anyone smoke at home?
□ Yes	□ No	In the past 12 months, did you worry that your food would run out before you could buy more?
□ Yes	□ No	In the past 12 months, did the food you bought just not last and you didn't have money to get more?
□ Yes	□ No	Do you often feel your child is difficult to take care of?
□ Yes	□ No	Do you sometimes find you need to slap or hit your child?
□ Yes	□ No	Do you wish you had more help with your child?
□ Yes	□ No	Do you often feel under extreme stress?
□ Yes	□ No	Over the past 2 weeks, have you often felt down, depressed, or hopeless?
□ Yes	□ No	Over the past 2 weeks, have you felt little interest or pleasure in doing things?

Thinking about the past 3 months

□ Yes	□ No	Have you and a partner fought a lot?
□ Yes	□ No	Has a partner threatened, shoved, hit or kicked you or hurt you physically in any way?
□ Yes	□ No	Have you had 4 or more drinks in one day?
□ Yes	□ No	Have you used an illegal drug or a prescription medication for nonmedical reasons?
□ Yes	□ No	Other things you'd like help with today: _____

Please give this form to the doctor or nurse you're seeing today. We encourage you to discuss anything on this list with her or him. Thank you!

APPENDIX 2: DO YOU FEEL SAFE?

SEEK™
Safe Environment for Every Kid

Is anyone hurting or controlling you?
If so, you may be a victim of domestic violence.
Domestic violence is when one person hurts another person in a relationship.
It can cause you health problems – now and in the future.
It can also harm your child's emotional and physical health.

Types of domestic violence:

- **Verbal:** Threatening to hurt you or your child
- **Psychological**: Calling you names or putting you down
- **Physical**: Slapping, choking or kicking you
- **Sexual**: Forcing you to have sex
- **Economic**: Not letting you work or go to school

Victims of domestic violence may feel:

- Many different things - it affects people in lots of ways
- Trapped or scared to leave or reach out for help
- Afraid, ashamed or alone

Create a Safety Plan:

- Individualized plan to keep your family safe when you're in a relationship, planning to leave or after you leave
- Helpful in a crisis when it's hard to think the same as when you're calm
- May include some of the following information, like a plan for how and where you can safely escape, bag prepared with important belongings, code word children know if they need to leave in an emergency, children know how to call 911 or a trusted contact
- Advocates from the National Domestic Violence Helpline can plan with anyone who is concerned about their own safety or safety of someone else

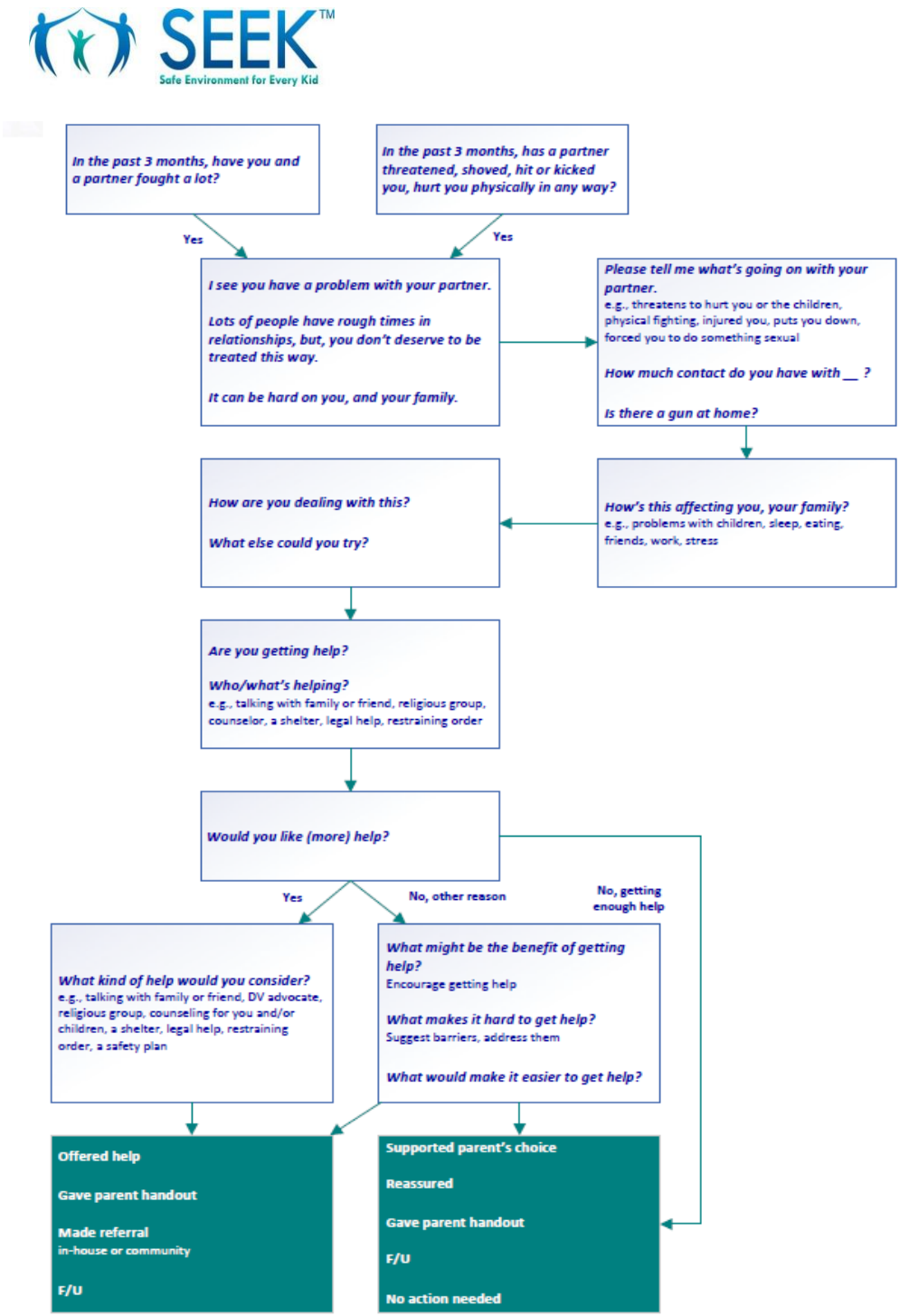
You don't deserve to be treated this way!
Make your family a safe place for love, not violence.
If you'd like help, please tell your child's doctor or nurse.

Helpful Resources

National Domestic Violence Hotline | www.thehotline.org

- Advocates available 24/7 for free, confidential help, information, crisis intervention, safety planning and connecting you to help nearby.
- Help in over 200 languages.
- Call **1-800-799-SAFE (7233)**, **1-800-787-3224 (TTY)** or **1-855-812-1001 (video phone - if deaf)**.
- Visit the website and choose **"Chat Now"** for English 24/7. **"Chat in Spanish"** available daily from 12pm to 6pm CDT.
- For your safety, computer use can be monitored and is impossible to completely hide so if you're afraid your usage might be monitored, call the hotline.
- Pamphlets with information on domestic violence should be hidden, like in a shoe, under clothes in a closet or other safe location.

APPENDIX 3: ALGORITHM FOR APPROACHING POSSIBLE PARTNER CONFLICT



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Chapter 22

PREVENTING CHILD MALTREATMENT THROUGH MEDICAL-LEGAL PARTNERSHIP

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ABSTRACT

There has been significant attention in recent years to health care delivery models that address social determinants of health. One such model is medical-legal partnership (MLP). MLPs join health care providers with lawyers to address health-harming legal needs in the lives of vulnerable patients. Research on MLPs has demonstrated their success in reducing stress and increasing health and well-being in the patients they serve and in their families. This chapter explores the possibility of using MLP as a tool to prevent child maltreatment.

INTRODUCTION

There has been significant attention in recent years to health care delivery models that address social determinants of health. One such model is medical-legal partnership (MLP). MLPs join health care providers with lawyers to address health-harming legal needs in the lives of vulnerable patients. Research on MLPs has demonstrated their success in reducing stress and increasing health and well-being in the patients they serve and in their families. This chapter explores the possibility of using MLP as a tool to prevent child maltreatment.

Data support the proposition that parental stress as well as conditions of poverty contribute to child maltreatment (1, 2). To the extent that MLPs reduce stress on families and alleviate conditions of poverty by addressing issues such as substandard housing and strained household resources, they may help prevent child maltreatment as well. MLPs will encounter ethical challenges if they strive to address child maltreatment through direct representation of parents or children, however. Given the competing professional obligations around mandatory

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reporting of abuse and neglect, direct representation of families involved in the child welfare system has the potential to disrupt the collaboration between healthcare providers and lawyers, which is the hallmark of medical-legal partnership. MLPs are thus better suited to "work upstream" and address conditions that lead to child maltreatment.

CAUSES OF CHILD MALTREATMENT

When this chapter refers to "child maltreatment" it includes both child abuse and child neglect. Child abuse is commonly defined as "the non-accidental commission of any act by a caregiver on a child (in most states defined as a person under age 18 years) that causes or creates a substantial risk of physical or emotional injury; constitutes a sexual offense, or any sexual contact between a caregiver and a child under the care of that individual" (3). Child neglect has been defined as "the failure by a caregiver, either deliberately or through negligence or inability, to take those actions necessary to provide a child with minimally adequate food, clothing, shelter, medical care, supervision, emotional stability and growth, or other essential care; provided, however, that such inability is not due solely to inadequate economic resources or solely to the existence of handicapping conditions" (3).

Much has been written about causes of child maltreatment (1, 4, 5). In particular, scholars have connected neighborhood poverty and family economic insecurity with child maltreatment (1, 4, 6). There is also evidence that child maltreatment is related to stress. One researcher has written, "[l]ack of income may influence parental emotional well-being and parenting practices through increased stress. Parents that are highly stressed are more likely to engage in rapid information processing as a way to control their children's behaviors" (1, 7). This means that parents form immediate, negative reactions to their children's behaviors, and that parental stress contributes both to the formation of those negative assessments of behavior and to the resulting abuse (8).

Lack of income may also lead to behaviors better characterized as neglect, as parents may not have the resources to provide for their children (6). For example, parents living in poverty may not be able to afford childcare and may leave their children unattended when they go to work. Parents living in poverty may struggle to provide safe housing for their children. Even affluent parents may struggle to manage their children on a day-to-day basis (9). Under the best of circumstances, children cry, resist toilet training, defy their parents, and create chaos in a family unit – all factors contributing to abuse (10). Children with disabilities also increase parental stress (9). Children who have a hard time achieving developmentally appropriate cognitive, emotional, and physical milestones, children who have conditions that include heightened fussiness or distractibility, and children who require high levels of care, put enormous strain on parents, which can affect the parent-child relationship and lead to higher rates of abuse (9). When you add poverty to the mix, the stress may cause some parents to lose their tempers more quickly and discipline their children inappropriately. One model for understanding this dynamic is the Family Stress Model, which puts forth the idea, based on decades of research around the globe, that economic hardship leads to economic pressure, which causes emotional distress that puts strain on family relationships and the ability of parents to respond appropriately to their children (7).

Scholars who have examined the relationship between poverty and child maltreatment have concluded "the available evidence indicated that few personal differences had been found to distinguish abusing and neglecting parents from other impoverished parents other than depression, low self-esteem, and feelings of helplessness . . . these factors undermine one's ability to cope with poverty and its stressors, which include its various material hardships" (4). The stress of poverty has also been shown to contribute to unhealthy coping methods, such as drug and alcohol abuse, which likewise compromise parental judgment (4). Strategies to reduce child maltreatment therefore must address parental stress, which includes conditions of poverty and child health (4).

Given the prominent role that parental stress plays in child maltreatment, and given that child maltreatment contributes to negative health outcomes for children that persist throughout their lives, the medical-legal partnership model of intervention may be a uniquely well-suited tool of child maltreatment prevention.

HISTORY AND PURPOSE OF MLPS: SOCIAL DETERMINANTS OF HEALTH AND ADVERSE CHILDHOOD EXPERIENCES

It is well-established that crucial components of health and well-being reside in social factors that lie outside the traditional purview of health care (3, 11-14). These factors are commonly referred to as "social determinants of health" (12). The social determinants of health – where people live, work, and play – contribute to overall health as much if not more than the quality of health care services (3). Social determinants of health consist of access to green spaces and clean air, access to nutritious food and safe housing, access to quality education, and so on. Whereas Americans used to have a narrow understanding of factors that contribute to overall health – focusing almost entirely on access to medical care for individuals – we now understand that personal health is intrinsically linked to living and working conditions in homes and communities, and the broader economic and social opportunities and resources available (3).

Another advance in our understanding of the factors that contribute to overall health is the role of adverse childhood experiences, or ACEs, in health and well-being (3, 15, 16). ACEs include emotional abuse, physical abuse, sexual abuse, domestic violence, household substance abuse, mental illness in the household, parental separation or divorce, and incarcerated household members (16). Researchers who study the consequences of adverse childhood experiences have noted that "childhood stressors such as abuse, witnessing domestic violence, and other forms of household dysfunction are highly interrelated and have a graded relationship to numerous health and social problems" (16).

Because long-term health relies so heavily on improving social determinants of health and on reducing the number of ACEs, health care delivery models must address both. It is in this context that American health care providers have devoted increased attention to social factors, as the health care system acknowledges the constraints on its ability to improve population health through individual access to traditional medical care alone (14).

One innovative way in which health care systems have begun to address social determinants of health is through medical-legal partnerships (11, 12). Many health-harming social conditions have legal remedies. For example, a family without adequate access to food may have been wrongfully denied governmental food assistance. A family whose child with a

disability is struggling in school may be entitled to an individualized education program under federal special education law. A family living in substandard housing where conditions are present that exacerbate health conditions may have protections in local housing codes. A child who has been prescribed a medical treatment or equipment but the child's Medicaid health plan refuses to cover it, may have protections in the Social Security Act. And a family experiencing intimate partner violence may benefit from a personal protection order. MLP lawyers use their legal expertise to help families gain access to these health-improving legal remedies.

The idea for MLP arose when Dr Barry Zuckerman, working with vulnerable families in the Boston Medical Center in 1993, kept encountering children who were failing to thrive (17, 18). Dr. Zuckerman hired a lawyer to help advocate for these patient families, particularly with regard to accessing public benefits and safe housing (17). Support for this model grew over the years and was endorsed by the American Bar Association in 2007, the American Academy of Pediatrics in 2007, and the American Medical Association in 2010. To date, there are over 300 MLPs in 48 states (19). They are housed in different types of health care institutions – from stand-alone health clinics to vast University hospitals; from legal aid offices to law school clinics (19). The MLP model allows health care providers and lawyers to work together to address social determinants of health for vulnerable patients (12). MLPs integrate lawyers into the health care team so that lawyers may address health-harming legal needs for patients (12).

How MLPs Work

Legal training for medical providers forms the foundation of an MLP. MLP lawyers work with medical providers to help them identify health-harming legal needs of their patients including, for example, issues with public benefits, special education law, domestic violence, and housing law. Lawyers may give providers some basic tools so that providers are able to engage in limited advocacy on behalf of their patients even before calling in the legal team. For example, a doctor trained in special education law may provide their patient with a letter requesting a special education evaluation from a school. Providers who have been trained in medical emergency exceptions to utility shut-offs may provide their patients with an advocacy letter that the patient can present to a utility company. And providers who have been trained in housing law may send a letter to a landlord asking the landlord to repair health-harming conditions such as cleaning mold or exterminating rodents. In these scenarios, lawyers equip providers with letter templates or with sample language to include in the provider's own advocacy letter so that health care providers may take the initiative to address social determinants of health for their patients.

If provider advocacy does not solve the problem, or if a problem is legally complex and requires attorney intervention from the outset, providers refer the patient to the MLP lawyer. Lawyers in MLPs typically provide direct legal representation to low-income clients on civil legal issues that affect health. As noted above, these might include any combination of housing matters, public benefits, family law, domestic violence, education law, and even immigration law or employment law (13). Researchers who have studied MLPs have observed that "medical-legal partnerships can become an essential component of the patient-centered medical home by making timely, on-site legal interventions available to patients and families" (11). There are many laws that exist to protect the health and well-being of vulnerable people. MLP lawyers are able not only to enforce these laws for patients, but also to help patients navigate

complicated bureaucracies that can feel overwhelming or impenetrable to families working on their own (13). In providing free legal representation to low-income families in these areas of law, MLPs reduce stress on families and alleviate conditions of poverty. This reduction in stress and alleviation of the conditions of poverty may in turn help prevent child maltreatment.

Some MLPs go beyond providing direct legal representation to clients and work to address health-harming policies as well (1). For example, one MLP provided comments to the Social Security Administration regarding revisions to the disability eligibility requirements (20). The Pediatric Advocacy Clinic at the University of Michigan Law School has worked with the Michigan Department of Health and Human Services to ensure that Medicaid Health Plans in Michigan have language in their manuals that conforms to the guarantees of federal Medicaid laws for children. And another MLP documented the health impacts of utility shut-offs on its patient population and successfully advocated for changes to the state regulations governing shutoffs (3).

Empirical support for MLPs

Empirical research into the effectiveness of MLPs at improving health outcomes is promising, though limited in scope. In a 2017 meta-analysis reviewing peer-reviewed research about MLPs from 1993-2016, a research team led by Temple University Professor Oscar Martinez found 13 studies with quantitative analysis of MLPs' impact (21). Of those, four incorporated pre-test and post-test data (21). Small pilot projects and studies identified in the meta-analysis have revealed favorable signs about MLPs' impact on health outcomes. In one example, an MLP improved asthma control. Asthmatic patients seen in a New York City teaching hospital lived in inadequate housing, with leaks, mold, and cockroach and rodent infestations exacerbating their symptoms. MLP attorneys assisted patients in securing necessary maintenance and structural repair to their homes, leading to improved asthma control, which manifested in a 90% decrease in emergency department visits and hospital admissions. Additionally, improved housing conditions led to the elimination of prescription systemic steroids, associated with a myriad of adverse effects, in 73% of the patients (22). In another example, low-income families with newborns who were randomly assigned a care team that included an MLP staff member demonstrated improved access to concrete supports, higher rates of on-time immunizations and preventative care, and less emergency department utilization relative to a control group (23). A third study evaluating a pilot program focused on "super-utilizers" of hospital services demonstrated decreases in both 30-day and seven-day readmission rates when the interdisciplinary care team addressed the patient's civil legal problems (24). The Robert Wood Johnson Foundation's County Health Rankings and Roadmaps program, which assigns "evidence ratings" to different medical interventions indicating their level of scientific support, gave MLPs its second-highest classification, reserved for strategies that are "likely to work, but further research is needed to confirm effects" (25). These strategies have been tested more than once and results trend positive overall.

