

Prevention of Child Abuse and Neglect:

Best Practices

Prepared for

Statewide Prevention Plan

Prevent Child Abuse Nebraska

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The prevention of child abuse and neglect is a laudable task – one that few would argue against. Successful strategies to prevent child abuse are surprisingly elusive and complex. Regardless of the hard work of so many, our current knowledge does not point us to any one method or approach that works to prevent child abuse with all populations, in all places, at all times. Each family is unique, and has its own constellation of strengths and weaknesses. The different types of abuse and neglect (i.e. neglect, physical abuse, sexual abuse) demand different approaches. The many risk factors overlap each other, and are often worthy of amelioration themselves. Different theoretical and human behavioral perspectives also lead us down different paths when working to prevent such a tragedy as child maltreatment.

Therefore, we must keep sight of the fact that there are indeed many different paths, and that no one path will always be the “right” one. Nevertheless, we must not become overwhelmed or spend our time wringing our hands in dismay. The children are waiting for us to stand up for them. While families at risk are not likely to outrightly ask for help, they will accept it when it is made available to them, when barriers are minimized, and when their self-determination is maximized.

This report seeks to review “best practices” in the prevention of child abuse and neglect, with an eye toward application in the State of Nebraska. After a summary of the levels of prevention, this report will review four governmental reports (meta-analyses) on child abuse prevention. This report then summarizes three home visitation models: Healthy Families America, Nurse Family Partnership, and Parent Aide (National Exchange Club Foundation). This report concludes with a summary and list of recommendations.

Levels of Prevention

Prevention efforts are diverse as they are numerous. Some are far-reaching, such as a media campaign to educate the general public on Shaken Baby Syndrome. Other prevention efforts are specific, such as a home-visiting program that uses lay visitors to visit at-risk families. Prevention can be conceptualized on a continuum from broad to specific (Browne, Hanks, Stratton, & Hamilton, 2002; Goldman, Salus, Wolcott, & Kennedy, 2003; Willis, Holden, & Rosenberg, 1992). Provided below is a brief description of each of these levels of prevention (see Figure 1).

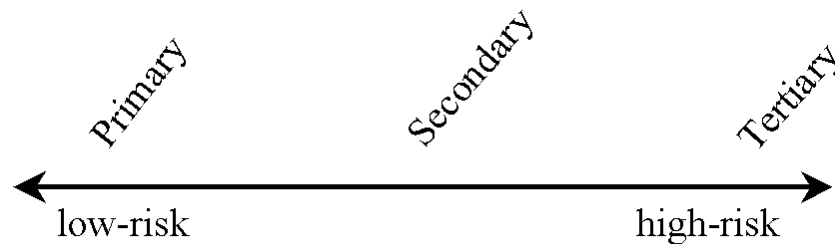


Figure 1 Levels of Prevention

Primary Prevention

Primary prevention services are offered to any family, regardless of risk level. They are designed to reduce the incidence or rate of occurrence of new cases (Willis, Holden, & Rosenberg, 1992). They include broadly conceived parenting education and universal programs that make prenatal care available to all pregnant women. Primary prevention includes universal services and prevention directed at the macro/community level.

Universal services are a form of primary prevention. When services are provided *universally*, clear parameters are set and all clients within those parameters are targeted, regardless of risk level. Parameters are most often defined geographically, or agency-wide. For

example, universal home-visiting services for the prevention of child abuse and neglect may be delivered to all mothers giving birth at a specific hospital/clinic, during a certain period of time.

Prevention services can also be directed at the community level. An example of child abuse and neglect prevention at the macro/community level includes the usage of media (TV, newspaper, radio, etc.) to educate about the difference between physical abuse and discipline.

Secondary Prevention

In secondary prevention efforts, a certain population of clients is targeted because of its perceived risk level. The goal is to reduce the overall prevalence of a disorder (Willis, Holden, & Rosenberg, 1992). In the work of preventing child abuse and neglect, service providers predetermine specific parameters that place a certain client group at higher risk for child maltreatment. The at-risk client group is then targeted for services. Most often, programs are deemed to be secondary prevention if they target families who are at-risk for abuse, but do not have known involvement with Child Protective Services.

Tertiary Prevention

Prevention services for child abuse and neglect at the tertiary level are targeted at client groups who have already been identified as having maltreated their children, as defined by their involvement with Child Protective Services. Most often in the area of child abuse and neglect, tertiary prevention services are targeted at parents who have been reported for child abuse and/or neglect, and have had their cases substantiated. Sometimes hard to distinguish from treatment, intervention is targeted at preventing further incidences of abuse and neglect.

