Introducing the Issue

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In 2007, the families of 1.86 million American children were investigated for child maltreatment, and 720,000 children—more than one in every hundred—were identified by state agencies as having been abused or neglected, most often by one of their parents. More than 1,500 children died as a result of maltreatment.[1] Not all children who are maltreated come to the attention of the child protection system (CPS) and not all child deaths caused by maltreatment are recorded as such. These high rates of maltreatment are a cause for grave concern. Maltreatment often has profound adverse effects on children's health and development. It can lead to permanent physical and mental impairments. A large body of research indicates that maltreated children are more likely than others to suffer later from depression, post-traumatic stress disorder, substance abuse, poor physical health, and criminal activity.[2]

After children have been identified by CPS as having been maltreated, their families are likely to enter the child welfare system, a complex web of social and legal services whose purpose is to ensure children's safety. The child welfare system in each state typically involves public agencies, such as departments of child and family services, which investigate reports of child maltreatment; private and not-for-profit organizations, which provide services to families; family courts, which make decisions about placing children into foster homes and terminating parental rights; and foster families and group homes, which are paid to care for children who are removed from their homes. The system is expensive. In 2007, state and local public child welfare agencies spent more than $25 billion for case management, administrative expenses, services to families and children, foster care, adoption services, and a variety of administrative and other services.[3] Taking into account the costs of hospitalization, mental health care, and law enforcement that stem directly from maltreatment, the total for direct expenses is $33 billion. Of this, a large share is spent on the approximately 500,000 children living in foster care.

In light of the toll that maltreatment takes on child well-being, as well as its high financial costs, the expert contributors to this volume explore the vexing question of how to prevent

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child abuse and neglect. Although several previous volumes of *The Future of Children* have addressed child maltreatment, none has focused explicitly on prevention. A 2004 volume examined best policies and practices in foster care. A 1998 volume considered how to protect children from abuse and neglect through improving the child protection system. Much of the material in both these volumes remains relevant today. But because both volumes examined primarily what happens to children and their families *after* the children are maltreated, neither explored how maltreatment might have been averted before it came to the attention of CPS.

Contributors to the current volume present the best available research on policies and programs designed to prevent maltreatment. They examine the gradual—and still partial—shift in the field of child maltreatment toward a "prevention perspective" and explore how insights into the risk factors for maltreatment can help target prevention efforts to the most vulnerable children and families. They assess whether a range of specific programs, such as community-wide interventions, parenting programs, home-visiting programs, treatment programs for parents with drug and alcohol problems, and school-based educational programs on sexual abuse, can prevent maltreatment. They also explore how CPS agencies, traditionally seen as protecting maltreated children from further abuse and neglect, might take a more active role in prevention.

Definitions: What Are We Trying to Prevent?

There is no single definition for child abuse and neglect. The federal Child Abuse Prevention and Treatment Act, as amended by the Keeping Children and Families Safe Act of 2003, sets a *minimum* standard for child abuse and neglect, which is "any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm."

Recently, the federal Centers for Disease Control and Prevention (CDC) highlighted the need for a set of uniform definitions. A CDC report issued in January 2008 offers five categories and definitions of maltreatment.[4] Physical abuse is "the intentional use of physical force against a child that results in, or has the potential to result in, physical injury." Sexual abuse is "any complete or attempted (non-completed) sexual act, sexual contact with, or exploitation (that is, noncontact sexual interaction) of a child by a caregiver." Psychological abuse is "intentional caregiver behavior … that conveys to a child that he/she is worthless, flawed, unloved, unwanted, endangered, or valued only in meeting another's needs." Neglect is "failure by a caregiver to meet a child's basic physical, emotional, medical/dental, or educational needs." Failure to supervise is the "failure by the caregiver to ensure a child's safety within and outside the home given the child's emotional and developmental needs."

While most state definitions are broadly consistent with the CDC definitions, state statutes vary widely in the details. States are free to set their own definitions of child abuse and neglect, provided they meet the federal minimum standard. For example, the definition of abuse used by New York requires that the child suffer or be at risk of suffering from death or physical injury.[5] Arkansas, by contrast, defines abuse in terms of specific actions, such as shaking a child or striking a child on the face or head, which need not result in serious injury.[6] States also vary widely in what they consider child neglect. As

noted in the article by Fred Wulczyn in this volume, such differences in how states define maltreatment, as well as in how they handle reports of maltreatment, make it hard to compare state maltreatment rates.