Multiple studies have also considered MLPs' impact on stress levels. An analysis of a University of Arizona MLP demonstrated significant improvements in patients' perceived stress score and well-being after receipt of legal intervention, reflected in notable decreases in patient caregivers' Perceived Stress Scale (PSS-10) scores and improvements in their Measure Yourself Concerns and Well-being (MYCaW) scores (26). The University of Arizona MLP

provided legal assistance to patients and their families on a wide array of civil legal issues, such as access to food assistance, family law matters, and access to social security benefits. A study of parental PSS-10 scores before and after their children received assistance from a Rutgers University-affiliated MLP showed drops in stress levels, though the change was more modest than in the Arizona study (27). Even so, the study supports the proposition that MLP assistance can reduce parent-reported stress arising from social determinants of health. As such, the study lends support to the importance of MLPs in improving overall child and family health and well-being (27).

MLPs' effect on stress has also been assessed in the context of specific health conditions: A New York-based MLP interviewed 20 of its cancer patients to understand the impact that MLP intervention had on their quality of life (28). Seventy-five percent of patients said that the legal services reduced stress, 50 percent said it had a positive effect on family or loved ones, 45 percent noted a positive effect on their financial situation, 30 percent said it helped them maintain treatment regimens, and 25 percent said the services helped them keep their medical appointments (28).

Taken together, this data lend strong support to the notion that MLPs provide much needed assistance and relief for low-income families and therefore could be well situated to prevent child maltreatment.

Using MLPs to address child maltreatment

Because the experience of child maltreatment has been shown to cause long-term negative health outcomes, and because child maltreatment is widely recognized as a public health problem (29), it is reasonable to explore whether MLPs could address child maltreatment in addition to other stressors on families. After all, medical providers, and pediatricians in particular, are on the front lines of identifying child abuse and neglect (3).

THE ROLE OF MEDICAL-LEGAL PARTNERSHIPS IN PREVENTING CHILD MALTREATMENT: ETHICAL CONSIDERATIONS

The defining feature of medical-legal partnership is its collaborative nature. Doctors, nurses, social workers, and lawyers in MLPs work together to address social determinants of health in the lives of their low-income patients and clients. Collaboration across disciplines requires careful consideration of each profession's code of ethics to ensure professional independence and to safeguard patient/client information (30, 31). Health care providers and MLP lawyers put systems in place that define the scope of their collaboration and provide for client consent to the necessary inter-professional communication.

Typically, in an MLP, the structure of the collaboration goes as follows: MLP lawyers train health care providers to identify health-harming legal issues. When the provider is meeting with a patient, the provider identifies the patient's potential legal issue and, with the patient's permission, refers the patient to MLP legal staff. The MLP conducts an intake to evaluate the patient's legal needs, the MLP lets the patient know whether it will accept the patient for representation, the MLP lawyer obtains permission from the patient to discuss their case with

medical providers, and communication with providers about the status and outcome of the patient's legal needs continues throughout the representation (3). Depending on the nature of the legal issue, medical providers and lawyers may collaborate quite closely throughout the case. For example, if a child has been denied Supplemental Security Income (SSI), the lawyer will work with the child's physician to understand the child's disabilities so that the lawyer may advance an argument to the Social Security Administration that the denial was in error. If a family's home has conditions – such as mold – that exacerbate a family member's asthma, the MLP lawyer might use medical records to demonstrate the harmful effects of the housing condition on the family member and might ask the physician to explain the connection between mold and asthma or allergies in court. And if a parent is experiencing domestic violence, the lawyer may rely on physician documentation of abuse to substantiate the client's claims. In each of these cases, the collaboration enhances the legal representation and, as a result, the patient's health and well-being.

In the case of child maltreatment, one can imagine a number of ways in which MLP lawyers might get involved. During an appointment, a provider might notice physical signs of abuse of a child or may learn of the possibility of abuse and neglect from listening to either the parent or child. If it were any other legal issue, the provider would obtain patient consent to speak to the MLP lawyer about what is going on and the interdisciplinary collaboration would begin. In an MLP, where the essence of the work depends on collaboration and communication, the possibility of intervening in an abuse and neglect case becomes complicated. The different ethical obligations of health care providers and lawyers are in tension in this context.

In an MLP, it is the patient or any family member of the patient, who becomes the "client" for purposes of legal representation. An MLP that is partnered with a children's hospital, for example, will address health-harming legal needs of a child patient by representing the parent of the child. This occurs because until children turn 18, parents hold the rights of their children in most contexts. The determination of who is the client has significant consequences for the lawyer's ethical obligations.

Lawyers have a duty of loyalty to their clients (32). Inextricably connected to this duty of loyalty is the duty of confidentiality (33). All information related to the lawyer's representation of the client must be kept confidential unless the client consents or unless one of the narrow exceptions apply (3). These exceptions include, for example, the ability to breach confidentiality to prevent death or bodily harm or to prevent or rectify fraud by the client. (3). In many legal cases in which an MLP is involved, this duty of confidentiality does not interfere with the inter-professional collaboration. Parents freely provide consent for their MLP lawyers to give information to, and receive information from, medical providers. They do this because it enhances the ability of their lawyers to work on their case and it strengthens the medical-legal partnership. If the lawyer learns information in the course of representing the client that the client does not want the lawyer to share with the healthcare provider, however, this could affect the quality of the partnership and possibly of the representation as well. This scenario is more likely to occur in a child abuse and neglect case than in other typical MLP cases.

The lawyer's duty of confidentiality, coupled with their duty of loyalty to a client, means that if a lawyer is representing a parent and learns of abuse or neglect of a child, in most states (with some exceptions) (34) the lawyer may not disclose that abuse and neglect to the medical providers who referred the parent to the MLP – or to anyone else – without the parent's permission (3). In contrast, medical providers are mandatory reporters of abuse and neglect (3, 34, 35). Failure to report suspected abuse or neglect to Children's Protective Services can have

significant negative consequences for healthcare professionals. These consequences may include civil and criminal liability for both the medical provider personally and for their employer as well as licensure complaints and penalties (36). This responsibility is not to be taken lightly.

If a medical provider sees signs of abuse in a child, or learns of potential abuse and neglect, should the provider make a referral to the MLP lawyer? If the provider decides to make the referral, who becomes the MLP client? If the provider refers the parent to the lawyer, the parent will become the MLP client. What if the patient is an adolescent and that adolescent confides abuse or neglect to the provider? Should the provider refer that adolescent to the MLP lawyer? Once the parent or child becomes the MLP client, all of the ethical obligations and protections – including the duties of loyalty and confidentiality – attach to that attorney-client relationship.

If a provider makes a referral to the MLP lawyer of either the parent or the child in a case of suspected child maltreatment, the lawyer would then represent the parent against allegations of abuse and neglect or the child against the parent. In so doing, the lawyer will become privy to confidential information regarding the parent's relationship with his/her child. Because of the lawyer's duty of loyalty and duty of confidentiality, assuming the parent would refuse to give the lawyer permission to discuss their case with the medical provider who is a mandatory reporter of abuse and neglect, the provider and the MLP lawyer will no longer be able to discuss the case. In fact, it is not a leap to imagine a medical provider being called upon to testify against a parent in an abuse and neglect case about bruises examined or stories of neglect heard. The MLP lawyer would be in the unfortunate position of cross-examining their medical partner in the course of representing the client.

MLPs depend on a cooperative relationship and on the exchange of information to be effective, and there are ethical constraints on both health care providers and lawyers in the abuse and neglect context (30). One researcher exploring the ethical tensions that could arise between doctors and lawyers has cautioned, "[de]spite the significant benefits of integrating the provision of legal services into the health care setting, such risks should be fully explored to avoid unintended consequences to these partnerships and the patients they serve" (30).

Seeking to avoid this tension, some MLPs explicitly decline to accept cases involving suspected abuse and neglect and attempt to limit mandated reporters' exposure to confidential or privileged information in this context. The University of Michigan Law School Pediatric Advocacy Clinic (PAC) for example, does not accept referrals for abuse and neglect cases to avoid the tension that they invariably cause between MLP providers and lawyers. The PAC goes so far as to instruct the social work intern conducting intakes to inform each family that the social worker is a mandatory reporter of abuse and neglect and thus, if the client is concerned about this, should request to complete their intake with a member of the MLP team who is not a mandatory reporter. Other MLPs treat social workers as part of the legal team and require them to adhere to attorney-client rules of confidentiality (3). Of course, while it may be possible to incorporate social workers working as part of the legal team into the law office of an MLP, the same is not possible with medical provider partners working in their health care setting (3). Such steps to protect this information underscore the difficulty of an MLP in successfully navigating an abuse and neglect case while keeping the partnership intact (30).

Because of these ethical tensions, despite the fact that child abuse and neglect is an adverse childhood experience that has negative long-term health consequences and therefore seems ripe for MLP intervention, MLPs do not typically provide direct representation to either parents or children once abuse or neglect has been identified in a family. An MLP may represent a parent

trying to shield her children from another parent in the domestic violence and child custody contexts, which can also cause ethical challenges along the same lines as abuse and neglect cases (3), but will typically not represent the parent accused of abuse or neglect.

MLPs are better suited to address child maltreatment in an "upstream" manner – by reducing overall stress on families, by helping families obtain additional financial resources, and by working on policies that prevent child maltreatment (10). These could include advocacy for all sorts of social and economic interventions that ease poverty, provide expanded access to health care, and reduces stress.

CONCLUSION

To the extent that medical-legal partnerships unite health care providers and lawyers to relieve stress on families and ease some of the conditions of poverty, they are a valuable preventative tool in addressing the scourge of child maltreatment. Ethical challenges may arise and complicate the collaboration between health care providers and patient families if MLPs provide direct representation to either children or parents in cases of suspected child maltreatment. MLPs are thus better equipped to address other family stressors that contribute to child maltreatment and to work on policy matters. Medical providers who are connected to an MLP may help prevent child maltreatment by making referrals for families who are struggling with conditions of poverty and unmet legal needs. By addressing social determinants of health and reducing stress on families, providers are working to prevent child maltreatment.

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Chapter 23

PREVENTION SERVICES THROUGH CHILD PROTECTIVE SERVICES

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ABSTRACT

The Child Abuse Prevention and Treatment Act (CAPTA) of 1974, the federal legislation that created the modern child protective services system, was designed to offer a public response serving maltreated children with secondary prevention and intervention. From its inception, CAPTA anticipated that community partnerships with the private and non-profit sectors would be key to primary prevention, and that is still the case in the United States. Over the decades, Child Protective Services (CPS) agencies initiated secondary prevention services in response to external pressure from legislatures responding to 'moral outrage' at crimes against children, and powerful advocates promoting promising service models with varying degrees of success. The most critical role for CPS professionals in prevention is strong community involvement, both to ensure that the needs of CPS clients are well-known and understood, and that CPS staff are aware of all of the resources in the community to serve their clients.

INTRODUCTION

This chapter is designed specifically to examine the role of the Child Protective Services (CPS) System in the prevention of child abuse; other chapters examine the role of related public systems serving children and families. Looking beyond CPS for primary prevention is necessary; research and practice experience support the concept that the primary prevention of

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child abuse should not be the responsibility of a CPS system, and in many states, it does not fit into a CPS system at all.

DEFINITIONS AND OVERVIEW

The traditional public health taxonomy of prevention as primary, secondary and tertiary will be used in this chapter (1), wherein primary prevention refers to strategies directed at a population with messages or services intended to intervene before detrimental health effects occur, secondary prevention targets people with known risk factors for health effects and tertiary prevention is directed to people already suffering the health effects with the goal of preventing a recurrence.

Some researchers and practitioners in mental health have produced scholarly work on these definitions, which can inform the work in child protective services. Long debates about classification of prevention in mental health have included the suggestion that "the category of tertiary prevention proposed by Caplan (2), which referred to the prevention of disability for those suffering from disorders, was excluded" (3). Many prevention advocates would concur. This chapter is written from the perspective that interventions designed to prevent further harm for those already suffering should not be considered prevention. This is informed both by the clinical perspective described by Caplan (2) as well as an administrative concern: prevention advocates argue that organizations treating children who have already experienced harm often have more opportunities to solicit and receive resources than do organizations offering primary prevention. There are more funding sources for interventions, and some of the public funds for interventions are uncapped, meaning that the funding increases as the caseload increases.

Further, private funders often find supporting intervention and treatment programs more appealing than supporting prevention programs because the effects of interventions can more easily be demonstrated. In my experience in public human services, I have heard elected officials questioning the wisdom of spending tax dollars raised during their administration on a service where the benefits would not be measurable until long after they were out of office.

"Key to CPS is tertiary prevention, that is preventing recidivism, specifically because chronic maltreatment predicted later emotional and behavioral problems, especially if it crossed developmental stages" (4). Tertiary prevention is the primary objective of CPS; this chapter will look more closely at primary and secondary prevention.

LEGISLATIVE AND PROGRAMMATIC HISTORY

Child Protective Services has a clear and mandated role in secondary and tertiary prevention. The Child Abuse Prevention and Treatment Act of 1974 included provisions to make grants "…for demonstration programs and projects designed to prevent, identify and treat child abuse and neglect" (5). By specifically differentiating prevention from identification and treatment, the intention to do more than tertiary prevention seems clear. However, CAPTA earmarked little money for primary and secondary prevention, and prevention funding was generally disbursed by grants or contracts with the non-profit and voluntary sector. A text search of the transcripts of the 1983 CAPTA reauthorization hearings shows the word 'prevention' primarily

when repeating the name of the Act (6, 7). Certain CAPTA funds were allocated to states as discretionary funds, which some states used for prevention, but primary prevention never enjoyed the general support or uncapped entitlement to funds earmarked in other CAPTA titles for investigation and intervention.

The National Center for Child Abuse and Neglect (NCCAN) was created by CAPTA as an office within the Administration for Children, Youth and Families (ACYF), a division of the federal Department of Health, Education and Welfare (HEW). When reauthorization hearings were held in 1983, ACYF Commissioner Clarence Hodges' testimony on NCCAN's achievements made relatively little mention of prevention. Testimony regarding prevention indicated that that NCCAN was supporting an "array of ongoing projects, several which are actively working to improve hospital practices and community education to support young parents facing particular difficulties with their parental responsibilities" (6). Hodges discussed community-based prevention projects including "[sex abuse prevention] materials (curricula and a film) to be used with school students from preschool through high school, to make children aware of sexual abuse, to provide them with help in preventing the problem and to let them know how to go about seeking assistance if abuse is happening to them, a sibling, or a friend" (6).

In another hearing Hodges said that "The programs where we use discretionary funds include a number of volunteer agencies and non-profit agencies. They work with those persons who might very well be suspected of child abuse" (7). The prevention projects highlighted by NCCAN in these hearings did not involve CPS at all. National non-profit organizations that were mentioned included The National Committee to Prevent Child Abuse and Neglect (now known as Prevent Child Abuse America), Covenant House, Parents Anonymous, Parents United and The American Humane Association.

In the House hearing HEW Secretary Dorcas Hardy actually objected to funding earmarked for prevention. He said, "We are spending a great deal already on prevention activities" (6). "The state grant proportion of the Act provides eligible states… funds to develop, strengthen and carry out prevention and treatment programs…" (6). He went on to express concerns "about your proposals to add a requirement in Section 4 of the act that the Secretary shall establish percentages of funding to be earmarked for prevention. We believe this could create an unnecessarily rigid requirement…" (6).

In 1996, the Community Based Child Abuse Prevention (known as colloquially as (CBCAP)) grants to states were established under Title II of CAPTA to provide grants to states for prevention (8). In order for a state to receive these funds, a governor must designate a lead agency to receive them; in most states, the lead agency is in the same cabinet-level department as CPS, but is not the CPS operating entity. There is a continuing emphasis on partnering with the non-profit sector. The CBCAP Program Instruction (PI) (9) states, "Given the limited funding available for prevention services, lead agencies are strongly encouraged to find ways to partner with other public and private organizations serving the same populations and sharing the same goals and objectives."

PRIMARY PREVENTION IN CPS

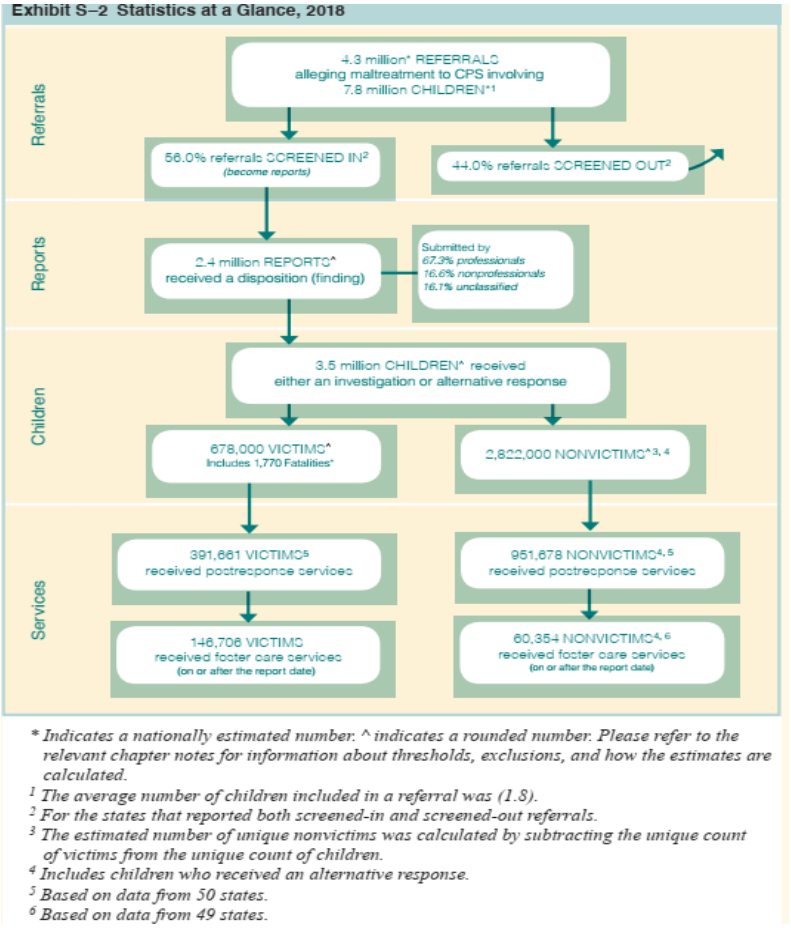
The study and practice of primary prevention of child maltreatment developed independently of the CPS systems. National non-profit organizations like Parents Anonymous and The National Committee to Prevent Child Abuse and Neglect were founded in 1969 and 1972, respectively. The early initiatives of The National Committee focused on public information and education, including collaborating with the Ad Council to develop a campaign based on the slogan, *"It shouldn't hurt to be a child,"* and a campaign to prevent psychological abuse featuring the slogan, *"Words can hit as hard as a fist. Listen to what you are saying; you might not believe your ears"* (10). Early initiatives of Parents Anonymous focused on strengthening and empowering parents. Both organizations continue to operate and maintain a focus in these areas, and have branched out to provide other services to families and communities. Parents Anonymous developed and has maintained a strong orientation toward parents' involvement and self-direction in its approach, while Prevent Child Abuse America (formerly the NCPCA) is a leader in early childhood home visiting programs.