Many times it is difficult or prohibitive to determine accurately whether a family has had involvement with Child Protective Services, and if so, if the abuse was substantiated. Given the stigmatization of the abuse or neglect label, many child abuse and neglect prevention programs

target clients at both the secondary and tertiary levels. In other words, families are served that are at-risk for child abuse and neglect, and/or have had substantiated case(s) of child maltreatment.

Governmental Reports on Child Abuse Prevention

The U.S. Government has sponsored a number of meta-analyses of research on effective models to prevent child abuse (see Table 1). Each of these reports will be discussed in turn below.

Table 1: Governmental Reports on Child Abuse Prevention

	Authors/Editors	Governmental Body(s)	Name of Report
1	Goldman, Salus, Wolcott, and Kennedy (2003)	U.S. Department of Health and Human Services, Office on Child Abuse and Neglect	A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice
2	Hahn, Bilukha, Crosby, Fullilove, Liberman, Moscicki, et al. (2003)	Centers for Disease Control and Prevention (CDC), the Department of Health and Human Services (DHHS), the Task Force on Community Preventive Services	First Reports Evaluating the Effectiveness of Strategies for Preventing Violence: Early Childhood Home Visitation
3	Layzer, Goodson, Bernstein & Price (2001)	U.S. Department of Health and Human Services, Administration for Children, Youth, and Families	National Evaluation of Family Support Programs - Final Report, Volume A: The Meta-Analysis
4	--	U.S. Department of Human Services, Children's Bureau, Office on Child Abuse and Neglect:	Emerging Practices in the Prevention of Child Abuse and Neglect

Report #1: A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice

Goldman, Salus, Wolcott, and Kennedy (2003) provided a report for the U.S. Department of Health and Human Services, Office on Child Abuse and Neglect, entitled: "A Coordinated

Response to Child Abuse and Neglect: The Foundation for Practice.” This report lists four major prevention program models:

- Public awareness activities – Public Service Announcements (PSAs), posters, kits and brochures, and documentaries.
- Parent education programs – focus on enhancing parental competencies and promoting healthy parenting practices, typically target teen parents and highly stressed parents.
- Skills-based curricula for children – teach children safety and protection skills; usually prevention of sexual abuse.
- Home visitation programs – focus on positive parenting practices (nonviolent discipline), child development, maternal and child health, accessing social services, establishing social support, advocating, and prevention of accidental childhood injuries through development of a safe home environment (Goldman, Salus, Wolcott, & Kennedy, 2003).

Report #2: Evaluating the Effectiveness of Strategies for Preventing Violence: Early Childhood Home Visitation

With support of the Centers for Disease Control and Prevention (CDC), and the Department of Health and Human Services (DHHS), the Task Force on Community Preventive Services was formed to assess the effectiveness of home visitation programs in preventing violence. After examining 22 studies that evaluated effects of early childhood home visitation on child maltreatment, the Task Force recommended early childhood home visitation for the prevention of child abuse and neglect (Hahn, Bilukha, Crosby, Fullilove, Liberman, Moscicki, et al., 2003).

The recommendations that emerged from this report included the following. “In selecting and implementing interventions, communities should carefully assess the need for such

programs . . . and clearly define the target populations Target populations included teenage parents; single mothers; families of low socioeconomic status; families with very low birth weight infants; parents previously investigated for child maltreatment; and parents with alcohol, drug, or mental health problems” (Hahn, et al., 2003, p. 7). In addition, this report suggests that policy makers should carefully consider the attributes and characteristics of the particular program to be chosen for implementation. “Given the heterogeneity of home visitation programs in the United States, which differ in focus, curricula, duration, visitor qualifications, and target populations, no single optimal, effective, and cost-effective approach could be defined for the multiplicity of possible outcomes, settings, and target populations. However, the robust findings across a spectrum of program characteristics increase confidence that these programs can be effective in a range of circumstances and reduce concern that effectiveness hinges on particular characteristics of one intervention or one context” (Hahn, et al., 2003, p. 8).

Report #3: National Evaluation of Family Support Programs - Final Report, Volume A: The Meta-Analysis

Child abuse prevention is a major goal of most family support programs. At the request of the U.S. Department of Health and Human Services, Administration for Children, Youth, and Families, Layzer, Goodson, Bernstein & Price (2001) conducted a meta-analysis of 260 family support programs around the U.S. This report described family support programs as working primarily with parents, perceiving them as the agents of positive outcomes for children.