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Uniform definitions are important for reporting purposes. Accordingly, in reporting data to the National Child Abuse and Neglect Data System (NCANDS), states usually combine "failure to supervise" with neglect and often make "medical neglect" a category of its own. According to NCANDS data from 2007, 59.0 percent of maltreatment victims were neglected, 10.8 percent were physically abused, 7.6 percent were sexually abused, 4.2 percent experienced psychological maltreatment, and 13.1 percent of victims experienced multiple kinds of maltreatment.[7]

The concept of "maltreatment prevention" itself falls into three categories. Primary prevention aims to stop maltreatment before it can happen. Secondary prevention aims to prevent maltreated children from being abused or neglected again. Both forms of prevention make use of interventions such as parent education, mental health and substance abuse treatment programs for parents, and other family support services. Because preventing a recurrence of maltreatment requires first detecting maltreatment, secondary prevention also involves identifying and referring suspected cases of child maltreatment to CPS for investigation. Tertiary prevention aims to prevent or mitigate the damage to children that results from maltreatment.

In this volume, we focus on primary and, to a lesser extent, secondary prevention and thus on the interventions, such as parent education, common to both. We do not, however, explore how to improve the detection and reporting of maltreatment (which falls under secondary prevention). Nor do we consider tertiary prevention.

How Do We Know Which Interventions Are Effective?

Contributors to this volume review evidence on the effectiveness of numerous prevention programs, paying special attention to the quality of the evidence. Studies that assess prevention interventions rely on a diverse set of research methods, some of which produce more definitive evidence than others. The "gold standard" research method assigns participants randomly to treatment and control groups to test for the effects of interventions. But even randomized assessments of similar interventions can yield different results. For example, a randomized evaluation of the Nurse-Family Partnership program in Elmira, New York (examined in greater detail below), found that it reduced substantiated cases of child maltreatment, but evaluations of other home-visiting programs failed to find an impact on substantiated cases. These apparently contradictory results may be driven by differences in how programs were designed and implemented or differences in the families that were eligible for the intervention. For these reasons, it is important to understand the details of programs that appear to be most successful.

Researchers have conducted relatively few experimental evaluations of prevention programs. Many "quasi-experimental" evaluations, however, compare groups of children or families who have received an intervention with matched (but not randomly assigned) groups that have not. For example, one carefully conducted quasi-experimental study, based on the Chicago Longitudinal Study, compared children who had attended Chicago Child-Parent Centers (CPCs), which combined preschool education and family support services to low-income families.[8] This study concluded that children who had attended CPCs had significantly lower rates of maltreatment by age seventeen than similar children who had attended alternative full-day kindergarten programs. Although studies such as this are quite valuable, some caution is required in drawing inferences based on their results. The families that choose to participate in programs, and the communities that welcome participation in community-wide interventions, may be different from families or communities that do not choose to be involved.

The absence of uniform definitions for child abuse and neglect can also complicate assessing the efficacy of specific prevention programs or policies. A program that improves parenting skills, for example, would be said to prevent child maltreatment only if it shifted some parents over a threshold that demarcates "abusive" and "non-abusive" (or "neglectful" and "non-neglectful") behavior. But because these thresholds between maltreating and non-maltreating behavior are blurry and vary across states, it may be tempting for analysts to discard the focus on preventing maltreatment as measured by administrative records from CPS, and instead consider whether programs have broader beneficial effects on the well-being of children and families as measured by tests or interviews with parents or professionals. Indeed, many of the evaluations discussed in this volume do not directly measure maltreatment from CPS administrative records, but instead examine how programs influence parental reports of maltreatment or other behaviors, such as spanking, that are assumed to be positively associated with maltreatment risk. Parental reports of abusive or neglectful behaviors could be superior to administrative records because they may pick up instances of maltreatment that have not come to the attention of CPS. However, parental reports may be unreliable. Furthermore, preventing families and children from becoming involved in the child welfare system is itself an important policy goal. For these reasons, this volume places greater reliance on studies that examine how programs or policies influence the chance that a child will come to the attention of CPS.

What the Volume Tells Us

The volume opens with two articles that lay the groundwork for those that follow. The first discusses how the field of child maltreatment has come to realize the importance of a prevention approach that is driven by investments in families and children. The second examines the characteristics of children and families that are associated with an elevated risk of maltreatment and explains how those characteristics may be used to target prevention efforts. The following three articles scrutinize a variety of prevention programs—community-wide prevention efforts, parenting programs, and home-visiting programs—that often involve health care professionals, social workers, child care staff, or schoolteachers. The next two articles consider unique prevention issues: preventing abuse and neglect by parents with drug or alcohol problems and preventing sexual

abuse. The final article discusses the role the child protection system has so far played in prevention and how that role might change in the future.