Public messaging about primary prevention of child maltreatment was emphasized in early 2003, when Prevent Child Abuse America and The Frameworks Institute developed a national reframing strategy to build public awareness that child abuse is a preventable condition, (11) based on an understanding of child and family development. The Center for the Study of Social Policy (CSSP) continued this work and developed the Strengthening Families Initiative (SFI) which was initially developed as an approach to use with early care and education programs to target families of children ages five years and younger (12). Early care and education programs were identified as a community touchpoint, capable of interacting with and influencing large numbers of parents with whom they already presumably enjoyed a level of trust. States generally targeted this initiative to early care and education centers serving low income families, many funded by CBCAP or other funds targeted for low income or CPS-involved families. New Jersey, for example, combined this effort with a court-ordered requirement to improve educational opportunities for low income children. While this initiative was intended to be primary prevention, in implementation it evolved into secondary prevention as the limited resources were directed toward a population with risk factors. In some communities, CPS was a partner in promoting these initiatives and in others it provided seed funding, but CPS clearly did not lead this prevention effort.

SECONDARY PREVENTION IN CPS

Child Protective Services agencies are in an ideal position to offer secondary prevention. One high risk group identified by advocates is the roughly two-thirds of 'referrals' to CPS who are screened out before becoming 'reports.' As seen in figure 1 (13) the annual report published by the Children's Bureau of the Administration on Children, Youth and Families to describe CPS activity, (13 p xiii), an estimated 1.9 million children were identified in 'referrals' to CPS with case characteristics that did not reach the standard to warrant an investigation. Nationally, of the 7.8 million children referred to CPS, only 678,000 were identified as 'victims' qualifying for comprehensive services. Children who are 'screened in' and receive either an investigation

or an 'alternative response' can be considered recipients of secondary prevention, assuming that there was no finding of abuse by CPS.



Preprinted with permission from US Administration for Children Youth and Families. Child Maltreatment 2018: xiii (https://www.acf.hhs.gov/sites/default/files/cb/cm2018.pdf).
Figure 1. Statistics at a clance.

A review of the major secondary prevention initiatives implemented by CPS shows that such initiatives were initiated either through a theoretical framework promoted by advocates, or in response to a public outcry about a real or perceived threat.

CPS prevention initiatives developed with a theoretical framework

Family preservation

As states faced pressure to reduce the number of children in out-of-home placements in the late 1980's, short-term intensive services designed to help stabilize a family in crisis and prevent both placement and further harm to children gained popularity. The widely used Family Preservation Services (FPS) model is "intensive and short-term." 'Intensive' means that social workers spend several hours a week with family members, particularly in the first weeks of

service. Workers carry small caseloads, sometimes as few as two cases, so as to permit extensive involvement" (14).

These programs generally provided service in the home, involved the entire family (15) and could spend program funds to meet incidental needs. FPS initiatives were touted for the reduced cost compared to placement and the benefits of keeping children with their parents. Some states contracted out for services with non-profit providers, while others developed specialized units where CPS workers had extremely low caseloads of two to three families. FPS was believed to hold great promise for families, but barely lasted ten years. Several factors lead to this outcome: While early evaluations showed promising results on the single outcome variable of "families intact at 12 months" (15), client characteristics at entry were found to have an impact on outcomes. Further, there was large variability in the services components offered by different providers and variability in the characteristics of the clients refereed to this program. Even as research and program evaluations began to show which clients and which components had a better chance of success (14), eligibility criteria were not sufficiently tightened to match the type of clients shown to benefit from this intervention. These conditions are not uncommon in public human services, where the availability of a service in a community is often a key factor in referring a family. While serving as a public official, I had many peers who were strong proponents of 'no reject-no-eject' publicly funded service contracts with providers. While this ensured that programs operated at funded capacity, it also lead to a mismatch between who a program was designed to best serve and who received the services.

FPS began to fall out of favor by the mid-nineties. An editorial in the New York Times blasts FPS, comparing two neighboring families in subsidized housing – one with two working, low wage parents, and one a single, drug addicted mother whose boyfriend abuses her children. Harking back to the concept of the 'deserving poor,' and asking which family is more deserving of "a free housekeeper up to five days a week…..up to $2,000 for a security deposit and the first month's rent on a new apartment, as well as furniture and up to $500 in cash." The writer laments that "giving services and money to parents who have abused their children does nothing but reward irresponsible and even criminal behavior" (16). Around the same time initial evaluations were being published that questioned the effectiveness of FPS (17).

Differential response

A differential response (DR), or alternative response, can be considered targeted secondary prevention; the 2010 reauthorization of CAPTA "requires State plans and assurances to describe laws, policies, or programs reflecting differential response in screening and assessment, including "triage procedures for the appropriate referral of a child not at risk of imminent harm to a community organization or voluntary preventive service" (5). As initially conceived, DR was designed to serve a low-risk population, "the approximately 20% of referrals to CPS agencies who would have been closed out upon competition of the investigation" (18). However, results of evaluations of DR efforts indicated a high rate of re-referral to CPS (18), as well as very high-risk families being referred to DR (19), thereby placing children at risk and leading to severe critiques of DR, including considering DR a violation of a child's right to a more comprehensive CPS evaluation that would ensure their safety (20).

While DR has shown positive effects in certain circumstances, issues similar to Family Preservation were noted in terms of client referral and selection (see 18 for example), and a lack of fidelity to the services model. When the options available to CPS workers are limited,

they may opt for a 'best -fit' to what's available, even if it is not perfect for the family, a phenomena that was well documented with FPS. A report describing a comprehensive review of evaluations coupled with key informant interviews with state officials (21) concludes that serious methodological flaws in evaluations, incomplete data to assess child safety, and uneven implementation and allocation of resources are among the weaknesses of DR as it has been implemented.

CPS prevention initiatives developed as reactionary responses to high-profile cases

Child Protection Services units are often central to well-intentioned but poorly constructed secondary prevention initiatives fueled by legislators reacting to moral outrage. Child maltreatment laws have been noted as being particularly vulnerable to reactionary responses by legislators after high-profile tragedies. Nelson (22) documented the unprecedented speed at which child abuse reporting laws swept through all fifty state legislatures between 1963 and 1967. Zgoba (23) described "spin doctors and moral crusaders" as drivers of certain types of child abuse legislation, seeking laws requiring specific interventions but having no empirical basis to support their claims of effectiveness.

Zgoba (23) described moral panic as the driver for such legislation, fueled by a "media-crafted threat of a moral decline [which perpetuates a collective outrage], which ultimately defines what society perceives as good or bad" (23). Crimes or perceived criminal behavior toward children have generated some of the highest levels of fear and anxiety, and laws have followed. Many of these laws have involved Child Protection Services, directing them to prevent specific types of maltreatment.

An early example, *the Baby Doe Rules,* was discussed in the 1983 CAPTA reauthorization hearings after the 1982 death of an infant in Indiana born with severe disabilities whose parents followed medical advice and did not pursue medical intervention. The case captured the attention of an attorney with a right-to-life organization, who sued on the infant's behalf. Federal officials, including then surgeon general C Everett Coop, agreed with the plaintiff's perspective, although debate raged in the medical and legal professions (24).

Interim rules to ensure that children received medical care were proposed in the 1983 CAPTA reauthorization, and a proposed amendment to CAPTA in 1984 extended the laws defining child abuse to include the act of withholding fluids, food and medically indicated intervention for medically challenged children. The first state Baby Doe Rules went into effect in 1985 and final rules were included in the 1988 CAPTA reauthorization. These rules, designed to protect severely handicapped children from medical neglect, have also been cast as government intrusion into parents' rights to make decisions about treating a child with a very poor prognosis for quality of life. Baby Doe Rules require that hospitals post signs and report such cases where "nourishment and medically beneficial treatment (as determined with respect for reasonable medical judgments) should not be withheld from handicapped infants solely on the basis of their present or anticipated mental or physical impairments," and listing three phone numbers – the hospital committee, state child protective agencies and the federal hotline – for reporting suspected cases. The 1988 rules also gave CPS agencies 60 days to "establish procedures to explicitly deal with baby Doe-type cases" (24). Debate continued in the medical and legal literature on the ethics and effects of Baby Doe Laws (25, 26).

Safe Haven Laws, also known as Baby Moses laws, were a much larger initiative than the Baby Doe Rules. After highly publicized incidents of infanticide starting in the late 1990s, Safe Haven Laws emerged as a popular, if unproven, solution. Beginning in 1999 with the first state law in Texas, these laws are designed to encourage parents to "anonymously and safety relinquish newborns to emergency medical providers such as police stations, fire stations and hospital emergency rooms" (27). State CPS agencies were uniformly charged with receiving babies so relinquished and many were also charged with publicizing and promoting this initiative. Safe Haven Laws have been found to have little effect in their intended goal (ibid) of preventing child fatalities and have been referred to, along with Amber Alerts, as political theater in response to moral outrage and "crime control theater" by Hammond et al. (27), who say "Like many emotionally charged policy responses to moral panic over child safety, Safe Haven Laws enjoy public and political support that is belied by their flawed conception and dearth of empirical validation." Zgoba et al. has questioned the efficacy of similar prevention laws (28).

Central registries

"[A]ll States, the District of Columbia, American Samoa, Guam, and Puerto Rico require a system of maintaining {CPS} records, usually in some form of a central registry, by either statute or regulation (31). CPS Central registries can help prevent child maltreatment by seeking to ensure that offenders known to CPS are limited in their ability to work around children. Many states require a 'background check' before allowing certain types of employment or volunteer work involving direct contact with children, or for a family to be licensed to provide in-home childcare. In most states, these pre-employment background checks generally include a check of the CPS central registry along with a criminal background check. There is, however, variability in the data maintained in central registries; "Some states maintain all investigated reports of abuse and neglect in their central registries, while others maintain only substantiated reports" (31).

Families First Prevention Services Act

After a steady decline in out-of-home placements for maltreatment, an uptick was noted in 2017. Federal officials determined that this was due to the opioid crisis sweeping the country, and in response, Congress enacted The Family First Prevention Services Act. "This landmark legislation offers states an unprecedented opportunity to transform state child welfare systems by providing substance abuse, mental health and other prevention and treatment services to prevent children's entry into foster care. The law also seeks to reduce states' reliance on group and residential treatment homes and instead prioritize family-based care" (29). Before this law passed, states could use their Federal Title IV-E funds only after a child had entered foster care. Since passage of this act, states can use IV-E funds for prevention programs with a research base that indicates that their effectiveness is "well-supported, supported, or promising" (30). Advocates strongly supported this initiative, particularly because it opened uncapped IV-E funds for services before placement.

BARRIERS TO PREVENTION IN CPS

Analysis of the CAPTA legislation and transcripts from early reauthorization hearings make it clear that the CPS systems built after its passage were not intended to have primary responsibility for prevention. But that did not stop the public, and often state legislatures, from pointing first to their CPS systems when seeking prevention solutions. There are, however, certain characteristics of prevention programs that make them generally incompatible with CPS agencies.

Perception of seriousness

Perception of seriousness impacts decisions made by CPS professionals about child protective services cases. CPS staff prioritize more serious situations when allocating limited resource like time, funds, and slots in intervention programs. Wolock (32) reports that "staff of offices in the more socially and economically disadvantaged catchment areas who handle more severe caseloads viewed the {same} situations as less serious than staff in offices in more advantaged areas who supervise a less serious caseload." Organizational features, such as how many reports were received on a day, also govern how staff respond. Cases that may be investigated on a day where there are few reports might be screened out on a day where there are many reports (33). Workers were more likely to investigate when they did not feel over- burdened or constricted by resources (34-36). While some of this discretion has been limited by structured decision-making models introduced in the 1990s, it still stands to reason that prevention cannot compete with the immediate needs of children at risk as long as resources are finite.

This concept is perfectly illustrated by this description of the efforts of pediatrician and child-abuse prevention pioneer Dr Ray Helfer (1929-1992) as presented in the history of the development of State Children Trust Funds:

> "Dr Ray E Helfer began using his influence to create a protected source of funding for prevention by persuading the state legislature in Michigan to increase funding to add 50 full-time "prevention workers" to the protective services budget. After the "prevention worker" positions had been created and filled, all 50 had full-time protective service caseloads and none of them was doing any prevention work. The needs and demands of children in crisis had compelled the decision makers to divert the money to treatment. This event helped shape the law that created Michigan's Children's Trust Fund and served as a model for all states." (37)

When resources are limited, as they generally are in CPS agencies where few types of funds are uncapped, workers allocate the limited resources of time and money to the most serious cases. Primary prevention cannot compete for limited resources with investigations and intervention.

Incompatible intervention models

The typical CPS service delivery model generally has one worker screening a call, another completing an investigation, and yet another providing follow up. This model is not conducive to providing a family with the type of experience consistent with effective family support and prevention models. A meta-analysis of prevention program models designed to illustrate which had an impact on prevention (38) looked at "home visiting, parent education, child sex abuse prevention, abusive head trauma prevention, multi-component interventions, media-based interventions, and support and mutual aid groups. Four of the seven – home-visiting, parent education, abusive head trauma prevention and multi-component interventions – show promise in preventing actual child maltreatment. Three of them – home visiting, parent education and child sexual abuse prevention – appear effective in reducing risk factors for child maltreatment, although these conclusions are tentative due to the methodological shortcomings of the reviews and outcome evaluation studies they draw on" (38). Developing a trusting and supportive relationship between home visitor and parent is an element of the home visiting models endorsed by the federal Maternal, Infant and Early Childhood Home Visiting Program (39).

Client perception of CPS as a sanction, rather than a service

Since its inception, services from Child Protection Service agencies have come to be perceived by the public as a sanction rather than a service (40, 41). "The literature recognizes that there are some inherently adversarial aspects of child protection that can cause negative reactions among parents, who may be non-voluntary or mandated" (42) Periodically, calls emerge to separate the investigation of child maltreatment from on-going services, and to lodge the investigations with law enforcement (33). But, as long as child protection services (CPS) has the ability to take legal actions against a family, including removing a child, it will be very difficult for a client to establish the trusting relationship with the caseworker, a relationship central to most secondary prevention programs, like home visiting. The emergence of Differential Response is attributed in part to this dilemma. "CPS workers faced seemingly conflicting objectives — to investigate and sanction perpetrators of maltreatment while also providing supportive services to families" (5).

COMMUNITY COLLABORATION IS KEY

There is a clear and important relationship between CPS and community-based prevention programs. The early framers of CAPTA sought to develop community partnerships for prevention and separate it from investigation and intervention. It is not surprising then that Maguire-Jack and Byers (43) found that the availability of prevention "programs had a direct impact on screening and case opening/closing decisions but not substantiation decisions. Substantiation decisions, rather, were impacted indirectly, as CPS staff members were able to justify a substantiation or court referral decision if families did not comply with the prevention program" (43). This underscores a critical role for CPS officials in prevention: involvement at both the state and community levels to learn of existing resources and ensure they are known

by CPS staff, and collaboration to support the development of a local continuum of prevention services. CPS professionals can have a voice in helping to identify needs of at-risk families *and* be a conduit of information about prevention resources for case workers.

Community partnerships seem to be particularly helpful as secondary prevention for neglect. "A significant result was the development of partnerships between child welfare workers and community resources to meet identified service needs. An impact analysis showed that families most helped were those who lived in poverty who received basic services that they may not have received under a traditional approach." (44).

There is a strong overlap in the objectives of primary and secondary prevention of child maltreatment and the objectives of promoting maternal and child health. Federal efforts supporting the healthy and safe development of children and providing resources for parents are initiated by the Department of Health and Human Services. Federally initiated efforts which are managed through State Health Departments Maternal and Child Health division are particularly important. The Early Childhood Comprehensive System (45) and the Maternal, Infant and Early Childhood Home Visiting Programs (MIECH-V) (46) are important examples. Both initiatives provide funds for services through state health departments and require input from CPS officials in developing state plans.

CPS should be represented in the advisory board or equivalent for the states' Children's Trust and Prevention Funds. Children's Trust and Prevention Funds (formerly known as Children's Trust Funds), "…hold vital and unique roles in their states as funders, collaborators, catalysts, implementers, overseers and evaluators of the largest collective body of child abuse prevention work in the country" (47). They are often funded by a tax check-off on a state income tax return form with funds earmarked for child abuse prevention, and in some states are co-located with the state chapter of Prevent Child Abuse America.

CONCLUSION

The CPS system created by CAPTA was designed for investigation and intervention. Prevention was meant to be carried out initially with community partners. State CPS systems have been ordered or incentivized to implement secondary prevention initiatives like Family Preservation and Differential Response, with mixed results.

Title II of CAPTA created the Community Based Child Abuse Prevention initiative (CBCAP), through which funds are distributed on a formula basis to states that can be used on a wide variety of community based programs. The entire federal allocation in FY 2020 was $53.6 million, with some states receiving as little as $175,000 (9). There is a continued focus on developing public private partnerships for prevention, as clearly these designated funds from CAPTA are insufficient.

Many states have developed public systems for prevention in which CPS is an important partner. Coordination and collaboration with public partners, including Maternal and Child Health, Early Care and Education, mental health, public education, juvenile justice, family courts and other public systems, is key, in many cases with CPS as the convener.