Services at family support programs typically included parenting education, social support, and case management services, counseling and/or referral to services. Some or all of these services were delivered in the home for over 60% of the programs, with nearly 50% of services being provided through center-based classes or groups. About half of programs sought

to provide social support through parent groups, and about half provided case management to improve access to community services (Layzer, et al., 2001).

Half of family support programs were often targeted for families with children under the age of 3 years; nearly 25% of programs targeted teen parents. Lengths of services offered varied remarkably, with nearly half of them offering services for 6 months or less – average length of time services were provided, however, was 15 months. Nearly all programs provided some form of parenting education (Layzer, et al., 2001).

The conclusions of this large study were threefold:

1. Family support services produce small but significant effects across a range of outcomes for parents and children. (Child outcomes included: cognitive development and school performance, social and emotional development, health, and safety (injury, abuse, neglect). Parent outcomes included parent attitudes and knowledge, parenting behavior, family functioning; parental mental health and health risk behaviors; and economic well-being.)
2. There is no single effective program model.
3. The effects of family support are not evenly distributed across different program models and service strategies (Layzer, et al., 2001).

Overall, this report stated that, “Larger effects on child safety outcomes are associated with programs that work with families of younger children (less than 3 years of age), with programs that provide case management services, with programs that provide parent-child activities, and with programs that work with teenage parents” (Layzer, et al., 2001, p. A5-42).

The authors of this report warns against the blanket *assumption* that parenting education is effective, and that non-targeted services are effective.

In addition, these authors suggest that:

- Family support services are effective in promoting children's cognitive development and school readiness only if they provide services directly to children.
- Family support services are effective with some important and vulnerable populations.

The authors state that a focus “on teenage mothers with very young children, families that contain a child with special needs or families that have a child with behavior problems, all had strong positive effects on parents, on children or on both.” These authors encouraged the provision of focused services to specific populations, not to use paraprofessionals to deliver services, and not to use home visiting as a service delivery strategy (Layzer, et al., 2001, p. A5-43).

Report #4: Emerging Practices in the Prevention of Child Abuse and Neglect

The U.S. Department of Human Services, Children's Bureau, Office on Child Abuse and Neglect launched a Child Abuse Prevention Initiative to promote greater visibility for child abuse prevention activities in 2003-2004. The *Emerging Practices in the Prevention of Child Abuse and Neglect* project was one important component of this Initiative. In this report, Leventhal (1997) suggested nine factors that are necessary for successful home-based services. They include: “early intervention, intensive services over a sustained period, development of a therapeutic relationship between the home visitor and parent, careful observation of the home situation, focus on parenting skills, child-centered services focusing on the needs of the child, provision of ‘concrete’ services (e.g., shelter, health care), inclusion of fathers in services, and ongoing review of family needs to determine frequency and intensity of services” (Leventhal, 1997).

Home Visitation Models

Home visitation is a *strategy* for service delivery, not a *model*. Many models use home visitation as a vehicle for delivery of services, either entirely or in conjunction with center-based services. The frequency and length of home visits vary as do the activities undertaken during the home visit. Some programs offer home visitation for 4-6 weeks, whereas others offer home visitation services for up to 5 years. In this report, we will review three home visitation models: Healthy Families, Nurse Family Partnership (formerly the Nurse Home Visitation Program), and the National Exchange Club Foundation's Parent Aide model.

Healthy Families America

Healthy Families America (HFA) is “a national program model designed to help expectant and new parents get their children off to a healthy start. Families participate voluntarily in the program and receive home visiting and referrals from trained staff. . . . The program was launched in 1992 by Prevent Child Abuse America . . . and was designed to promote positive parenting, enhance child health and development and prevent child abuse and neglect” (Healthy Families America, 2005). HFA exists in over 430 communities in the U.S. and Canada (Healthy Families America, 2005).

Critical elements of HFA include the initiation of services to a family prenatally or at the birth of a child, and the intense provision of services (at least once a week) for 3-5 years. Service providers are provided intensive training and ongoing, effective supervision (Healthy Families America, 2005).