The Prevention Perspective

Matthew Stagner and Jiffy Lansing, both of Chapin Hall at the University of Chicago, note that the child welfare system has historically been geared toward preventing further abuse and neglect of children who have already come to the attention of CPS. No one would argue that preventing the recurrence of maltreatment is unimportant. But primary prevention efforts offer the promise of reducing the number of children who need such protection and minimizing the costly services required to undo the damage done by maltreatment. Stagner and Lansing call for a new framework, with prevention efforts focusing on investments in children, families, and communities. They cite many possible approaches to prevention: parent education programs to improve the care children receive in their homes, support groups to reduce negative parenting behaviors, home-visiting programs to deliver services to vulnerable families, and community-based programs to orchestrate prevention services and build communities that support families.

But can the promise of primary prevention be realized? To answer that question, it is essential to know which prevention approaches are most effective and—because budgets are tight—to understand how best to reach the children and families at risk of maltreatment. Some prevention programs, such as media campaigns, are "universal" and directed to all families. Some interventions, such as home-visiting programs, are highly targeted to individual families at risk. Other programs fall along a continuum between the two extremes. Media campaigns, for example, can be targeted to neighborhoods in which maltreatment rates are high. Both targeted and universal programs can be worthwhile. Because universal programs spread spending widely across many families, the "treatment" any family receives will not be intensive. But the field of public health boasts highly successful universal programs, such as the "Back to Sleep" campaign to prevent Sudden Infant Death Syndrome.[9] Targeted programs, by contrast, treat fewer families in a more intensive (and, typically, more expensive) manner. As long as the programs are effective and reach the right families, however, the larger per-family investment of targeted programs may be worthwhile.

How Epidemiological Data Can Help Shape Prevention

Fred Wulczyn, also of Chapin Hall at the University of Chicago, presents and analyzes data on the incidence and distribution of child maltreatment and shows how such data can inform the design and implementation of prevention programs. He notes that the fraction of children identified as victims of maltreatment declined from the mid-1990s to the year 2000, but has since remained stable at approximately 12 per thousand children. The causes of the decline remain in doubt, although reductions in teen childbearing, in crack cocaine and other drug use, and in child poverty are all possible explanations. Nonetheless, rates of maltreatment remain high by historical standards.

Wulczyn identifies a number of risk factors for maltreatment. The first is a child's age. In 2000, for example, the victimization rate for infants (under age one) was 16 per thousand children, higher than the rate for children of any other age. The second-highest rate, that for one-year-olds, was less than half that for infants. Wulczyn also presents evidence that

poverty and race are risk factors for maltreatment, with poor children having markedly higher rates of maltreatment than non-poor children and black children having higher rates than white children. Although there is no simple explanation for racial differences in maltreatment rates, the evidence suggests that black children have higher rates in part because of the interweave between poverty and race. Children in families with substance abuse problems are also at a sharply elevated risk of having maltreatment cases substantiated and are also more likely to be placed in foster care than other maltreatment victims. Overall, these findings suggest that prevention efforts may be best targeted toward families with infants living in impoverished communities, especially if the parents have substance abuse problems.

Community-Wide Prevention Programs

Noting that maltreatment rates vary sharply across communities, Deborah Daro, of Chapin Hall at the University of Chicago, and Kenneth Dodge, of Duke University, examine community-wide interventions to prevent maltreatment in high-risk communities. The two key goals of such interventions are to foster community-wide norms of positive parenting and to coordinate the patchwork of individualized family services in most communities. Although few such interventions have undergone rigorous evaluation, a few carefully evaluated programs show promise.

The Triple P–Positive Parenting Program has perhaps the best evidence of actually preventing maltreatment. It combines universal and targeted elements, ranging from media campaigns, to appointments with individual parents in easy-to-access settings such as preschools and physicians' offices, to formal group parenting seminars and individualized behavioral interventions. To better integrate services, the Triple P model offers training to local service providers. Triple P is the only intervention identified by Daro and Dodge that assigns communities randomly to its program, thus permitting a rigorous evaluation of its effects. In addition, some non-experimental research concluded that Triple P communities had lower rates of victimization, out-of-home placements, and hospital admissions for injuries than did matched comparison communities.

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Parenting Programs

In addition to being key to community-wide interventions, parenting programs are also offered as "stand-alone" services to families that maltreat their children or are at high risk of doing so. Richard Barth, of the University of Maryland, highlights the many forms that parenting education can take, from residential programs for parents struggling with substance abuse and mental illness, to programs designed to reduce child conduct problems (which may place children at risk of maltreatment), to parent support groups, parent-child therapy, and home-visiting programs. Although some of these interventions are known to be effective in reducing child conduct problems,

few have been rigorously evaluated for effectiveness in reducing child abuse.