CPS systems have also been vulnerable to reactionary legislation, which created secondary prevention initiatives including Safe Haven and Baby Doe laws, neither of which has shown clear impact in preventing child deaths. CPS was initially conceived as a public system

designed to serve a heretofore unserved population – children and families involved in maltreatment. Instead, some legislation has moved CPS into areas that might better be served by the income maintenance functions of public welfare programs, public health, or public safety systems. The latest federally mandated prevention initiative, the Family First Prevention Act of 2018, appears to be novel in that it specifically calls for the implementation of evidence-based interventions and its mission is congruent with the CPS mission – to support and strengthen families to avoid placing children in foster care. A thorough, empirical evaluation of this initiative will be critical, and can hold promise for the field of secondary prevention.

The critical role for CPS in primary prevention is advocacy, as a strong, credible voice to public and private planners and funders who share the concern about child safety, health, and wellbeing.

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Chapter 24

DOES MANDATORY REPORTING HAVE A PLACE IN A MORE PREVENTION-FOCUSED CHILD MALTREATMENT SYSTEM?

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ABSTRACT

Mandatory reporting is often portrayed as the initial misstep in what some critics believe is a child protection system that has been overtaken by police-like investigative and punitive intervention. We argue that if mandatory reporting were included in a more prevention-focused system, one that is instituted with fidelity and caution, it could enhance the ability of prevention strategies and programs to best serve children and families as well as play an important part in the development of new, more effective prevention strategies. This chapter begins by presenting a clear understanding of the specific function that mandatory reporting plays in the child protection-focused system currently employed in the United States and assesses whether reporting achieves this functionality. It then examines the specific role mandatory reporting could fill in a different system as well as potential barriers to an effective reporting system.

INTRODUCTION

To some people, mandatory reporting and child abuse prevention may seem like strange bedfellows. This is unsurprising, as mandatory reporting is often portrayed as the initial misstep in what some critics believe is a child protection system that has been overtaken by police-like investigative and punitive intervention. However, if mandatory reporting were included in a

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more prevention-focused system, one that is instituted with fidelity and caution, it could enhance the ability of prevention strategies and programs to best serve children and families. Further, it could play an important part in the development of new, more effective prevention strategies as our knowledge of prevention science continues to grow and evolve.

To explore this potential partnership, this chapter will begin by presenting a clear understanding of the specific function that mandatory reporting plays in the child protection-focused system currently employed in the United States and exploring whether reporting achieves this functionality. Then, the specific role that mandatory reporting could fill in a different system—one focused more on child maltreatment prevention—is considered. Next, a potential model of this new system is described, and a more robust system of mandatory reporting integration is explored. Finally, potential barriers to an effective reporting system are considered.

The necessity, goals, and functionality of mandated reporting systems in child protection

The necessity and effectiveness of mandatory reporting systems continues to be a hotly debated topic in the child maltreatment field. As it stands, mandatory reporting is a component of the overall child protection system (CPS) in the US, as well as in other countries like Australia, Northern Ireland, and Wales. One of the strongest arguments supporting the need for a system of mandatory reporting is that without such a system, societies would be far less able to effectively protect at-risk children (1). If this is the case, it seems to follow logically that the primary goal of mandatory reporting laws is to better protect children (2). This is certainly true, but only in part. As a unique component of the larger CPS system, mandatory reporting has another more specific goal that is related to its specific functionality—case identification.

Mandatory reporting and case identification

If mandatory reporting systems did not exist, critics of mandatory reporting hypothesize that there may be enough voluntary-reporting or self-reporting to accomplish the same task, and perhaps more accurately, than under current laws that require individuals to report "reasonable suspicion." On the other hand, research seems to indicate that reporting laws are likely to result in more effective case identification, fewer instances of failure to report (3), and increased likelihood that cases of serious maltreatment, which would not otherwise come to light, are identified (4). As Besharov declared, "there is no dispute that the great bulk of reports now received ... would not have been made but for the passage of mandatory reporting laws" (5).

One study of a newly enacted mandatory reporting law in Western Australia provides a particularly useful insight into the efficacy of reporting laws at identifying cases. This event gave researchers a rare opportunity to directly observe outcomes post-introduction of reporting duties and compare those outcomes with data from a pre-introduction period. The results of this research support the idea that mandatory reporting laws, at least for child sexual abuse, are associated with a substantial and sustained increase in case identification (6).

The hidden nature of child maltreatment

The necessity of mandatory reporting laws as a means of case identification is justified by some researchers and advocates because of the hidden nature of child maltreatment. They assert that children typically are dependent on the very adults who are most likely to maltreat them, and thus, children's safety can only be guaranteed if a mechanism is available for *other* adults to help uncover maltreatment (2).

Opponents of this theory interject that the necessity of mandatory reporting laws is based on an assumption that without mandatory reporting laws, it is possible there would be sufficient levels of voluntary reporting or self-reporting to achieve similar levels of child safety. Hutchinson critiques this assumption, claiming it is "supported by very little empirical evidence about the inability of children to self-identify and the unwillingness of families with abuse or neglect problems to come forth voluntarily" (7). He notes that a report from Boston (8) found that, "adolescents frequently reported their parents to agencies and that children often enlisted the help of relatives or friends in contacting the agencies" (7). Furthermore, he notes that while data may show only 2-5% of reports come from a combination of children and perpetrators and another 15-30% come from friends, relatives, neighbors, there is no data to show the extent to which children have enlisted the help of these reporters (7). Finally, he points out that the current rate of reporting by families has declined since the enactment of mandatory reporting laws. It is unclear if that decline is due to an actual reduction in the number of family members reporting, or due to an increase in the rate of reporting by other groups, like professionals who are mandated to report (7).

In contrast to Hutchinson's views, most of the literature on the necessity of mandatory reporting supports the idea that the hidden nature of child maltreatment is not an assumption. It suggests that without a system where people outside of an abused or neglected child's family are tasked with bringing the children's circumstances to the attention of authorities, many—perhaps most—of these cases would remain hidden (1). Several studies exploring the potential of children to adequately self-report their maltreatment conclude that data does not exist to suggest that children can adequately self-report (1, 9). Trocmé and colleagues reported that children are rarely the direct source of their own referrals, and account for only 0.5% of substantiated reports in the USA and 2% of substantiated reports in Canada (9). Likewise, reliance on parents to self-report seems unrealistic. In 2004, only 0.1% of substantiated cases in the United States resulted from self-reports; only 4% were made by a non-perpetrating parent (9). If substance abuse is at issue for a family, this reliance on self-reporting seems even less realistic (10). Not only does reliance on voluntary reporting appear to have the potential to decrease child safety, it also might increase overall spending on child maltreatment. The economic cost of maltreatment is well-documented, and to help reduce those costs, the US Department of Health and Human Services recommends ongoing efforts to improve both prevention efforts *and* efforts at identifying potential cases of maltreatment (1).

Overall, the notion that voluntary *anything* related to child maltreatment has the means to be as effective as mandatory actions is not supported by research. Looking at program evaluation of voluntary services in differential response programs, for example, research continues to indicate that parents do not take advantage of offered services on a voluntary basis. As one differential response program evaluation points out, "It's one thing to identify potential service needs of families; it's an entirely other thing to convince them to take advantage of voluntary services, even if they match the family's stated needs" (11). It appears that most

families will refuse voluntary services across the board because they do not want children's protective services in their homes (11).

Thus, taken as a whole, the current body of research related to self-reporting or voluntarily seeking services suggests that parents—who inflict most abuse and neglect—are unlikely to self-report or seek assistance. Similarly, data does not exist to support the conclusion that children are capable of bearing the burden of being their own protectors by reporting their own maltreatment. Without proof that voluntary or self-reporting approaches would suffice as a replacement for mandatory reporting to identify potential cases, maintaining some type of mandatory reporting system seems both an ethical imperative and a practical necessity.

ASSESSING THE EFFECTIVENESS OF MANDATED REPORTING

Although it is ethically imperative to have a method for identifying potential cases of child maltreatment, it does not necessarily follow that mandatory reporting is effective. To justify maintaining mandatory reporting, its effectiveness should be demonstrated.

It is common to see criticisms of mandatory reporting that claim it is a failed system because there is no indication that it causes children to be safer. A variety of measures are used to justify these claims, including number of children in out-of-home care, number of reports compared to number of unsubstantiated cases, or number of child fatalities. However, none of these measures of child safety really address the case identification function assigned to mandatory reporting. The nature and efficacy of mandated reporting systems and the nature and efficacy of the systems that exist to respond to reports and address child maltreatment are both critical—albeit separate—challenges (1). This is not to say that the failures of the overall system and the failures of mandatory reporting are completely unrelated. To some degree, the effectiveness of mandatory reporting laws does rely upon the successes of the entire system - upon "robust interagency collaboration, system integration, role clarity, clear policy and procedure, regular cross-agency training and mindful management" (12). Since case identification is the goal of mandatory reporting, its effectiveness at accomplishing that goal must be the focus when assessing its effectiveness.

Avoiding logical fallacies

At this point in the discussion, it is worthwhile to address how this tendency to evaluate mandatory reporting only by the effectiveness of the larger CPS system is an example of a pervasive and frustrating logical fallacy called the *fallacy of division.* This logical fallacy, along with the *false dilemma (or false dichotomy) fallacy*, has the tendency to hinder productive discussion about reforming and evaluating many aspects of strategy and programming across the field, mandated reporting systems included (13).

Fallacy of division

An example of this logical fallacy can be seen in interpretation of data that, as described previously, have the tendency to assign responsibility for the failures (or successes) of the larger child protection system on a single component of that system — in this case, mandatory reporting. One way this fallacy manifests is when low substantiation rates of reported cases is used to discredit mandatory reporting generally, or used to discredit the ability or utility of identifying certain professionals as mandatory reporters (4, 12). However, issues related to substantiation are not actually arguments against mandated reporting *per se*. The successful identification of abused or at-risk children does not necessarily correlate with increased or decreased mandatory reporting requirements (14). Instead, they are more correctly arguments that highlight problems in the way reports are responded to or about how a case is handled *after* a report is made. Barriers to effective responses to reports, such as insufficient resourcing, or less than optimal screening procedures, do not have much to do with whether or not mandated reporting is effective at identifying cases (1). Thus, these barriers are not flaws in mandated reporting, but challenges in administration of the larger child protection system (3, 15, 16, 1).

False dilemma fallacy

This is another logical fallacy in the discourse about mandatory reporting (4). Binary in nature, false dilemma fallacies are usually configured as "either/or" statements. Here, the term "either" is used to imply exclusivity rather than neutrality, meaning "on one hand, but not neither, nor both." This type of logical fallacy infects many of the most problematic thought-dilemmas in child maltreatment besides mandatory reporting, including discussions about child's rights vs. parents' rights; intervention vs. prevention; traditional response vs. alternative response; voluntary vs. coercive; adversarial vs. engaging; and, child safety vs. family integrity, just to name a few. For mandatory reporting, *false dilemma fallacies* sometimes present as scenarios where reporting systems are situated as being "up against" other potential solutions for addressing child maltreatment. An example is the claim that if legislative action and focus is directed toward individual failures (as is mandatory reporting) instead of systemic failures, this action and focus is misguided because it does not work toward relieving social disadvantage, which is a major factor in many cases of abuse and neglect (17). Considering this claim, it is obviously not true that focus is exclusive; rather, it is reasonable to focus on both individual and systemic failures. Similarly, voluntary and mandated reporting are presented as a dichotomous choice, but in fact, there is no reason that efforts to increase voluntary assistance-seeking and community care cannot coexist with mandated reporting (1). A final example—and one of the most common false dilemmas writ large—is the tendency to cast mandatory reporting systems in binary terms—as either wholly good or wholly bad (4).

These are just a few examples of the logical fallacies present in theoretical discussions and in data interpretations related to mandatory reporting. Spending time debunking logical fallacies is a waste of precious resources, and it is exhausting. It is arguing rather than argumentation, and it diverts attention from the overall goal of developing effective and workable solutions to better serve children and families. Therefore, in the remainder of this chapter, discussion of these fallacies is avoided so as to enable a more productive analysis of the issues at hand.

HOW MANDATORY REPORTING CAN FACILITATE EFFECTIVE CHILD MALTREATMENT PREVENTION

Mandatory reporting may be a necessary and effective component of a reactive, child-protection focused system. But does it have a role to play in the continuum of a redesigned system that is more proactively focused on preventing child maltreatment? We think unequivocally, the answer is yes.

There is a strong theoretical argument for including mandatory reporting within a more prevention-focused system. Functioning as a means of case identification, mandatory reporting helps to ensure that more potential cases of child maltreatment are noticed, thus fulfilling an important secondary and tertiary preventative role by helping sentinel reporters outside the child's family bring cases to the attention of the authorities when maltreatment has occurred or in some instances, before it occurs (4). Although questions remain about the efficacy of voluntary and self-reporting as important tools for case identification, without more evidence to justify relying solely on these methods, the ethical implications of abandoning a reporting system that brings to light hundreds of thousands of cases each year seems dubious, especially considering that alternatives could be more harmful to at-risk children. Plus, an increased focus on prevention does not require decreased focus on protection. In a more prevention-focused system, there will still be the need to identify cases of possible maltreatment—some known to the prevention system, others not. The number, type and the process of identification may be different, but the utility of reporting will still exist.

As part of a more prevention-focused system that is better equipped to offer differentiated services and support to children, families, and communities, mandatory reporting would be even more efficient and valuable because it is more likely that appropriate services would exist to handle reports of all types of maltreatment, including those types stemming from problems that are more ecological in nature. Consider, for example, a commonly debated issue for mandatory reporting: whether to include mild-to-moderate neglect as a reportable type of maltreatment. The potential for children who are neglected to suffer severe health and mental health problems is well-documented. More children die from neglect than abuse; data from 2018 shows that 72.8 percent of child fatalities for that year suffered neglect, and 46.1 percent suffered physical abuse. Some of the 46% suffered both forms of maltreatment; for example, children who died from physical abuse experienced either physical abuse exclusively or in combination with another maltreatment type (18). Failure to include neglect as a reportable type of maltreatment, regardless of whether that neglect stems from poverty or from intentional acts or omissions, ignores children's right to safety as well as the *parens patriae* responsibility of the state as the ultimate guardian of the child. Children who experience dependency-neglect may suffer the same deprivation as a child neglected in a family of greater means (19). Should the child in the poor family not have the same opportunity for his or her case to be brought to the attention of authorities and helping agencies (19)? Given the harms caused by neglect, is it justifiable to ignore it by excluding it from reportable maltreatment?

Some neglect is rooted in problems at the level of structural economics rather than dysfunction within the specific family or parenting. These types of problems are not really what CPS was designed to address. Arguments for omitting mild-to-moderate neglect from reporting statutes articulate concern that reporting less severe neglect could also be unethical because, very often, families will be forced into an adversarial system simply because they are

impoverished. Furthermore, whilst there is evidence that statutory approaches may be successful in addressing the most egregious forms of harm (20, 21), there is little evidence that these have been successful in reducing the prevalence or impact of neglect (22). Additionally, less severe neglect, at its core, has a more ecological or social context, and when employing mandatory reporting, child protection agencies are prone to ignore or minimize the social structural dimensions, potentially undermining public health approaches that promote early intervention and prevention (12). In a system that is more prevention focused, dilemmas related to structural inequality are less problematic because access to appropriate services would increase.

A final rationale that supports including mandatory reporting in a more prevention-focused system is the potential utility of mandatory reporting laws for communicating important social values upon which the entire system is dependent. Because the state is the ultimate guardian of the child, it follows that a state has a moral obligation to take care of children. A jurisdiction's mandatory reporting laws provide an opportunity to widely communicate expectations related to accountability, both in terms of how society holds individuals and communities accountable, and also in terms of how individuals and communities hold the local, state, and federal governments accountable. The purpose of mandatory reporting laws should be framed in the "preamble" or related section of the reporting statute. Framed in this way, mandatory reporting is a method of holding everyone accountable for the well-being of the most vulnerable members of society. They communicate that parents must be held accountable for ensuring a certain level of well-being for their children, that communities should provide a certain level of wellbeing for families, and that the government should provide a certain level of wellbeing for all citizens. When any one of these duties are not being met, it is mandatory reporters who notice, care, and put the system in motion to address the imbalance. By vesting duties and giving instructions to reporters, mandatory reporting laws mark out the edges of this accountability.

THROUGH A PUBLIC HEALTH LENS: ENVISIONING A NEW, BETTER, PREVENTION-FOCUSED SYSTEM

In the United States, the current system set-up to handle child maltreatment was not the result of comprehensive strategic design or planning, especially when it comes to achieving prevention-related outcomes. Instead, the current system developed reactively. As child maltreatment entered the collective conscience as a critical social problem in the wake of Henry C Kempe's publication of the battered child syndrome in 1962, and as science and research increased knowledge across the field, laws such as the Child Abuse Prevention and Treatment Act were passed. As a result, the "child protection system" is focused on investigating reports of child maltreatment and providing services to children and families. "Child welfare," on the other hand, encompasses more of a social welfare perspective, focusing on broader social policies such as economic supports for all families. These systems are more similar to the agencies that would have been charged with handling cases related to the now defunct Aid to Families with Dependent Children. Over time, the laws, policies and programs were amended, revised, and supplemented in the best way that people knew how. Thus a patchwork emerged that resulted in a muddied conceptual relationship between child protection and broader notions

of child welfare. Today, the institutions of child protection and child welfare are often cast as adversaries with contradictory missions, made to compete for the same funding and resources.

It does not have to be this way. This patchwork system can be re-sewn, and this time, with a purpose and a plan. Re-conceptualized as a *continuum of care focused on child well-being*, "child protection" and "child welfare" can be redefined and refocused as mission-separate components, yet united under a system-wide vision of achieving optimum health and well-being for all children and families. Described below is an imagined redesign of our current system based on a popular model for prevention science—the public health approach.

The healthcare analogy

In the world of healthcare, the emergency room, urgent care facilities, and primary care practices are integral yet programmatically separate segments that unite to create a continuum of medical care for the general public. These components share a single underlying mission: to ensure the health and well-being of the populations they serve, thereby achieving optimum health and well-being of the population, generally.