Because parenting programs take so many forms, Barth emphasizes the need to identify the elements that make some programs more effective than others. Characteristics of successful programs include high-intensity treatment, well-trained staff, a practical focus on specific parenting skills, and the ability to engage and motivate parents at high risk of maltreating their children. Finally, Barth stresses the need for multiple types of services that parents can access through multiple referral routes. Evaluating the effectiveness of these programs is essential, says Barth, but the programs that are studied must, first, be designed to be responsive to the ages and problems of the children and families and not one-size-fits-all.

Home-Visiting Interventions

One highly popular strategy for delivering a range of family services is home visiting. Most home-visiting programs do not focus exclusively on preventing abuse and neglect; some do not even include maltreatment prevention as a goal. Nevertheless, such programs offer services, such as social support, referrals to community resources, parenting "coaching," health information, and educational materials, that may help prevent maltreatment.

Mindful that the youngest children are at highest risk for maltreatment, Kimberly Howard and Jeanne Brooks-Gunn, of Columbia University, assess the effects of home-visiting programs geared to infants and young children in preventing maltreatment. They review randomized evaluations of nine programs, offered in thirteen sites, which include different design elements and target different populations of children. The evaluations did not all assess the same family outcomes. Only five sites (covering four programs) tracked whether families in the treatment groups were less likely to experience substantiated child abuse and neglect; only five sites (three programs) collected parent reports of abuse and neglect. Evaluations were more likely to assess changes in parenting responsivity and sensitivity, depression, and parenting stress, all of which are, however, linked with how parents treat children.

Overall, the evaluations provide little evidence that home-visiting programs reduce maltreatment as measured by substantiated cases of child abuse and neglect. Only one study—of the Nurse-Family Partnership (NFP) trial in Elmira, New York—showed that families in the treatment group were less likely to experience maltreatment. By contrast, evaluations of Hawaii Healthy Start, Healthy Families America (in two sites), and Early Start indicated that home visiting did not prevent maltreatment under the substantiated cases definition.

Despite sparse evidence that home visiting reduced substantiated cases of child abuse and neglect, some programs resulted in fewer parental reports of maltreatment, and more programs resulted in more sensitive and less harsh parenting, as well as improved home environments. The studies yielded mixed findings on child health and safety, the quality of the home environment, depression and parenting stress, and child cognition.

Overall, these findings paint a somewhat disappointing picture of the value of home-visiting programs in preventing child abuse and neglect. It does not follow, however, that the programs are of no value. Indeed, as noted, many set out not to reduce maltreatment, but to improve parenting skills, encourage healthy child development, and

help families attain economic self-sufficiency. The research does suggest that home-visiting programs are more effective at preventing maltreatment among low-income teenage mothers than among other groups. One program—the Nurse-Family Partnership—delayed second births among teenage mothers, an outcome that could protect the first child, as well as reduce maltreatment overall by lowering the number of at-risk younger siblings born to teen mothers. The evidence also indicates that more intensive programs are more effective. Taking these findings together, it may make sense to invest in intensive home-visiting programs for high-risk groups such as first-time teen mothers, rather than providing less intensive programs to a wider array of families.

Maltreatment and Parental Substance Abuse

Noting that parental abuse of alcohol and other drugs is linked with elevated rates of child abuse and neglect, Mark Testa, of the University of Illinois–Urbana-Champaign, and Brenda Smith, of the University of Alabama, examine how maltreatment can be prevented in substance-abusing families. Testa and Smith stress that parents who abuse drugs and alcohol usually face other problems, such as mental illness, poverty, and domestic violence. The co-occurrence of those multiple problems not only complicates the task of discerning whether it is substance abuse itself, or the accompanying conditions, that heightens the risk of child maltreatment, but also underscores the need to provide such parents with services that extend beyond treatment for substance abuse. As Barth notes in his article, substance abuse treatment rarely includes a parenting component.

Few high-quality studies examine whether substance abuse treatment is effective in reducing child maltreatment. Testa and Smith, however, discuss promising evidence from a program that assigned substance-abusing families (whose children had been removed) to "recovery coaches," who focused on removing barriers to drug treatment and helping parents stay in treatment. The program raised slightly the reunification rates of parents and children and lowered substantially the chance that parents subsequently gave birth to substance-exposed infants.

Active debate continues over whether newborns who test positive for intrauterine substance exposure should be removed from their families and, if so, under what conditions they should be returned. In Illinois—one of several states that treats intrauterine exposure to illegal drugs as evidence of maltreatment—approximately 50 percent of substance-exposed infants are removed to foster care, and rates of reunification are low. Reunification often hinges on completion of drug treatment programs leading to complete abstinence from drugs. It is unclear, however, whether abstinence should be used as a litmus test for reunification. Testa and Smith suggest that reunification could take place after parents have engaged in drug treatment, rather than after they stop using drugs altogether.

Child Sexual Abuse

David Finkelhor, of the University of New Hampshire, examines two quite different strategies for preventing child sexual abuse. The first, offender management, aims to keep sexual predators away from children by means of offender registration systems, background checks for employment or volunteer work, community notification, restrictions on where sex offenders can reside, and lengthy prison sentences. The second strategy, education, teaches children how they themselves can reduce their chances of being victimized.

Offender management strategies offer little robust evidence that they are effective. One flaw in programs that aim to fence sex offenders off from children is that most sexual abuse is perpetrated not by strangers, but by family members or family acquaintances. Offender management policies also rest on the mistaken stereotype that most sex offenders are incorrigible recidivists, and thus fail to allocate scarce management resources strategically. Finkelhor thinks more use of promising tools to distinguish high-risk offenders from low-risk offenders would improve offender management programs. In addition, based on the assumption that getting caught is a strong deterrent to future offending, he urges enhanced efforts to detect and arrest previously undetected offenders.

The second strategy to reduce sexual abuse and its consequences is to teach children how to identify situations where sexual abuse could occur, how to refuse sexual advances or break off physical contact at an early stage, and how to summon help from nearby adults once inappropriate contact has begun or appears imminent. Education programs, although lacking true experimental evidence, do have some promising empirical support. Children are able to learn these techniques, and children who participate in the programs show less evidence of self-blame than nonparticipants if they are subsequently sexually abused. Children who participate in these programs are also more likely to exhibit self-protective behaviors in simulated situations. As Finkelhor points out, learning protective behaviors and using them in simulated situations is not the same as being able to avoid sexual abuse, but the strategies used in education programs to prevent sexual abuse do parallel those that have shown success in clinical trials in other prevention efforts such as in bullying and dating violence.

Prevention and the Child Protection System

Like Stagner and Lansing, Jane Waldfogel, of Columbia University, notes that the child protection system's traditional focus on investigating reports and dealing with substantiated cases of maltreatment has been broadened in recent years to include prevention. Using national data on the progression of maltreatment cases from reports of suspected cases, to investigations of reports, to handling of both substantiated and unsubstantiated cases, Waldfogel shows that CPS agencies could expand their role in prevention through services to families whose cases are unsubstantiated. Such services include individual and family counseling, respite care, parenting education, home visiting, housing assistance, substance abuse treatment, and day care. These same services, of course, are also given to families with substantiated cases of abuse. There is little evidence, however, that the services are effective. In 2005, for example, 6.6 percent of open CPS cases had new incidents of substantiated cases of maltreatment within six months of being opened—a disturbingly high number when one considers that these are the cases that have come to the attention of the CPS professionals.

Implications

The articles in this volume have a host of implications, many supported by good evidence, for the field of child maltreatment prevention. Most researchers and CPS workers believe that prevention holds the key to reducing child maltreatment in the United States and to bringing down its well-documented long-term costs, both human and financial.

One implication that cuts across the articles is the importance of accurate risk assessment. The classic approach to prevention is to

identify those who are at risk for a condition and then to intervene to prevent them from getting an acute case of that condition. Risk assessment is never perfect. Experience and evidence both show that risk factors that can predict a given condition also identify many people who never get the condition; in addition, many people who are not at risk can nonetheless wind up with the condition. In the case of child maltreatment, for example, Wulczyn shows convincingly that infants are far more likely to be maltreated than children of any other age. Yet the overwhelming majority of infants are never maltreated, and many children are maltreated who are not infants. Adopting a preventive intervention and applying it to all infants would mean investing resources in many families that do not need the intervention and missing some that do.

The hope of developing an epidemiological profile that reveals precisely which families need intervention is a chimera. Nonetheless, it is possible to identify the types of families most at risk as well as the communities where large shares of such families live. In his article Wulczyn identifies four risk factors that are consistently correlated with maltreatment—the child's age, race, poverty, and parental drug involvement. Another risk factor is single parenting. These five factors interact in complex ways, but children who are characterized by all five are at far higher risk for maltreatment than children who have only one. As we discuss below, children whose families have been referred to CPS but whose cases have not been substantiated are also at higher risk, as are children from impoverished neighborhoods. None of these factors can perfectly identify children at risk for maltreatment, but they can be used to guide the targeting of interventions.