An emergency room (ER) is where individuals go to receive critical, lifesaving treatment when they are in the midst of a health crisis. ERs treat injuries received as a result of traumatic events, like car crashes, strokes, and heart attacks, among others, when severe injury or death is a possibility. ERs are not intended to provide primary preventative care. After treatment at the ER, information is provided to primary care doctors in order for patients to continue receiving needs-based care to optimize health. Next, urgent care facilities (UCFs) are a step below the emergency room in terms of targeted services for critical issues. UCFs still provide targeted services and, as their name implies, patients seek treatment for urgent health issues, but issues that UCFs treat are not as severe or critically life threatening as the issues handled by ERs, say, broken bones, sprains and cuts requiring stiches. Often, when individuals visit UCFs, if the patient needs a different level of care than what the facility can provide, the doctor at the UCF will redirect the patient to the ER, or maybe provide limited treatment and advise a patient to seek further care from their primary care practitioner. Finally, primary care practices exist to help patients prevent, diagnose, and treat illnesses and also to provide well-visits to maximize and sustain long-term health and well-being. These are the facilities and doctors who are equipped to provide general healthcare and health assessment.

Some of the potential interactions between the components of the healthcare continuum that were mentioned above illustrate how, despite their distinct functionalities, there exists a high level of cohesion and cooperation between them, both in terms of how they must work together to help patients achieve better health overall, and also in how their individual performances affect each other's activities. If, for example, primary practitioners are less effective, perhaps ER visits will increase because of reduced patient health. Similarly, if emergency rooms do not provide adequate care for patients in crisis, primary practitioners must work must harder to help patients achieve and sustain their long-term health. Additionally, UCFs must be quick and efficient at engaging emergency services when an individual seeks treatment that the UCF is not prepared to provide, or risk increasing the likelihood of adverse health outcomes and more work for both ERs and primary practitioners.

Applying the healthcare analogy to child maltreatment systems

Very similar to the relationship between the emergency room, urgent care, and primary practice in the public health sphere, child welfare services (CWS), differential or alternative response (DR), and child protective services (CPS) could be re-conceptualized as distinct, cooperative components along a child protection continuum. Together, the components provide a unified vision to enhance well-being for all children and families by ensuring the safety of the population they serve, but each component would also have its own distinct function. Like the components of the public health continuum, each component on the child safety continuum would be equipped to play a different role to better achieve the overall shared mission. (See Figure 1. for a visual comparison of the following description).

In this conceptualization, the child protection services (CPS) component would function similarly to ERs. CPS would be responsible for ensuring the safety of the children who have experienced or are most at risk for maltreatment. Regarding the levels of prevention, services provided by the CPS component would sometimes, but less commonly, be secondary, and mostly tertiary in nature. As CPS was originally intended to deal with only more serious cases of child maltreatment, this may be the easiest component of the continuum for readers to visualize. And, just as hospital emergency rooms have become overrun with inappropriate cases due largely to a lack of sufficient funding (i.e., health insurance) and inadequate focus on preventative medicine, child protective services has become overwhelmed with inappropriate cases due to poor strategic development, support, and focus on the child welfare portion of child protection continuum.

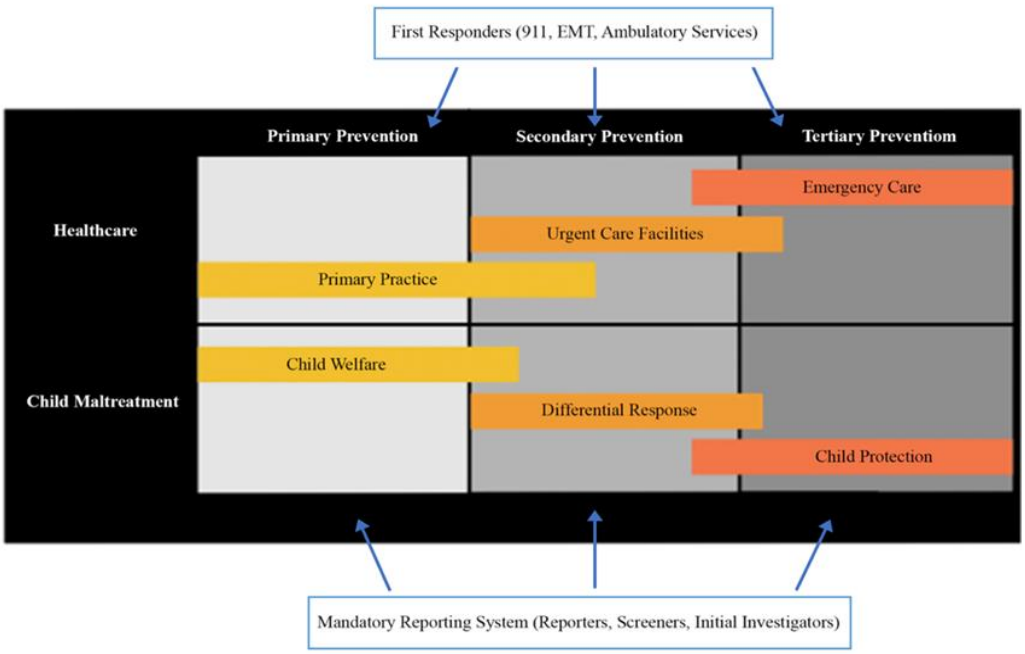

Figure 1. Compatison of Healthcare and Child Maltreatment Continuums.

The component filled by primary practitioners in the health care continuum would be filled by child welfare services (CWS) in the child protection continuum. CWS would be tasked with implementing universal prevention programming and other primary prevention services like well-child checkups, vaccination campaigns, prenatal and postnatal parent education, and universal basic resources, among others. Finally, the component filled by UCFs in the public health continuum would be filled by a component of the child protection continuum tasked with handling services and programs related mostly to secondary levels of prevention, but also some tertiary levels of prevention—i.e., families with elevated levels of risk. Thus, this component would need the capability to address specific, targeted issues, but ones that are perhaps not quite so dire as to require involvement by CPS. In short, this component would probably be very similar to current-day differential response or alternative response (DR) programming—but with some *very* important differences.

At its core, the theoretical foundation of DR reform strategy was strong and sound, for the most part. As originally expressed, the purpose of such strategies included the following: "(1) to strengthen, support, and empower families without compromising child safety, (2) to consider the efficacy of serving families with different needs in different service responses, (3) to use less intrusive interventions for low-risk families, and (4) to create the infrastructure to institutionalize and sustain family-centered practices in child welfare" (23). However, as implemented to date, DR has led to growing concern about the potentially detrimental consequences to children's safety, particularly in jurisdictions that had abandoned investigations, risk and safety assessments, the option to adopt more authoritative compliance when necessary, and ongoing safety planning with families in alternative tracks (23). These abandonments were rationalized as being more "family friendly" (23).

As questions mounted about the safety of DR programming, program evaluations came to the conclusion that DR's effectiveness depended on the reliability and validity of safety and risk assessments (24). Furthermore, it started to become clear that an accurate determination of safety and risk may be impeded by practices central to the theoretical underpinnings of DR programs. These practices included an aversion to formal investigations or risk and safety assessments, conducting joint rather than individual interviews of family members, and interviewing collateral contacts and alleged child victims in the presence of family members rather than individually, to name a few (25). Additionally, one of the primary theoretical assumptions underlying DR strategy as it currently exists is that reports can be accurately sorted by risk level and assigned to the appropriate track without any elements of investigation or assessment. Perhaps this assumption is part of what lead to such wild levels of variability in the percentage of reports assigned to DR tracks.

As a result of some of these theories and practices, DR programs have experienced considerable trouble accurately identifying protective and risk factors in families that are reported, and accurately determining which families should get what services or resources. Evaluation research on DR consistently recommends the universal use of safety and risk assessments. Not only does the ability of DR as a program to best serve families depend on the reliability and validity of safety and risk assessments, but it depends on these assessments to be compressive in nature, and include information from all relevant collateral sources (e.g., out-of-state CPS records, the family's history of maltreatment reports, and ongoing safety and risk assessments conducted as part of case management) (24). For example, in Minnesota, the Governor's Task Force on the Protection of Children recommended that law and policy be changed to allow consideration of information about a family's prior CPS history, including

prior referrals that had been screened out; a complete review of CPS, court and Department of Corrections (DOC) records; information from collateral contacts; and in-person interviews with the child and family before making track assignments (26). Returning to the health care analogy, this trouble that DR has experienced matching families with services makes a lot of sense. Imagine going to the doctor and the doctor failing to take a detailed health history, failing to order imaging, blood tests or the like, and failing to collect more than just very basic information about vital signs before diagnosing a serious medical condition. It is unlikely that, under those circumstances, a patient could expect to receive adequate care for any of their present health concerns. Indeed, we would not hesitate to call such lapses in the medical care context malpractice.

Furthermore, even though the original concept was that families served by DR programs should be low-risk families, this did not turn out to be the case. One study from Washington, D.C., demonstrates the myth of this concept, concluding that the hypothesis "that CPS-FA [AR] is composed only of low-risk families is not supported" (11). Those researchers found that 21.6% of AR cases had had three or more prior reports, which the study claimed was "a clear indication of high or even intensive family risk" (11). Similarly, in Louisiana, an audit of the state's DR system concluded that "DCFS intake staff improperly referred 2,602 (2.8%) of 95,178 victims and perpetrators to AR, which is intended for low-risk individuals, instead of to CPI [child protection investigation]. As a result, these individuals may not have received services consistent with their risk level and needs" (27). The audit also found that DCFS caseworkers had not referred, either properly or in a timely manner, 3,611 (56%) of 6,473 individuals in AR to CPI, and 560 (31%) of 1,784 individuals in AR to Family Services, when it was determined that these cases were higher risk than originally assessed or needed ongoing monitoring (27). As a result, these cases may not have been investigated as required or may not have received appropriate services (27). What data also implies here is that these failed practices impeded communication between DR programs and other services for children and families. In a reformulated child protection continuum, this could be fatal to the effectiveness of the continuum overall.

Thus, to be justified in using DR as a model for this "UCF-level" functionality on the child protection continuum, there would need to be significant revision made to fundamental aspects of DR's strategy as it currently exists in many jurisdictions. The most pressing change would be to ensure that cases served by the DR component are appropriately assigned to that component. There are some successful examples of differential response programs that could serve as potential models for a revised DR component, including in the state of Michigan. In Michigan, the Child Protection Law (Mich Comp Laws 722.628d) mandates that caseworkers conduct a field investigation as well as administer safety and risk assessments for every screened-in case. They then assign cases to one of five categories that range from no evidence of abuse and neglect to a category in which the child is either deemed unsafe in the home or by law the agency must file a petition in the family court. The three categories between these ends of the spectrum provide for more or less intensive in-home services based upon the presences of maltreatment and the risk of future harm. In essence, track assignment is postponed until after the information is gathered from all of these initial assessments.

A more robust mandatory reporting system might address some of the most critical errors in current DR programming, thereby serving as the lynchpin for the effective functionality of the entire child protection continuum.

The mandatory reporting system as "first responders"

Returning again to the health care analogy, the question becomes where and how mandatory reporting can be integrated in the new child protection continuum. The previous articulation of the biggest concern with integrating DR into the continuum—the concern regarding DR's failure to ensure that reports are filtered into the right track based on a deep understanding of the needs of the child or family that is the subject of the report—actually helps to clarify not only where and how mandatory reporting could be integrated into this continuum, but also why it's absolutely critical that mandatory reporting is a part of it.

In this child protection continuum, a more robust mandatory reporting system would include screeners, initial assessors and investigators. Mandated reporters would report potential cases, and screeners would act as the initial "gatekeepers," collecting information from reports and making the initial determination of whether or not the reported case should be screened-in. Then, initial assessors or investigators would take information from the report and the screener, and perform the necessary safety and risk assessments, as well as an initial investigation, in order to collect whatever other information is necessary to direct the case to the component best suited to meet the needs of the child or family that is the subject of the case. Functionally, combining screeners, initial assessors and investigators under a larger mandatory reporting system makes sense because each is focused on correctly identifying cases. Really, what each adds to case identification is the terminus of their services to the children and families being served. Thinking of mandatory reporting systems more like this more-robust system, it is as if this robust reporting system is what many of the original DR programs were missing. Removing the screening and track assignment responsibility from DR would alleviate the concerns related to the overall capacity of DR to keep children safe, thus removing the major potential barrier to including DR as a model for the UCF component of the child protection continuum. However, this does not mean that the system must be adversarial or that it cannot be family friendly. If it is universally implemented, then the activities of the mandatory reporting component could be framed as a way to ensure that families get the services or resources that they need in order to achieve better overall health and safety outcomes.

Keeping with the medical analogy, this robust mandatory reporting system is similar to the general system of "first responders" in the public health world. If a person believes they are having a heart attack, they are sometimes incapable of transporting themselves to the ER, so they call 911. The 911 operator makes the determination of whether or not ambulance and emergency medical technician (EMT) services are needed, and they dispatch those services. Once the ambulance and EMTs arrive at the patient's location, they take information about the potential medical crisis the patient is experiencing, as well as taking an introductory patient history and taking the necessary vital statistics. Then, the EMTs help to determine if it is best to transport the patient to the ER. Sometimes, though, the EMTs might discover that this patient is not having a heart attack, and instead, may be suffering from bloating or gas. In the latter case, the EMTs might advise the patient to wait and visit an UCF or primary practitioner. Reporting systems, likewise, take the call, screen it for immediacy, and dispatch the investigator. After collecting family history and information about the acute episode that prompted the report, the investigator can help determine which component of the child protection continuum is most appropriate for the specific needs of the subjects of the report at hand. This more comprehensive system of prevention would almost certainly result in fewer reports or cases in for CPS, much in the same way that good preventive healthcare can diminish

the need to access the emergency room by matching needs with services and by catching problems early.

ADDRESSING BARRIERS TO ENSURE AN EFFECTIVELY INTEGRATED REPORTING SYSTEM

After this discussion, perhaps mandatory reporting and prevention do not seem like such unlikely bedfellows after all. Maybe it even appears that integrating mandatory reporting into a more prevention-focused system is both rational *and* essential. To be thorough, however, it is still important to consider a few potential barriers that research has suggested may prevent reporting systems from being effective and to consider how these barriers may negatively impact this new child protection continuum. The barriers considered below are drawn from articles by academics, researchers, and professionals, and are comprised of criticisms of mandatory reporting as it relates to the current child protection-focused system in the United States. The legitimacy of these potential barriers is examined, including whether or not they are likely to have an impact on the hypothetical child protection continuum described above. Undoubtably, more specific barriers would arise upon integration of a mandatory reporting system with any new child maltreatment system, but to avoid attempting to fix what is not yet broken, purely theoretical barriers are not discussed.

Systemic Overload

One potential barrier for mandatory reporting systems is related to issues of "over-reporting" cases, thereby creating a systemic overload that wastes or diverts precious resources away from children and families who need them the most (3, 7, 17, 28-30).

But what is meant by the term "over-report"? One possibility is that "over-report" means reports that cause an increase in workload that is unmanageable for children's services caseworkers. In other words, all reports, regardless of the individual case outcome, are collectively too many in number for the CPS to handle. Unfortunately, it is difficult to assess the validity of this concern with any degree of certainty because there is not enough dispositive data to allow for a definitive answer. However, considering the data that does exist, it seems unlikely that mandatory reporting is the "but-for" cause of "over-reports" of this nature. In fact, researchers and academics conclude that an increase in the overall number of reports is unlikely to overburden the system, regardless. A large proportion of reports (around 40%) are screened out prior to any assessment or investigation services, thus resulting in minimal burden (4). The reports that are screened in and lead to assessments and investigations do lead to a certain amount of burden imposed on the system, but research seems to indicate that even these activities result in a very small proportion of the overall systemic burden (33). Likewise, economically, data indicates that the cost of investigations to children's services agencies imposes a relatively small burden, accounting for less than 19% of the total child protection budget, and even possibly below 5%. For the sake of comparison, in the United States in 2006, the majority of the costs for child protection were for foster care and residential services, totaling about 50% of the entire child protection budget (33). Finally, it is also possible that a

large proportion of the number of reports made are actually multiple reports about the same children, reducing the potential for over-burdening even more (4). For instance, using data for unique reports of children, in 2018, 3.5 million children received either an investigation or alternative response, but when using data that includes duplicative counts, that number rises to approximately 4.3 million children who were the subjects of screened-in referrals or reports (18).

Another possibility could be that "over-report" means reporting too many cases that are investigated but not substantiated. In other words, an "over-report" would be a report where CPS invests time and resources, only to end up being unable to substantiate the case. As a result, again, children's services agency workloads increase, resources are wasted, and there is an overall reduction in the quality of services that an agency can provide to children and families who really do need them (1, 29). However, as discussed earlier, a lower number of substantiated reports cannot rationally be used to discredit the mandatory reporting system or to indicate that reporting does not work, but it can be used to explore the implications of reporting as it relates to a larger system. This holds true even if one assumes that investigation without substantiation is a bad thing. As was also discussed earlier, maybe this assumption no longer holds in a system with components that can actually provide useful services to families, regardless of case disposition. Additionally, data suggests that, in systems with mandatory reporting, the majority of social workers' time - as well as government money - is spent on services and activities besides investigating unnecessary reports (3, 31).

One final possibility is that "over-report" could mean an unnecessary increase in reports due to the actual structure and language of the reporting laws themselves. Some professionals and academics claim that the statutes themselves encourage professionals to report inappropriately or incorrectly, thereby ever-diluting the ability of the CPS to respond aggressively to genuine emergencies (28). In a sense, these professionals point out that mandatory reporting laws are designed not only to increase case identification, but also to ensure the smooth operation of the reporting system. For instance, reporting laws help to define abuse and neglect, mandate and regulate training, mandate and regulate reporting processes, provide immunity for people who make reports, and ensure reporter safety through safeguards to reporter confidentiality. They even go so far as to begin describing how professionals should "layer" the various "hats" they wear when filling the role of both licensed professional and mandated reporter by clarifying the ways in which the various professional codes of ethics should interact with the duty to report. Additionally, reporting laws attempt to "incentivize" desirable behavior by providing penalties for failing to report and for making intentionally false reports. Although these functions are not central to reporting systems, they provide mechanisms for the smooth operation of the reporting system. Thus, especially in jurisdictions with adequate immunity clauses, broadly defined key terms like "child abuse," and penalties for failing to report, if a professional were to ask a lawyer whether or not they should report, the lawyer will most certainly say that they should. He or she would most likely explain how, considering the above-stated provisions of reporting law, the safest thing to do is to make a report, describing how the public interest or purpose of reporting law is very clearly to cast a wide net in order to identify the most cases possible.