Though it is possible to identify families and communities at elevated risk for child maltreatment, the nation's child welfare system does not have adequate resources to provide prevention programs for the families and communities most at risk. Every day parents at risk bring their babies home from the hospital without any formal guidance on child rearing or information on where to turn if they have problems. Instead of taking a more prevention-oriented approach to child maltreatment, states across the nation have enacted mandatory reporting laws that require professionals who come into contact with children to report all instances of suspected abuse or neglect. Every community has a reporting system that both professionals and other concerned citizens must or can use to report abuse. But the reporting system itself, vital though it may be, is largely incapable of primary prevention because it is based on evidence that abuse or neglect has already occurred.

Even so, advocates of primary prevention would do well to attend carefully to the current system for handling maltreatment reports and deciding which families need services or need even to have their children placed in out-of-home care to prevent further maltreatment. In her article, Waldfogel provides a comprehensive flow chart that details what happens after a maltreatment report is filed. Indeed, that flow chart provides a broad representation of how the child protection system works. Of the 6 million reports to CPS in 2006, 3.5 million (60 percent) were screened into the system as being at least plausible instances of maltreatment that required investigation. Of the 3.5 million cases that were investigated, 1 million (30 percent) were substantiated as maltreatment. About 600,000 of these 1 million cases were opened for services and 220,000 (37

percent of the open cases) were judged to be so serious that the child was removed from the home. Surprisingly, of the 2.5 million cases that were not substantiated, 750,000 were nonetheless opened for services and in 100,000 (13 percent) of these the child was placed in out-of-home care.

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We draw two lessons for prevention from this summary of how CPS functions. The first, to which we return below, is that communities with large numbers of maltreatment reports or of screened-in or substantiated cases are prime targets for community-wide prevention. It is a good bet that communities with disproportionately high levels of maltreatment under any of these measures (reports, substantiated reports, family taken into the child protection system for services, child removal, termination of parental rights) would also be communities likely to have the epidemiological characteristics identified by Wulczyn as predictive of abuse and neglect. A second lesson is that the progression of cases suggests a need for preventing cases at each level of Waldfogel's flow chart from progressing to the next level. Along with Stagner and Lansing, we define primary prevention as providing help to at-risk families before maltreatment occurs. Under the Waldfogel schema, reported cases that were not screened in and screened-in cases that were not substantiated could be considered prime cases for some type of action that, under our definition, would be primary prevention.

The 30 percent of unsubstantiated cases that are nonetheless opened for services by CPS constitute a special type of prevention. Even though the reported maltreatment was not formally substantiated, something about the cases—perhaps having previous reports or substantiated cases on the same family—convinced investigators that a problem existed and that something should be done to help the family. Whether we call these cases primary prevention matters less than recognizing that children from these families are likely to be at elevated risk and that public funds should be invested to prevent maltreatment (or additional maltreatment).

The risk to the families reported to CPS is even greater if a parent is addicted to drugs or alcohol. Although estimates vary widely, perhaps as many as half (some estimates are even higher) of all parents who have committed substantiated child maltreatment are addicted. Many policy makers seem to believe that placing these parents in drug treatment programs would be an effective strategy for preventing abuse. But as Testa and Smith demonstrate, that approach has three flaws. First, most drug treatment programs are not effective. Second, even effective programs tend to require many years of treatment and follow-up before the addiction is broken, raising the question of what happens to the children of program participants in the meantime. Third, and most important, because

addiction is almost always accompanied by problems such as mental illness, homelessness, or domestic violence—all of which are also correlated with maltreatment—drug treatment alone is not enough. Effective treatment requires progress on all fronts.

Two recommendations by Testa and Smith carry important implications for prevention. First, addictions alone are not a sufficient reason for removing children from their homes. As shown by a host of studies, being in the child protection system itself is a risk factor both for further maltreatment and for many years of shuffling back and forth between the homes of strangers.[10] Every unnecessary removal of a child from home is a threat to the child's well-being, exactly the opposite of the outcome that prevention programs are designed to promote. Second, CPS agencies should require drug-addicted parents with substantiated maltreatment reports to enroll in drug treatment within a few months and allow them up to eighteen months to show progress in all problem areas, including addiction. In the absence of measurable signs of progress on every front, it makes sense to implement a permanency plan for the child that involves placement with relatives or in an adoptive home. This is a worthwhile prevention proposal, although allowing a year rather than eighteen months for parents to show measurable progress might be even better.

A family's neighborhood can also be a risk, or a protective, factor for child maltreatment. The availability of parks and other recreational facilities; the proximity, number, and quality of facilities that provide education, child care, mental health counseling, medical treatment, and other services; and the existence of positive social relationships among neighborhood residents all have been shown to influence the frequency of child maltreatment within communities. And as evidence has mounted that the physical and social characteristics of communities can affect the incidence of child maltreatment, researchers and practitioners have begun to design interventions to influence community characteristics in such a way as to prevent child maltreatment.

According to Daro and Dodge, however, only one program—Triple P–Positive Parenting Program—provides solid evidence that community-wide initiatives can prevent child abuse. The program consists of five levels of intervention. The most general level, which can reach nearly everyone in the community, is a media-based campaign that teaches the basics of positive parenting, including the major Triple P message: how to promote child safety, manage child behavior, use effective discipline, and ensure basic health care. This parenting message is communicated through relatively low-cost newspaper articles, newsletters, mass mailings, presentations at community forums, and a community website. Triple P reserves the more intensive, and expensive, treatments for progressively smaller groups of families that are at progressively greater risk for maltreatment. The final and most intensive level is individual family treatment, which, like all other levels, is organized around the Triple P positive parenting message. Triple P has its own tested family treatment program, but other programs or effective elements of several programs to help individual families could also be used.

It might, for example, be possible to integrate any of several home-visiting programs into a Triple-P type of graduated approach to prevention. Cost considerations seem certain to dictate that all community-wide programs use a multi-stage approach like Triple P. The

success of a Triple P-like program hinges in large part on the success of the intensive family intervention reserved for the highest-risk parents. As noted, one widely used family intervention is home visiting, whereby trained professionals visit parents in their homes and administer a standard program that can range in intensity from one visit to multiple visits over months or even years. Although Howard and Brooks-Gunn were unable to find consistent evidence that the nine home-visiting programs they examined reduced the substantiated incidence of child maltreatment, some of the programs had positive effects in areas of family life related to child abuse risk. For example, at least two (and often more) programs reduced parent reports of abuse, increased child health and safety, improved the child's home environment, increased parent responsivity and sensitivity to the child, reduced harshness, reduced parent stress or depression, and improved child cognition. Thus, the programs may affect the incidence of maltreatment even though the effects are difficult to document. Howard and Brooks-Gunn conclude that the programs would be most likely to reduce child maltreatment if service providers were to follow faithfully and completely the protocols of the various programs, employ well-trained staff, and evaluate their programs' outcomes continuously. For the field of child maltreatment prevention, then, the conclusion is that carefully implemented programs delivered to parents in their homes may have a role to play in preventing child maltreatment, though the evidence is equivocal.

The evidence on preventing sexual abuse is only somewhat less equivocal. Surprisingly, the offender management strategies that have attracted considerable media attention and widespread public support offer little to no evidence of effectiveness. As David Finkelhor shows, it is simply not known whether registering sex offenders, notifying communities when offenders move in, controlling where convicted offenders can live, and imposing longer prison sentences reduce sexual offending. Based on research and experience with sexual abusers, it seems unlikely that these strategies will ever work. As Finkelhor explains, they are based largely on mistaken stereotypes and unfounded assumptions about sex abusers. Not least, offender management interventions focus on previous offenders, when most known acts of sexual abuse are committed by offenders with no previous record of abuse. Thus, even if previous offenders are supervised or rehabilitated, the nation will still face a serious sexual abuse problem because of the frequency of new offenses.

Given the lack of evidence that offender management efforts are effective, it is fortunate that schools, religious groups, and youth-serving organizations are now operating programs that teach children what to do in situations of potential abuse, how to stop potential offenders, and how to find help. Such programs also teach children not to blame themselves if they are victimized, a tertiary prevention strategy aimed to head off emotional problems often triggered by abuse. Research provides modest evidence that these courses can successfully impart to children, even preschool children, the necessary concepts and skills without increasing children's anxiety. Although there are no well-designed studies providing evidence that these programs prevent sexual abuse, there is reason to believe that they might, and they do provide evidence of other beneficial effects, such as increased disclosure and less self-blame following abuse. Expanding these programs may be justified.

A final possibility for preventing abuse and, especially, neglect that was not directly examined by any of the articles is lower birth rates for young unmarried women who are at increased risk for committing abuse or neglect. A recent careful study by Robert George, Allen Harden, and Bong Lee at the University of Chicago showed that young teen mothers in Illinois were more than twice as likely as other mothers to have their children removed and placed in foster care during the first five years after birth.[11] Extrapolating from this finding, Saul Hoffman has estimated that preventing these births would save about $2.3 billion in public funds and would reduce the foster care caseload by 58,000 cases.[12] Prevention among this high-risk group could take the form of discouraging first births to teens and encouraging delays in childbearing by teens after a first birth. Strong evidence from many random-assignment programs indicates that teen births can be delayed.[13] Similarly, home-visiting programs have been effective at reducing second births to young mothers. Evidence from both types of programs suggests that preventing births to mothers at high risk for having children who are maltreated may be a promising strategy. It should, however, be stressed that the evidence that reducing teen births will reduce maltreatment is, at this point, only suggestive. Rigorous evaluations, such as those that have been conducted for home-visiting programs, would be worthwhile.