Overall, however, research seems to indicate that regardless of which meaning is assigned to the term "over-report," the potential for over-burdening a more prevention-focused system is unlikely. Quite to the contrary. It seems that over-reporting may uncover problems that would improve with the provision of appropriate services (3). This potential is heightened when

thinking about "over-report" in terms of the reporting of cases that are not substantiated. In a more prevention-focused system, investigations of screened-in reports that are unsubstantiated is a means of identifying cases that would be better served by a more prevention-focused component on the child protection continuum. In such a system, where there is opportunity to employ more family- or community-focused services, this perceived barrier may actually turn out to be something positive if it means that more families get more help earlier and are healthier because of it.

Issues related to multi-professional and system collaboration

Another potential barrier for mandatory reporting laws relates to multi-professional collaboration. To a large degree, the success of mandatory reporting systems, both in their ability to increase case identification and to increase the effectiveness of the entire system, relies on their ability to facilitate increased interagency collaboration. For reporting laws to be as effective as possible, there must be careful system integration, clarity of roles, clearly articulated and implemented policies and procedures, regular cross-agency training, and mindful management and administration. This may be particularly important in a more prevention-focused system to ensure the whole system shares responsibility for the welfare of children and in providing assistance to struggling families (12).

In addition to interagency collaboration, there likely will be situations that require collaboration among professionals across disciplines. To ensure effective reporting in these situations, each professional must be able to see beyond their own set of ethics and practices and understand the perspective and principles of other professions (12). Data from a study comparing the opinions of different professional groups of mandatory reporters indicated widespread disagreement between the groups about the nature of appropriate reports, the requirements of the law, and the process designed to protect children and help families (32). The literature on mandatory reporting also cites many possible and actual instances that pit the code of ethics and duties of one professional group against those of another professional group. One such situation is exemplified by the tension between psychologists or psychiatrists and attorneys related to reporting crimes that may be divulged during psychological or psychiatric evaluations (33). In psychology and psychiatry, there are well-known exceptions to confidentiality for mandatory reporting duties, including various "Tarasoff" duties and "warn or protect" laws. The corresponding duty for attorneys to report child maltreatment, or to warn or protect intended victims of threatened harm, is much narrower than that of a psychologist or a psychiatrist (34). This difference in reporting responsibilities, professional regulations and ethics can create significant difficulties when attorneys need to retain forensic psychologists and psychiatrists to evaluate clients, especially in a criminal context (34). If the retained psychologist or psychiatrist is required to report suspected abuse or threatened harm, the attorney may be harming his or her client's legal interests by using the forensic psychologist or psychiatrist to evaluate his or her client (34). This dilemma has serious implications for all parties involved. Without an answer, it puts the safety and security of all parties in limbo.

Finally, the perceptions that different professional groups have of other professional groups could cause barriers to effective reporting (35). For instance, research and commentary suggests that many mental health professionals (MHPs) are reluctant to see the intervention of social service agencies as uniformly beneficial to every abusive family. Research also suggests a

reciprocal reluctance by social service agencies to trust MHPs to be directly involved in the reporting decision and/or post-report treatment planning (36).

Data collection and definition issues

Across jurisdictions, there is wide variation in the type of data and the terms that define the data that is collected about mandatory reporting. For studies that seek to look at trends in mandatory reporting across the United States, the aggregated data used for these analyses are independently provided by each state agency (37). Reporting jurisdictions have different definitions of, and standards for, confirming abuse (14, 37). Entire sets of data might be missing for certain jurisdictions if a jurisdiction opts not to collect data on certain variables. Additionally, reporting practices can differ both between states and territories and within states and territories (37). Variations across jurisdictions related to, for example, which professionals are required to report, may affect reporting and report outcomes (37). These differences compound to create even more differences. The reporting practice of one group of reporters about one kind of maltreatment in a specific location is likely to be different as each of the variables are changed. Using evidence from aggregate studies that include this transmuted data, especially if it is uncategorized, can substantially skew total statistics on reporting (38). To foster the best possible evaluation methods, it is important that data be as standardized as possible. As stated above, it is not just important to ensure general similarity in the type of data collected across jurisdictions, it is also important to ensure that there is similarity of definitions related to specific variables. One way to do this might be for jurisdictions to adopt standardized definitions of key terms like "child abuse" and "child neglect." Additionally, jurisdictions may want to ensure a certain baseline level of standardization in reporting statutes generally across jurisdictions.

REVISITING AND REVISING REPORTING LAWS FOR A PREVENTION-FOCUSED SYSTEM

The last potential barrier considered here relates to the actual laws encompassing the boundaries of the reporting system. If mandatory reporting were to be included in a more prevention-focused system, it is likely that all jurisdictions participating in that system would need to revise their reporting statutes. Not only would this potentially have a positive impact on the ability to use data to improve programs and practice, it could also allow jurisdictions the opportunity to reassess the rationale of certain sections of their reporting law. It is also possible that a new system may require an entirely new set of reporting laws. If so, these laws should be designed, using the current evidence-base as a tool, to achieve very specific outcomes. For example, limiting mandated reporting to certain professionals rather than adopting a system of universal reporting shifts the types of maltreated children who enter the system (39). To achieve a more optimal level of specificity, other areas of mandatory reporting laws to assess could include who should be chosen to be mandatory reporters, what types of maltreatment should be reported, who would get immunity, and for what, and ensuring that training for reporters is mandated.

Additionally, another section of reporting laws that may need to be revised under a more prevention-focused system is the section that deals with penalties. The need for penalties for failure to make a report could change drastically. In a system that is more suited to handle even the unintentional neglect of children, reporting feels less like "telling on" someone for bad behavior. Instead, reporting begins to seem more like a neighborly activity, almost like rendering assistance. In this case, does it still make sense to penalize a person for not reporting? Already, reporting statutes run counter to the responsibilities we place on citizens in many nations related to other criminal offenses. In the United States, the law generally imposes no duty on a citizen to intervene to assist another who is in trouble. If a child is drowning in your neighbor's pool, the law generally imposes no duty on you to intervene and save that child. Thus, mandated reporting laws are completely opposite of how the general law deals with legal duties in that they impose a duty to act where, in the absence of the statutory mandate, none would exist. Knowing this, does it make sense to penalize someone for something that seems even less egregious, like not making a call if a child needs a coat? This is a consideration that lawmakers may want to examine, especially considering that penalties for failure to report have a questionable efficacy in increasing desired reporting behavior.

No matter what changes might ensue to reporting statutes, legislators and policy-makers should remember that laws have the ability to act as blueprints to facilitate the structure of systems. Flexibility may be one of the characteristics of successful prevention strategies, but in terms of the structure of laws, this is not necessarily so. "Tighter," more clearly defined laws lead to more control over the accuracy of activity based on those laws. For example, if the legislature tightens or more clearly defines what is to be reported, there would likely be more accurate reporting. The balancing act here is that by narrowing definitions, the burden of error shifts. In other words, if the definition of what constitutes neglect or abuse is narrowed, this shift may place certain children at increased risk for maltreatment (40, 41). Training for mandated reporting is an important mediator in this balancing act, and legislators should ensure that reporting laws also mandate quality training for reporters in order to facilitate correct interpretation of the laws they so carefully and intentionally craft. Both pre-service and in-service training programs should provide statutory definitions of child maltreatment and examples of child maltreatment to help professionals recognize signs and to enable them to establish early detection systems for minimizing maltreatment (42). Abstract terms such as "reasonable suspicion," "reasonable grounds," and "reasonable belief" should be clarified and operationally defined so mandatory reporters do not rely on their subjective beliefs about what these concepts mean. Establishing "reasonable suspicion" that child maltreatment has occurred, for example, must be based on specific, objective indicia that the mandatory reporter can articulate and describe.

It is worth pointing out that, if reporting laws were comprehensively revised, the simple fact that all of these related components exist could help to overcome some of the individual barriers. Some examples of this phenomenon are highlighted in the discussions above. Another example is how the component/continuum system could help to curb the pervasive mission confusion that has plagued the field for well over 40 years now (43). When the Child Abuse Prevention and Treatment Act was passed and any existing welfare agencies were blended into the newly required CPS, it created an anxious combination of principles of intervention-but-also-non-intervention into the lives of children and families. More disconcerting is that it also created two different, and potentially contradictory, desired outcomes for the child maltreatment system – that children be safe and that children be kept in their families whenever

possible. If all the components previously described existed concurrently along a continuum, there would likely be less mission confusion. The overarching goal of ensuring the safety of the population served by each of the components, in the end, helps to achieve the larger mission of the child protection continuum, the ultimate goal of which is healthy children, families, and communities.

CONCLUSION

The current spread and variability of systems designed to address and prevent child maltreatment is vast, but it is not at all exhaustive. As our knowledge of child maltreatment continues to grow, it remains promising that if we want to effect more positive outcomes for children and families, as well as achieve more robust prevention of child maltreatment, it is time to get creative and look beyond the orthodoxies that have been set for us by previous iterations of policy and programming. Prevention-focused systems continue to be a promising area of interest. To effect change at the systematic level, it is not necessary—nor desirable—to discard mandated reporting, as some have suggested. Rather, the system of mandated reporting should be refined as our knowledge about its effectiveness in a more prevention-focused system grows. Mandatory reporting of child abuse and neglect has proven to be a valuable tool in our attempts to identify children and families that are struggling and would benefit from services and resources. In order to best serve children, families, and the communities in which they live, mandatory reporting should be included in the strategic development of a new, more prevention-focused system that addresses child maltreatment more holistically.

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SECTION V: ACKNOWLEDGMENTS

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Chapter 25

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Award for "Distinquished Contributions in Adolescent Health", the 2000 Mayo Clinic Pediatrics Honored Alumnus Award for "National Contributions to the field of Pediatrics," and the 2003 William B Weil, Jr., MD Endowed Distinguished Pediatric Faculty Award from Michigan State University College of Medicine for "National and international recognition as well as exemplary scholarship in pediatrics." Received the 2004 Charles R Drew School of Medicine (Los Angeles, CA) Stellar Award for contributions to pediatric resident education and awarded an honorary membership in the Indian Academy of Pediatrics—an honor granted to only a few pediatricians outside of India. Was the 2007-2010 Visiting Professor of Pediatrics at Athens University, Athens, Greece and received the Michigan State University College of Human Medicine Outstanding Community Faculty Award in 2008. In 2010 he received the title of Doctor Honoris Causa from the University of Athens (Greece) as a "distinguished scientist who through outstanding work has bestowed praise and credit on the field of adolescent medicine (Ephebiatrics)." In 2010 he received the Outstanding Achievement in Adolescent Medicine Award from the Society for Adolescent Medicine "as a leading force in the field of adolescent medicine and health." In 2014 he was selected by the American Medical Association as AMA nominee for the ACGME Pediatrics Residency Review Committee (RRC) in Chicago, Illinois, USA. Past Chair of the National Conference and Exhibition Planning Group (Committee on Scientific Meetings) of the American Academy of Pediatrics and member of the Pediatric Academic Societies' (SPR/PAS) Planning Committee (1998 to Present). In 2011 elected to The Alpha Omega Alpha Honor Society (Faculty member) at Michigan State University College of Human Medicine, East Lansing, Michigan. Former member of the Appeals Committee for the Pediatrics' Residency Review Committee (RRC) of the Accreditation Council for Graduate Medical Education (Chicago, IL) in both adolescent medicine and general pediatrics. Numerous publications in adolescent health and lectureships in many countries on adolescent health. Email: donald.greydanus@med.wmich.edu

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Chapter 26

ABOUT THE DEPARTMENT OF PEDIATRICS, NEW YORK UNIVERSITY GROSSMAN SCHOOL OF MEDICINE AND BELLEVUE HOSPITAL, NEW YORK, UNITED STATES

INTRODUCTION

In 1841, six eminent physicians and scientists opened a medical college under the aegis of the University of New York, one of the nation's first progressive universities dedicated to providing widely accessible higher education. Valentine Mott, John William Draper, Granville S. Pattison, Gunning S. Bedford, John Revere, and Martyn Paine made major contributions to the diagnosis and treatment of disease, as well as to medical research and education, defining the three fundamental aspects of NYU Langone Medical Center's mission today: to serve, to teach, to discover.

The Department of Pediatrics began with the development of Pediatrics as a field, with its first chair being Abraham Jacobi, the father of American pediatrics. The second chairman, Job Lewis Smith, is a "forgotten" father of American Pediatrics, and faculty member Stephen Smith went on to found the American Public Health Association. Infant disease, malnutrition and dehydration were early foci of its research, and chairmen such as L. Emmet Holt Junior, Saul Krugman, and Joseph Danicis were internationally known leaders in their fields. Jacobi and Job Smith have been recognized for their contributions to the founding of child abuse pediatrics in New York City.

A pediatrician and a research scientist, Joseph Dancis was a pioneer in the study of the placenta and its crucial role in the immediate welfare of the fetus and newborn, as well as its contribution to some late-appearing adult diseases, such as hypertension and diabetes. He advanced the understanding of the role of the placenta as an organ of synthesis and maternal-fetal transport, and made major contributions to knowledge about genetic diseases including maple syrup urine disease, Lesch-Nyhan disease, dysautonomia, and Zellweger syndrome. He later developed an interest in the transfer and metabolism of anti-HIV drugs intended for use during pregnancy to protect the fetus.

As they better understood the biological basis of disease through the 19th and 20th centuries, the doctors and scientists of NYU's medical school and Bellevue Hospital's medical school increasingly turned their attention to its causes and prevention, in addition to its treatment. They advocated for sanitation, both urban and personal, and worked to eliminate breeding sites for disease and its carriers. They researched, identified and treated genetic and metabolic disease, studied HIV, tuberculosis, hepatitis and other infections among children, and developed child psychiatry, pediatric orthopedics and physical medicine and rehabilitation, Emergency Medical Services for Children (EMS-C), forensic medicine and toxicology, and neonatal transport among other groundbreaking pediatric services. They championed the development of vaccines, quarantine, record keeping, and other methods of minimizing the spread of disease, transforming the landscape and expectations of public health, a transformation that continues into the 21st century.

Bellevue Hospital and the Frances L Loeb Child Protection and Development Center

Bellevue Hospital (officially NYC Health + Hospitals/Bellevue and formerly known as Bellevue Hospital Center) opened in 1736 and is the oldest public hospital in the United States and part of New York City's network of public hosptials. One of the largest hospitals in the United States by number of beds, Bellevue is located in the Kips Bay neighborhood of Manhattan. By 1787, Columbia University's College of Physicians and Surgeons had assigned faculty and medical students to Bellevue. Columbia faculty and students would remain at Bellevue for the next 181 years, until the restructuring of the academic affiliations of Bellevue Hospital in 1968. New York University faculty began to conduct clinical instruction at the hospital in 1819. The hospital contains a 25-story patient care facility and has an attending physician staff of 1,200 and an in-house staff of about 5,500. Bellevue is a safety net hospital, providing healthcare for individuals regardless of their insurance status or ability to pay. It handles over half a million patient visits each year. In 2014 Bellevue was ranked 40th overall best hospital in the New York metro area and 29th in New York City by U.S. News and World Report.

In 1799, Bellevue opened the first maternity ward in the United States. By 1808, the world's first ligation of the femoral artery for an aneurysm was performed there, followed by the first ligation of the innominate artery ten years later. In 1849, an amphitheater for clinical teaching and surgery opened. Bellevue physicians promoted the "Bone Bill" in 1854, which legalized dissection of cadavers for anatomical studies; two years later they started to also popularize the use of the hypodermic syringe. In 1862, the Austin Flint murmur was named for Austin Flint, a prominent Bellevue Hospital cardiologist. By 1867, Bellevue physicians were instrumental in developing New York City's sanitary code, the first in the world. One of the nation's first outpatient departments connected to a hospital (the "Bureau of Medical and Surgical Relief for the Out of Door Poor") was established at Bellevue that year. In 1869, Bellevue established the second hospital-based, emergency ambulance service in the United States. In 1861, the Bellevue Hospital Medical College, the first medical college in New York with connections to a hospital, was founded. By 1873, the nation's first nursing school based on Florence Nightingale's principles opened at Bellevue, followed by the nation's first children's clinic in 1874 and the nation's first emergency pavilion in 1876; a pavilion for the

insane, an approach considered revolutionary at the time, was erected within hospital grounds in 1879.

In 1889, Bellevue physicians were the first to report that tuberculosis is a preventable disease; five years later was the successful operation of the abdomen for a pistol shot wound. William Tillett discovered streptokinase, later used for the acute treatment of myocardial infarction, at Bellevue in 1933. Nina Starr Braunwald performed the first mitral valve replacement in 1960 at the hospital. In 1967, Bellevue physicians perform the first cadaver kidney transplant. In 1971, the first active immunization for hepatitis B was developed by Bellevue pediatricians. Bellevue played a key role in the development of the "Triple Drug Cocktail" or HAART, a breakthrough in the treatment of AIDS, in 1996. Since 2001, Bellevue has developed and provided services for survivors of the World Trade Center attacks and a program for international surviors of torture. In October 2014, Bellevue succesfully treated an Ebola patient, becoming a federally recognized center for the treatment of special pathogens. Though Bellevue is a full-service hospital, it was once popularly associated with its treatment of mentally ill patients who required psychiatric commitment. Bellevue is also home to a daycare, a school, drug treatment programs, EMS and comprehensive healthcare services, including outpatient, specialty, and skilled nursing care, as well as emergency and inpatient services. It houses one of the few childrens comprehensive psychiatric evaluation programs in the country, a poison control center, and a level 2 pediatric trauma center.

The Frances L Loeb Child Protection and Development Center (CPDC) opened on November 15, 2000 as a component of the Bellevue Hospital Pediatric Resource Center, a national model for preventive health care for high-risk families. Within the Loeb Center, the child abuse team evaluates children from the Greater NY Metropolitan area. The interdisciplinary nature of this service, the techniques, and the comprehensive nature of the evaluations make the Center unique among hospital-based child abuse evaluation programs in New York City. Its goal is to minimize trauma to children and provide treatment interventions that are developmentally appropriate. The CPDC opened as the result of several gifts from the Loeb family. Frances Lehman Loeb (1907-1996) had spent a dozen years as New York City's liaison to its vast corps of foreign diplomats and a lifetime maintaining a family tradition of philanthropy. In addition to money, Mrs. Loeb gave time. For 12 years in the 1960s and 70s during the administrations of Mayors John V. Lindsay and Abraham D. Beame, Mrs. Loeb was New York City's unsalaried commissioner for the United Nations and for the Consular Corps. Directing a staff of nine full-time and six part-time employees, Mrs Loeb eased cultural shock and fostered amity in a foreign diplomatic community that numbered 35,000 people from 197 missions and 91 consulates. She helped found the Children of Bellevue Inc, a nonprofit organization, founded in 1949 to initiate, develop, and fund special programs and to advocate for children and their families within Bellevue Hospital Center. She died in May, 1996. The Center continues to reveive some support from the Children of Bellevue.

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Chapter 27

ABOUT THE CHILD ADVOCACY LAW CLINIC, SCHOOL OF LAW, UNIVERSITY OF MICHIGAN, ANN ARBOR, MICHIGAN, UNITED STATES

The University of Michigan Law School was established in 1859. From its earliest days, the Law School has had a national reach, graduating students from across the country who have gone on to practice law in every state. The school's alumni include leaders in the law both in the United States and around the world.

The school graduated its first African American student, Gabriel Hargo, who was only the second Black law school graduate in the country, in 1870. Sarah Killgore Wertman was the first woman to graduate from the Law School a year later; she then became the first woman licensed to practice law in the State of Michigan.

The school has had an international reach since the late 1800s. In the 1870s a group of 80 students from Japan, who had been sent by the Emperor, matriculated at the Law School. The first of these Japanese students graduated in 1878.

The School has produced three Supreme Court Justices. William Rufus Day was appointed by President Theodore Roosevelt; he served on the Court from 1903 to 1922. George Sutherland, who served on the Court between 1922 and 1938, was appointed by President Warren G. Harding. Finally, Frank Murphy, who graduated from the law school in 1914. He was appointed to the Court by President Franklin Roosevelt in 1940 and served until his death in 1949.

For over 150 years, the University of Michigan Law School has been among the nation's premier institutions for legal education, consistently ranking as one of the top ten schools in the country. The faculty is nationally and internationally renowned in subspecialties of the law ranging from criminal law and procedure to health law, from legal history to insurance and tax law. Today the school has a student body of some 1100 students from around the country and across the globe. Graduates of the Law School are leaders in private law firms, government, non-profit organizations and academia in the United States and countries around the world.

The Child Advocacy Law Clinic

Clinical legal education is a relatively recent phenomenon though the University of Michigan Law School was an early entrant into the field. It established one of the nation's first child advocacy clinics in 1976.

The Child Advocacy Law Clinic (CALC) is a live client clinic that teaches law students to practice law under the close supervision of clinical faculty. CALC students handle cases of child maltreatment, representing children, parents and the state child protection agency. Over the years, CALC students have represented thousands of individuals in protection, guardianship, adoption and child custody cases. Students may also work on special projects such as writing amicus briefs, researching and drafting legislation, testifying at legislative hearings and participating in special research projects.

CALC's former students serve in various capacities in non-profit, governmental and private law firms around the country.

For more information about CALC, visit:
https://www.law.umich.edu/clinical/calc/Pages/default.aspx.

In: Preventing Child Abuse
Editors: Vincent J Palusci, Frank E Vandervort et al.
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Chapter 28

ABOUT THE DEPARTMENT OF PEDIATRIC AND ADOLESCENT MEDICINE, WESTERN MICHIGAN UNIVERSITY HOMER STRYKER MD SCHOOL OF MEDICINE, KALAMAZOO, MICHIGAN, UNITED STATES

Mission and service

The Western Michigan University Homer Stryker MD School of Medicine (WMed) was started in 2012 and its first class of medical students began in 2014. The Department of Pediatric and Adolescent Medicine has a pediatric residency program which is accredited by the Accreditation Council for Graduate Medical Education (ACGME) in Chicago, Illinois, USA and the current residency program in Pediatrics started in 1990.

The WMed Department of Pediatric and Adolescent Medicine has a commitment to a comprehensive approach to the health and development of the child, adolescent, and the family. The Department has a blend of academic general pediatricians and pediatric specialists. Our academic pediatric practice provides a broad spectrum of general well and sick child care (birth through 21 years) including immunizations, monitoring general physical and emotional growth, motor skill development, sports medicine (including participation evaluations and evaluation of common sports injuries), child abuse evaluations, and psychosocial or behavioral assessment. WMed Pediatrics believes in immunizations as a protection against preventative disease processes. WMed is recognized as a Patient-Centered Medical Home (PCMH) model of care delivery. A PCMH is a way to deliver coordinated and comprehensive primary care to our infants, children, adolescents and young adults. It is a partnership between individuals and families within a health care setting, which allows for a more efficient use of resources and time to improve the quality of outcomes for all involved through care provided by a continuity care team.

Research activities

The Department has a variety of research projects in adolescent medicine, neurobehavioral pediatrics, adolescent gynecology, pediatric diabetes mellitus, asthma, and cystic fibrosis. The WMed Department of Pediatric and Adolescent Medicine has published a number of medical textbooks: Essential adolescent medicine (McGraw-Hill Medical Publishers), The pediatric diagnostic examination (McGraw-Hill), Pediatric and adolescent psychopharmacology (Cambridge University Press), Behavioral pediatrics, through 4th Edition, Nova Science, New York, Pediatric practice: Sports medicine (McGraw-Hill), Handbook of clinical pediatrics (Singapore: World Scientific), Neurodevelopmental disabilities: Clinical care for children and young adults (Dordrecht: Springer), Adolescent medicine: Pharmacotherapeutics in medical disorders (Berlin/Boston: De Gruyter), Adolescent medicine: Pharmacotherapeutics in general, mental, and sexual health (Berlin/Boston: De Gruyter), Pediatric psychodermatology (Berlin/Boston: De Gruyter), Substance abuse in adolescents and young adults: A manual for pediatric and primary care clinicians (Berlin/Boston: De Gruyter), and tropical pediatrics (New York: Nova); Second edition in press.

The Department has edited a number of journal issues published by Elsevier Publishers covering pulmonology (State of the Art Reviews: Adolescent Medicine—AM:STARS), genetic disorders in adolescents (AM:STARS), neurologic/neurodevelopmental disorders (AM:STARS), behavioral pediatrics (Pediatric Clinics of North America), pediatric psychopharmacology in the 21st century (Pediatric Clinic of North America), nephrologic disorders in adolescents (AM:STARS), college health (Pediatric Clinics of North America), adolescent medicine (Primary Care: Clinics in Office Practice), behavioral pediatrics in children and adolescents (Primary Care: Clinics in Office Practice), adolescents and sports (Pediatric Clinics of North America), and developmental disabilities (Pediatric Clinics of North America). The Department has also edited a journal issue on musculoskeletal disorders in children and adolescents for the American Academy of Pediatrics' AM:STARs; in April of 2013 a Subspecialty Update issue was published in AM:STARs.

The department has developed academic ties with a variety of international medical centers and organizations, including the Queen Elizabeth Hospital in Hong Kong, Indian Academy of Pediatrics (New Delhi, India), the University of Athens Children's Hospital (First and Second Departments of Paediatrics) in Athens, Greece and the National Institute of Child Health and Human Development in Jerusalem, Israel.

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Chapter 29

ABOUT THE NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT IN ISRAEL

The National Institute of Child Health and Human Development (NICHD) in Israel was established in 1998 as a virtual institute under the auspices of the Medical Director, Ministry of Social Affairs and Social Services in order to function as the research arm for the Office of the Medical Director. In 1998 the National Council for Child Health and Pediatrics, Ministry of Health and in 1999 the Director General and Deputy Director General of the Ministry of Health endorsed the establishment of the NICHD.

Mission

The mission of a National Institute for Child Health and Human Development in Israel is to provide an academic focal point for the scholarly interdisciplinary study of child life, health, public health, welfare, disability, rehabilitation, intellectual disability and related aspects of human development. This mission includes research, teaching, clinical work, information and public service activities in the field of child health and human development.

Service and academic activities

Over the years many activities became focused in the south of Israel due to collaboration with various professionals at the Faculty of Health Sciences (FOHS) at the Ben Gurion University of the Negev (BGU). Since 2000 an affiliation with the Zusman Child Development Center at the Pediatric Division of Soroka University Medical Center has resulted in collaboration around the establishment of the Down Syndrome Clinic at that center. In 2002 a full course on "Disability" was established at the Recanati School for Allied Professions in the Community, FOHS, BGU and in 2005 collaboration was started with the Primary Care Unit of the faculty and disability became part of the master of public health course on "Children and society". In the academic year 2005-2006 a one semester course on "Aging with disability" was started as part of the master of science program in gerontology in our collaboration with the Center for Multidisciplinary Research in Aging. In 2010 collaborations with the Division of Pediatrics,

Hadassah Hebrew University Medical Center, Jerusalem, Israel around the National Down Syndrome Center and teaching students and residents about intellectual and developmental disabilities as part of their training at this campus.

Research activities

The affiliated staff have over the years published work from projects and research activities in this national and international collaboration. In the year 2000 the International Journal of Adolescent Medicine and Health and in 2005 the International Journal on Disability and Human Development of De Gruyter Publishing House (Berlin and New York) were affiliated with the National Institute of Child Health and Human Development. From 2008 also the International Journal of Child Health and Human Development (Nova Science, New York), the International Journal of Child and Adolescent Health (Nova Science) and the Journal of Pain Management (Nova Science) affiliated and from 2009 the International Public Health Journal (Nova Science) and Journal of Alternative Medicine Research (Nova Science). All peer-reviewed international journals.

National collaborations

Nationally the NICHD works in collaboration with the Faculty of Health Sciences, Ben Gurion University of the Negev; Department of Physical Therapy, Sackler School of Medicine, Tel Aviv University; Autism Center, Assaf HaRofeh Medical Center; National Rett and PKU Centers at Chaim Sheba Medical Center, Tel HaShomer; Department of Physiotherapy, Haifa University; Department of Education, Bar Ilan University, Ramat Gan, Faculty of Social Sciences and Health Sciences; College of Judea and Samaria in Ariel and in 2011 affiliation with Center for Pediatric Chronic Diseases and National Center for Down Syndrome, Department of Pediatrics, Hadassah Hebrew University Medical Center, Mount Scopus Campus, Jerusalem.

International collaborations

Internationally with the Department of Disability and Human Development, College of Applied Health Sciences, University of Illinois at Chicago; Strong Center for Developmental Disabilities, Golisano Children's Hospital at Strong, University of Rochester School of Medicine and Dentistry, New York; Centre on Intellectual Disabilities, University of Albany, New York; Centre for Chronic Disease Prevention and Control, Health Canada, Ottawa; Chandler Medical Center and Children's Hospital, Kentucky Children's Hospital, Section of Adolescent Medicine, University of Kentucky, Lexington; Chronic Disease Prevention and Control Research Center, Baylor College of Medicine, Houston, Texas; Division of Neuroscience, Department of Psychiatry, Columbia University, New York; Institute for the Study of Disadvantage and Disability, Atlanta; Center for Autism and Related Disorders, Department Psychiatry, Children's Hospital Boston, Boston; Department of Pediatric and Adolescent Medicine, Western Michigan University Homer Stryker MD School of Medicine,

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Targets

Our focus is on research, international collaborations, clinical work, teaching and policy in health, disability and human development and to establish the NICHD as a permanent institute in Israel in order to conduct model research in this field.

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SECTION VI: INDEX

INDEX

A

abuse prevention training, 255, 292
abusive head trauma (AHT), xviii, 7, 9, 18, 23, 27, 29, 32, 35, 36, 65, 71, 74, 78, 79, 80, 89, 95, 97, 100, 132, 149, 161, 166, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 315, 325, 332, 337, 338, 348, 354, 380
accountability, 157, 253, 259, 261, 322, 391
Administration for Children, Youth and Families (ACYF), 26, 88, 373
adolescent sexual offenders, 283
adolescent sexual perpetrator, 274, 276, 277, 282
adolescent sexual predator, 267, 275
adolescents, 7, 21, 23, 30, 31, 33, 37, 138, 145, 200, 203, 211, 212, 220, 232, 233, 234, 235, 236, 238, 239, 243, 244, 245, 249, 258, 262, 263, 264, 267, 269, 270, 271, 273, 274, 275, 276, 277, 279, 283, 284, 290, 297, 298, 303, 304, 306, 307, 310, 311, 340, 354, 367, 387, 415, 416
adverse childhood experiences, 8, 12, 27, 32, 123, 172, 217, 223, 280, 328, 361, 368
Affordable Care Act (ACA), 68, 102
Aid for Families with Dependent Children Act (AFDC), 66, 75, 76, 391
alternate light sources, 145
American Academy of Pediatrics (AAP), xv, 11, 15, 27, 29, 32, 35, 36, 37, 79, 89, 117, 145, 168, 171, 183, 195, 197, 199, 204, 211, 286, 297, 306, 313, 337, 340, 349, 350, 362, 407, 416
Article 19, 42, 44, 45, 46, 47, 48, 50
Article 34, 42, 50
artificial intelligence, 127, 131, 151
augmented or mixed reality, 146

B

Baby Doe Rules, 377, 378
basic income, 66, 100
battered child syndrome, 75, 76, 391
big data, 130, 131, 142, 148, 149, 150, 151
Black athletes, 288, 298
body image, 287
breakeven costs, 191
brother-sister incest, 268, 270, 279
bruises, 14, 28, 29, 145, 151, 366
bruising, 28, 29, 145, 205, 206
bystander programs, 245

C

cardiac arrest, 287, 292, 298
case identification, 147, 386, 387, 388, 390, 396, 398, 399
Center for the Study of Social Policy (CSSP), 26, 110, 353, 374, 382
Centers for Disease Control and Prevention (CDC), 9, 26, 32, 90, 93, 94, 98, 99, 116, 123, 157, 165, 185, 186, 196, 211, 242, 254, 265, 298, 302, 310, 321, 325, 332, 348, 368, 382
central registries, 201, 378, 383
child abuse fatalities, 29, 33, 36, 163, 170, 175, 314, 321, 330
Child Abuse Prevention and Treatment Act of 1974 (CAPTA), 54, 59, 61, 62, 63, 64, 70, 76, 84, 85, 156, 169, 316, 369, 371, 372, 373, 376, 377, 379, 380, 381, 382, 391, 401
child abuse prevention month, 162
child death review, 133, 315, 331

child fatality review (CFR) process, 319, 320
child fatality review (CFR) teams, 315, 319, 321, 322, 332
Child Fatality Review (CFR), 313, 315, 316, 317, 318, 319, 320, 321, 322, 323, 329, 330, 331, 332
child maltreatment deaths, xviii, 7, 76, 313, 321, 322, 329, 330
child maltreatment prevention, xvii, 8, 31, 42, 48, 49, 62, 68, 70, 73, 74, 77, 78, 79, 81, 82, 83, 86, 87, 90, 98, 101, 105, 110, 126, 131, 144, 149, 150, 153, 154, 160, 161, 162, 326, 327, 328, 352, 361, 367, 386, 390
child pornography, 43, 44, 50, 51, 52, 55, 56
child protection budget, 397
child protection continuum, 393, 394, 395, 396, 397, 399, 402
Child Protection Law (Michigan), 395
child protection law, 47, 53, 66, 67, 70
child protection system, 7, 49, 54, 60, 62, 65, 71, 88, 149, 154, 155, 156, 159, 161, 169, 174, 175, 176, 385, 386, 389, 391
Child Protective Services (CPS), xviii, 4, 7, 8, 11, 16, 18, 19, 20, 22, 23, 28, 33, 47, 63, 66, 69, 73, 74, 75, 76, 83, 84, 85, 86, 105, 126, 133, 154, 155, 157, 160, 169, 175, 176, 189, 315, 339, 342, 344, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 386, 388, 390, 393,394, 395, 396, 397, 398, 401, 403
child rights, 142, 166
child sexual abuse victimization images, 146
child sexual abuse, 12, 19, 32, 34, 37, 56, 146, 151, 154, 157, 158, 165, 225, 226, 228, 229, 230, 240, 242, 243, 246, 247, 249, 251, 252, 255, 256, 264, 265, 266, 278, 279, 280, 281, 282, 283, 284, 289, 290, 295, 298, 300, 303, 348, 380, 386, 402, 403, 404, 407
child support, 78
Child Welfare Information Gateway, 33, 35, 71, 141, 222, 224, 382, 383
child welfare services, 93, 135, 148, 383, 393, 394
child welfare, xvi, xvii, 7, 27, 35, 71, 72, 76, 78, 85, 86, 88, 90, 92, 93, 99, 105, 117, 125, 126, 127, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 144, 147, 148, 149, 150, 151, 156, 165, 167, 169, 174, 175, 284, 305, 307, 315, 316, 317, 319, 321, 322, 323, 325, 328, 338, 342, 349, 360, 367, 378, 381, 383, 392, 393, 394, 402, 404, 408
Children's Health Insurance Program (CHIP), 68, 71, 72
Children's Protective Services (CPS), 4, 7, 8, 11, 16, 18, 19, 20, 22, 23, 28, 33, 47, 63, 66, 69, 73, 74, 76, 83, 84, 85, 86, 105, 126, 133, 154, 155, 157, 160, 169, 175, 176, 189, 315, 342, 344, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 386, 388, 390, 393, 394, 395, 396, 397, 398, 401, 403
Choose Your Partner Carefully Campaign (CYPC), 323, 324
Chronicle of Social Change, The, 56, 160, 166
citizen review panels (CRP), 62, 111, 331
CLICK for babies, 184
Cloud, 127, 128, 136, 139, 146, 148, 150
Coach Education & Training (Coach training and education), 289, 291
coaches, received training, 293
cognitive computing, 148
commercial sexual exploitation of children (CSEC), 4, 12, 15, 306, 311
Commission to Eliminate Child Abuse and Neglect Fatalities, 33, 177, 330
Committee on the Rights of the Child, 32, 44, 46, 55, 115, 200, 211
Community Based Child Abuse Prevention (CBCAP), 93, 373, 374, 381, 382
Comprehensive Child Welfare Information System, 125, 136
concussions, 287, 289, 291, 292, 298
confidentiality, 127, 142, 143, 156, 275, 341, 365, 366, 369, 398, 399
connected and smart homes, 139
consent, 13, 14, 44, 53, 142, 151, 156, 221, 225, 234, 237, 238, 239, 245, 246, 251, 302, 364, 365
continuum of care focused on child well-being, 392
corporal punishment, xviii, 7, 17, 29, 33, 36, 46, 47, 53, 55, 56, 78, 89, 113, 114, 115, 116, 117, 118, 119, 120, 121, 123, 159, 199, 200, 201, 202, 203, 204, 205, 206, 207, 210, 211, 212, 213, 215, 258, 316, 339, 340, 342, 367
cost-effectiveness analysis, 191, 196
crying, xviii, 7, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 192, 193, 194, 195, 196, 197, 202, 208, 313, 323, 324, 325, 337, 348
cyberbullying, 130, 145, 148, 151