Where We Go from Here

Waldfogel's article paints a somewhat dismal picture of the state of efforts to prevent child abuse and neglect in the United States. Although it is difficult to compute total U.S. spending on prevention programs, it appears that the sum of federal, state, and local outlays on primary prevention is small relative to the total spent on secondary and tertiary prevention. In addition, relatively few prevention programs have been rigorously evaluated. Yet the evidence reviewed in this volume suggests several promising strategies to prevent child abuse and neglect. Two steps are now in order. The first is to redouble efforts to collect evidence on program effectiveness. Focusing on collecting evidence does not mean putting prevention efforts on hold until more is known about "what works." Rather, it means constructing programs in ways that make it possible to evaluate rigorously their effects. The second step is to fund prevention programs. As Waldfogel notes, prevention efforts have increased in recent years, in part because of changes in the Child Abuse Prevention and Treatment Act when it was reauthorized in 2003. More generally, policy makers have shown increased interest in strengthening early childhood programs by expanding home-visiting programs and improving the quality of child care. These initiatives, if properly designed and targeted, could well help prevent child abuse and neglect.

Endnotes

1. U.S. Department of Health and Human Services, Administration on Children, Youth, and Families, *Child Maltreatment 2007* (Washington: U.S. Government Printing Office, 2009). The figures for investigations come from appendix table 2.4 and exclude Maryland and Michigan because of a lack of data. The figures for victimizations come from appendix table 3.1 and also exclude Maryland and Michigan. The number of fatalities is from table 4.1. The states of Maryland, Massachusetts, Michigan, and North Carolina are not included in the count of fatalities.

2. Studies on the short-term and long-term consequences of maltreatment are reviewed in the first article of this volume. See also Jack P. Shonkoff, W. Thomas Boyce, and Bruce S. McEwen, "Neuroscience, Molecular Biology, and the Childhood Roots of Health Disparities: Building a New Framework for Health Promotion and Disease Prevention," *Journal of the American Medical Association* 301, no. 21 (2009): 2252–59.

3. Cynthia Scarcella and others, *The Cost of Protecting Vulnerable Children,* vol. V: *Understanding State Variation in Child Welfare Funding* (Washington: Urban Institute, 2006); Ching-Tung Wang and John Holton, "Total Estimated Cost of Child Abuse and Neglect in the United States" (Chicago: Prevent Child Abuse America, September 2007).

4. R. T. Leeb and others, *Child Maltreatment Surveillance: Uniform Definitions for Public Health and Recommended Data Elements,* Version 1.0 (Atlanta: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2008).

5. The specific language in the statute is "death, serious or protracted disfigurement, protracted impairment of physical or emotional health, or protracted loss or impairment of the function of any bodily organ." Soc. Serv. Law § 371.

6. Ann. Code § 12-12-503.

7. U.S. Department of Health and Human Services, *Child Maltreatment 2007* (see note 1).

8. A. J. Reynolds and D. L. Robertson, "School-Based Early Intervention and Later Child Maltreatment in the Chicago Longitudinal Study," *Child Development* 74, no. 1 (2003): 3–26.

9. National Institute of Child Health and Human Development, "SIDS: 'Back to Sleep' Campaign," see www.nichd.nih.gov/sids.

10. Joseph J. Doyle Jr., "Child Protection and Child Outcomes: Measuring the Effects of Foster Care," *American Economic Review,* forthcoming.

11. R. M. George, A. W. Harden, and B. J. Lee, "Effects of Early Childbearing on Child Maltreatment and Placement in Foster Care," in *Kids Having Kids: Revised Edition,* edited by R. Maynard and S. Hoffman (Washington: Urban Institute, 2008).

12. Saul D. Hoffman, *By the Numbers: The Public Costs of Teen Childbearing* (Washington: National Campaign to Prevent Teen and Unplanned Pregnancy, October 2006).

13. Douglas Kirby, *Emerging Answers 2007: New Research Findings on Programs to Reduce Teen Pregnancy* (Washington: National Campaign to Prevent Teen and Unplanned Pregnancy, 2007).