D

data collection, 13, 130, 142, 218, 315, 317, 347
data linkage, 127, 133, 147, 151
deep learning, 132, 146
Department of Health and Human Services (DHHS), 35, 61, 70, 88, 98, 99, 100, 297, 314, 330, 363, 368, 369, 381
dependency-neglect, 390
Detroit Free Press, the, 160

developmental, 3, 4, 19, 28, 30, 31, 54, 64, 82, 83, 106, 108, 117, 123, 138, 181, 183, 195, 208, 210, 211, 218, 219, 221, 224, 227, 231, 233, 234, 243, 296, 303, 337, 345, 346, 347, 372, 416, 418
Dias model, the, 182, 184, 190, 191, 192, 193, 194
Dias, Dr Mark, 182, 184, 186, 187, 190, 191, 192, 193, 194, 196, 197, 324, 332, 354
differential or alternative response, 393
differential response (DR), 17, 33, 57, 64, 71, 215, 224, 243, 278, 279, 282, 284, 331, 368, 376, 380, 381, 383, 387, 393, 394, 395, 396, 402, 403
digital revolution, 125, 130
disabilities, 21, 64, 195, 217, 218, 219, 220, 221, 222, 223, 224, 277, 284, 287, 288, 360, 365, 377, 416, 418
disabilities, athletes with, 287

E

Earned Income Tax Credit, 78, 91, 92, 94, 99
economic supports, 6, 60, 91, 98, 391
e-Health, 128, 137, 150
emergency room, 86, 107, 110, 197, 378, 392, 393, 397
emotional abuse, 4, 16, 27, 173, 219, 251, 261, 262, 286, 294, 295, 361
emotional trauma, 146, 276
ethical considerations, 134, 156

F

failure to report, 369, 386, 401
fallacy of division, 388
false reports, 369, 398
Families First Prevention Services Act (FFPSA), 136
Family First Prevention Act (FFPA), 84
Family Medical Leave Act (FMLA), 65
Family Preservation Services (FPS), 375
fathers, 97, 100, 108, 111, 188, 190, 191, 192, 193, 208, 212, 213, 270, 279, 324, 339
fidelity, 78, 138, 181, 186, 187, 191, 194, 376, 385, 386
First Amendment, 48, 52
first responders, 396
food insecurity, 67, 318, 340, 343, 344
Frameworks Institute, the, 374

G

Geneva Declaration on the Rights of the Child, 43
geographic information systems (GIS), 126, 137, 138, 150
Great Recession, 181, 187, 189, 194

H

health effects, 7, 27, 28, 35, 372
healthcare analogy, 392, 393
healthcare continuum, 392
heat-related illness, 287
Helfer, Dr Ray E, xv, 6, 9, 92, 98, 168, 171, 174, 177, 379, 407
home visiting, 6, 49, 63, 65, 68, 69, 78, 89, 92, 93, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 135, 163, 193, 348, 349, 374, 380
hospital-based prevention programs, 325
housing, 15, 19, 24, 25, 65, 69, 72, 78, 106, 295, 304, 307, 308, 315, 318, 339, 345, 359, 360, 361, 362, 363, 365, 376
Housing Choice Voucher Program (Section 8), 61, 69

I

immigrant families, 327, 332
immunity, 398, 400
incest, 232, 252, 267, 268, 269, 270, 271, 276, 277, 278, 279, 280, 281, 282
incidence, 11, 12, 16, 18, 22, 23, 33, 65, 80, 133, 137, 149, 181, 183, 186, 187, 190, 192, 194, 196, 212, 219, 226, 238, 241, 264, 315, 325, 326, 330, 403
inconsolable crying, 182, 183, 184, 188, 192, 194
information and communication technology, 131
initial assessors, 396
injury, xiv, 3, 4, 12, 13, 14, 16, 21, 22, 27, 28, 29, 30, 34, 35, 37, 46, 78, 107, 132, 145, 151, 182, 191, 193, 195, 200, 202, 215, 250, 272, 278, 285, 286, 287, 289, 291, 292, 295, 296, 298, 299, 314, 324, 330, 360, 392
interagency collaboration, 388, 399
international law, 42, 55
Internet of Things (IoT), 126, 127, 129, 139, 146, 148, 150
investigators, 79, 142, 193, 235, 236, 317, 319, 396

K

Kalamazoo, Michigan, xix, 3, 267, 277, 407, 415, 419

Kempe, Henry C, 75, 84, 88, 98, 169, 171, 177, 182, 183, 193, 195, 391
Krugman, Richard, xviii, 9, 74, 81, 87, 177, 260, 265, 409

L

League of Nations, 43
LGBTQA+ athletes, 287
lifetime AHT costs, 191
lifetime societal costs, 191
logical fallacies, 388, 389
Los Angeles Times, the, 153, 164

M

mass media, 48, 153, 155, 156, 160, 165, 241, 246, 314, 329, 330
media, xvii, 6, 48, 49, 56, 78, 80, 89, 126, 131, 139, 143, 145, 148, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 172, 188, 240, 241, 246, 250, 254, 273, 292, 305, 306, 316, 322, 329, 331, 377, 380
Medicaid, 18, 68, 71, 110, 168, 352, 362, 363
medical care neglect, 12, 15
medical cost, 191, 197
medical emergency room, 189
medical-legal partnership (MLP), xviii, 7, 345, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368
medically-fragile children, 139
Meyer v Nebraska, 53, 56, 70
Michigan Comp Laws 772.628d, 395
mobile technology, 138, 149
Mondale, Walter, 84
morbidity, 15, 29, 65, 167, 174, 217, 223, 275, 320
mortality, 23, 29, 33, 34, 65, 167, 174, 217, 218, 223, 269, 315, 331
mother-son incest, 270, 271, 280
multi-professional collaboration, 399
multisystemic therapy (MST), 275, 283

N

National Center for Child Abuse and Neglect (NCCAN), 31, 373
National Center on Shaken Baby Syndrome (NCSBS), 182, 184, 188, 332
National Child Abuse and Neglect Data System (NCANDS), 12, 16, 17, 18, 19, 21, 23, 24, 25, 33, 34, 126, 131, 314
National Fatality Review-Case Reporting System (NFR-CRS), 317, 318, 331
National Institutes of Health (NIH), 31, 167, 168, 169, 174
National Public Radio (NPR), 49
National School Lunch Program, 67
negative experiences, 281, 285, 286, 296
neglect, xv, xvi, xvii, xviii, 4, 5, 7, 8, 9, 11, 12, 13, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 28, 29, 31, 32, 33, 34, 35, 37, 42, 45, 46, 54, 57, 59, 60, 61, 62, 63, 64, 65, 66, 67, 69, 71, 74, 75, 76, 78, 79, 81, 83, 84, 85, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 101, 102, 111, 116, 117, 123, 125, 126, 135, 136, 147, 151, 159, 160, 163, 165, 167, 169, 170, 172, 173, 175, 176, 177, 211, 212, 217, 218, 219, 222, 224, 232, 251, 261, 262, 264, 265, 266, 267, 271, 274, 277, 278, 282, 295, 304, 308, 314, 315, 317, 319, 321, 323, 327, 328, 330, 331, 337, 339, 343, 344, 349, 350, 352, 353, 354, 360, 364, 365, 366, 369, 372, 377, 381, 382, 383, 384, 387, 390, 400, 401, 402, 403, 404
New York Foundling, 126, 204
New York Society for the Prevention of Cruelty to Children, 76
New York v Ferber, 52, 56
No Hit Zones (NHZs), 30, 78, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122
normal crying curve, 183, 184, 197
nurse advice line, 188, 189, 194, 348

O

Office of the National Coordinator for Health Information Technology, 141
Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography, 42
over-reporting, 134, 397, 398

P

paid family leave, 71, 80, 87, 91, 93, 94, 96, 100, 349
parens patriae, 53, 54, 390
parent education, 7, 78, 79, 80, 196, 289, 294, 325, 332, 354, 380
parent-child interaction therapy, 126, 135, 138, 150
Parents Anonymous, 168, 373, 374
parents, role of, 252, 288, 294, 300
Pediatric Advocacy Clinic, 359, 363, 366
penalties for failing to report, 398
Period of PURPLE Crying, 182, 184, 186, 187, 188, 191, 193

pharmacologic agents, 276
physical abuse, 4, 6, 12, 14, 16, 18, 20, 21, 22, 23, 24, 25, 27, 28, 29, 33, 34, 35, 36, 46, 47, 78, 84, 113, 114, 118, 135, 138, 144, 159, 182, 193, 200, 201, 202, 204, 212, 213, 219, 226, 233, 251, 261, 262, 273, 286, 292, 303, 342, 354, 361, 367, 390, 404
physical, psychological, or developmental harm, 87
policy, xv, 7, 9, 32, 44, 48, 49, 53, 56, 62, 64, 73, 74, 75, 78, 81, 82, 83, 84, 86, 88, 89, 90, 93, 94, 96, 97, 98, 99, 109, 110, 114, 115, 116, 117, 118, 120, 121, 123, 124, 126, 127, 131, 134, 143, 147, 149, 154, 155, 157, 158, 175, 200, 204, 211, 228, 229, 240, 242, 245, 254, 257, 258, 259, 261, 264, 290, 291, 296, 299, 311, 315, 317, 319, 320, 321, 322, 327, 328, 340, 367, 368, 378, 388, 394, 401, 402, 403, 419
pornography, 15, 44, 48, 51, 52, 56, 228, 232, 233, 234, 235, 236, 244, 245, 269, 275, 276, 305
positive aspects, 251, 285, 286
positive youth development, 293, 300
poverty, 6, 7, 9, 15, 20, 22, 23, 63, 64, 65, 66, 67, 68, 69, 75, 78, 83, 92, 95, 102, 106, 108, 130, 134, 157, 162, 163, 240, 305, 318, 330, 339, 352, 359, 360, 361, 363, 367, 381, 390
predictive analytics, 87, 126, 127, 130, 132, 149
prenatal and postnatal parent education, 394
Prevent Child Abuse America (National Committee to Prevent Child Abuse and Neglect), xv, 28, 35, 91, 158, 159, 165, 168, 169, 171, 176, 245, 373, 374, 381
prevention approaches, 103, 260, 277, 288, 289, 290, 295
prevention effectiveness, 181
Prevention Zones, 80, 81, 82
prevention-focused system, 92, 385, 386, 390, 391, 397, 398, 399, 400, 401, 402
primary care practices, 392
primary prevention, 6, 46, 85, 88, 93, 98, 105, 234, 237, 241, 371, 372, 373, 374, 382, 394
primary prevention services, 394
PROTECT Act, 50, 51
protective factors, 6, 23, 26, 31, 34, 35, 74, 77, 78, 83, 87, 88, 103, 244, 326, 338, 339, 341, 345, 346, 347, 352
public health approaches, 115, 391

Q

quality evaluation, 83, 86

R

racial inequity, 288
randomized controlled trials, 79, 188, 343, 351
reasonable suspicion, 255, 386, 401
recurrence, 11, 12, 18, 19, 20, 33, 34, 372
reportable type of maltreatment, 390
reporting statutes, 390, 400, 401
risk factors, 6, 11, 12, 19, 22, 23, 25, 26, 27, 31, 33, 34, 49, 74, 77, 78, 83, 84, 103, 105, 106, 111, 129, 131, 132, 133, 134, 135, 138, 184, 187, 197, 213, 218, 220, 221, 229, 232, 234, 252, 291, 301, 303, 304, 305, 306, 307, 309, 310, 314, 316, 317, 318, 326, 330, 332, 337, 340, 341, 343, 345, 346, 350, 351, 352, 372, 374, 380, 394
role of parents, 252, 288, 294, 300
Roper v Simmons, 41, 55

S

Safe Haven Laws, 378
SafeCare®, 135, 149
SafeSport, US Center for, 286, 288, 293, 294, 295, 297, 299, 300
safety and risk assessments, 394, 395, 396
safety education, 226, 236, 240
screeners, 396
secondary levels of prevention, 394
secondary prevention, 61, 63, 64, 86, 93, 371, 372, 374, 375, 376, 377, 380, 381
self-harm, 283, 287
self-reporting, 386, 387, 388, 390
sex tourism, 15, 43, 50, 52
sex trafficking, 15, 30, 31, 50, 52, 160, 301, 303, 305, 309, 310, 311
sexual abuse, xviii, 4, 7, 12, 13, 14, 16, 19, 20, 21, 23, 24, 25, 27, 28, 29, 30, 32, 33, 34, 37, 41, 46, 50, 51, 98, 146, 157, 160, 163, 169, 219, 220, 221, 225, 227, 228, 229, 230, 231, 232, 233, 234, 235, 240, 241, 242, 243, 246, 250, 251, 254, 255, 256, 257, 259,261, 262, 263, 264, 265, 266, 269, 270, 271, 272, 274, 278, 279, 280, 281, 282, 284, 286, 292, 298, 300, 310, 337, 348, 349, 361, 373
sexual predators, 275
Shaken Baby Syndrome, 161, 166, 182, 195, 196, 197, 324, 325, 332
shaking, 14, 182, 183, 184, 188, 193, 194, 195, 196, 200, 316, 324, 348
sibling abuse, 267, 271, 272, 273, 274, 277, 281
smartphones, 129, 134
social determinants of health, 28, 141, 150, 340, 345, 347, 352, 353, 359, 361, 362, 364, 367, 368

Social Interventions Research and Evaluation Network, 141
social media, 7, 126, 127, 128, 130, 139, 143, 145, 148, 154, 159, 160, 162, 164, 311, 323, 329
social robots, 144, 151
social structural dimensions, 391
social values, 391
social welfare perspective, 391
Society of Professional Journalists Code of Ethics, the, 156
sport situational prevention approach (SSPA), 295, 296
sports participation, 285, 286, 287, 293
sports related, 285, 286
sports-related injury, 289, 292
standardized definitions, 84, 400
State v Kargar, 47, 56
Strengthening Families Initiative (SFI), 374
(step)father-daughter incest, 270
Strong Communities, 89
structural inequality, 391
substance abuse, 19, 20, 27, 30, 60, 61, 63, 64, 69, 72, 103, 107, 108, 157, 163, 176, 211, 232, 303, 304, 340, 342, 343, 346, 351, 361, 378, 387
Substance Abuse and Mental Health Services Administration (SAMHSA), 70, 72
Supplemental Nutritional Assistance Program, 67
Supreme Court of the United States, 41, 49, 52, 60
systemic overload, 397

T

targeted universalism, 82
technology, xvii, 6, 8, 50, 98, 125, 126, 127, 128, 129, 130, 131, 132, 134, 135, 136, 137, 138, 139, 140, 141, 143, 144, 146, 147, 148, 149, 150, 151, 166, 236, 306, 318, 330, 403
telemedicine, 30, 37, 127, 137, 138, 146, 150
teleradiology, 137
Temporary Assistance to Needy Families (TANF), 66, 71, 97
tertiary prevention, 61, 63, 64, 70, 85, 93, 349, 372
texting, 135, 145
Title IV-B, 61, 63, 64
Title IV-E, 61, 64, 71, 378, 383
training for coaches, 292
trauma survivors, 274, 277
trauma-focused cognitive-behavioral therapy, 137
trauma-informed care, 304
two-generation approach, 101, 102

U

U.S. Department of Health and Human Services (HHS), 33, 72, 88, 148, 168
United Nations Convention on the Rights of the Child (CRC), xvii, 9, 11, 12, 13, 32, 41, 42, 43, 44, 45, 46, 48, 50, 52, 53, 54, 55, 115, 126, 142
United Nations International Children's Emergency Fund (UNICEF), 43, 55, 148, 299
United Nations' Convention on the Rights of the Child, 42
United States v Clark, 51, 56
United States v Nagarwala, 47
United States v Park, 51, 56
universal basic resources, 394
Universal Declaration of Human Rights, 43, 45
universal prevention programming, 394
urgent care facilities, 392
US Advisory Board on Child Abuse and Neglect, 74, 81, 89, 170, 177, 317, 330
US Center for SafeSport, 286, 288, 293, 294, 295, 299, 300
US Centers for Disease Control and Prevention, 87, 91, 92, 199, 280, 301, 302
US Children's Bureau, 75
US Commission to Eliminate Child Abuse and Neglect Fatalities, 79, 315, 322
US Committee on the Assessment of Family Violence Interventions, 74, 83
US Department of Health and Human Services, 26, 31, 32, 33, 34, 35, 72, 88, 89, 98, 105, 109, 224, 242, 264, 298, 330, 387, 403
US National Child Death Review Case Reporting System, 23
US Office of Human Research Protections, 142

V

vaccination campaigns, 394
virtual reality, 127
voluntary reporting, 386, 387
voluntary services, 387

W

wearable devices, 130, 139
web platforms, 136
well-child checkups, 394
Women, Infants and Children (WIC), 67, 71, 106, 110, 349
workforce, 96, 101, 107, 108, 109, 110, 126, 127

World Health Organization (WHO), 12, 13, 32, 64, 70, 87, 117, 123, 200, 211, 218, 224, 302, 332

Y

Youth Today, 160, 166

When we think of child abuse, we imagine several different forms of harmful parenting and injuries to children. Most are not visible to the naked eye, but can be seen if you look more deeply. X-rays can detect fractures and other imaging can find internal injury and bleeding, but most maltreated children have more long-lasting harm that reveals itself through behavioral and emotional maladjustment, developmental delay, sadness, and other destructive behaviors later in childhood, adolescence and into adulthood. These injuries to their personality, sense of self, relationship to society and mental health change the trajectory of their lives and dim their potential, with social and financial costs for safety, treatment and their lost personal growth. We think of these as affecting everybody's children and that the responsibility lies with everyone to respond. This is why we put together this book: to address prevention from a number of perspectives and a variety of professions. We hope that it successfully brings together a number of disciplines and perspectives to address child abuse and neglect among the world's families, governments and cultures. We hope that those reading these chapters will realize that there are replicable best practices that can be reliably implemented based on child and family experiences and needs rather than single approaches designed to attack single forms of maltreatment, and we look forward to the day that books like these are not needed.

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