Research on HFA has been ongoing, purposeful, and varied in results. The first evaluation was on Hawaii's Healthy Start Program, and showed significant program effects on child maltreatment (Daro, McCurdy, & Harding, 1998). These initial results were promising, but

were hampered by methodological problems (Healthy Families New York, 2005). A second major evaluation was less favorable. This research showed that at the child's 2nd birthday, mothers reported using nonviolent discipline more often, less parental stress, and increased maternal mental health; however, results did not show any differences in CPS reports. At the child's 3rd birthday, results showed no difference on official or self-report on child abuse and neglect, child hospitalization patterns, or parental risk factors (including mental health and domestic violence) (Duggan, Fuddy, Burrell, Higman, McFarlane, Windham, & Sia, 2004; Duggan, Fuddy, Burrell, Higman, McFarlane, Windham, & Sia, 2004; Duggan, MacFarlane, Windham, Rohde, Salkever, & Fuddy, 1999).

Therefore, Duggan and her colleagues concluded that the Healthy Families program has had little impact on child maltreatment and parental risk factors. They attributed the program's shortcomings to "home visitors' lack of skills and supervision in dealing with risk factors for abuse and neglect – in particular, domestic violence, substance abuse, and mental illness – and to properly link families to necessary professional services" (Healthy Families New York, 2005, p. 5). They also noted that HFA had moved to a strengths-based approach, and consequently, were ignoring many risk factors. Duggan and colleagues recommended "a more targeted approach that identifies risk and develops the expertise in workers to adequately support families with such complex and challenging issues" (Healthy Families New York, 2005, p. 6).

Research on Healthy Families Florida also produced mixed results. They noted several issues with treatment integrity, including the ability to engage and retain families, difficulty in setting goals with families, and challenges in following protocol when a family was ready to "graduate" from the program (Healthy Families Florida, 2005). The conclusions from this research stated: "The HFA model as presently defined may not be fully realized in practice given

family, staffing and environmental constraints. If the model is not implemented fully, then outcomes cannot be met and findings are difficult to interpret. Intensity and retention are two continuing challenges faced by most projects” (Healthy Families Florida, 2005, p. 94).

Healthy Families New York, in a deliberate effort to remedy problems experienced in other states, provided more training to home visitors and tighter guidelines on provision of home visitation services. Results were more positive, including:

- Mothers have more positive parenting attitudes, contributing to lower child abuse and neglect behaviors. Mothers had lower support for physical punishment, more appropriate expectations for their children.
- Fewer incidents of emotional abuse, physical punishment, and neglect
- Reduced risk factors that lead to long-term health problems for children; i.e. significantly fewer low birthweight babies, more mothers have health insurance for baby, more likely to breastfeed
- Reduce mothers’ use of harmful substances, preventing later problems related to health, parenting, and social relationships. Less cigarette smoking, alcohol, and illicit drugs” (Healthy Families New York, 2005).

Whipple and Nathans (2005) reported on their evaluation of the HFA model in a rural context. In a large geographical area with dispersed, low-density populations, programs must adopt a more generalist approach, “be willing to work from a team approach, and use community resources (e.g., transportation) in a different manner. The rural service provider must understand and be oriented to the community to become an effective, positive part of it” (Whipple & Nathans, 2005, p. 72). While the program did not appear to promote many positive changes in meeting abstract goals, they did fare better in concrete areas. “While the riskiest families should

always be given the opportunity to participate, we suggest that rural implementation may be most effective when utilized as part of a triage case management model which better integrates child welfare, mental and physical health care systems” (Whipple & Nathans, 2005, p. 71).

Nurse Family Partnership

The Nurse Family Partnership (NFP) (formerly known as the Nurse Home Visitation Program (NHVP)) was initiated by David Olds and his colleagues in Elmira, New York, in 1977. Direct service workers in the Nurse Family Partnership (NFP) are public health nurses who receive extensive training in maternal and infant development, and in teaching problem-solving skills to new mothers. The threefold goals of NFP are: (a) To improve pregnancy outcomes, including the prevention of preterm delivery and low birth weight; (b) To promote children's health and development through the prevention of child maltreatment, child injuries, developmental delays, and behavioral problems; and (c) To strengthen parenting skills and families' (mothers') economic self-sufficiency through the prevention of substance abuse (particularly smoking) during pregnancy, improving the quality of caregiving, and effecting maternal life course (frequency and spacing of pregnancies, work-force participation, and welfare dependence). Mothers participating in NFP are visited during pregnancy and through their child(ren)'s 2nd birthday(s). The intensity (frequency and length) of home visits fluctuates with the anticipation of the mother's needs during pregnancy and the child's first 2 years of life, and are adapted to each mother's needs (Olds, Henderson, Kitzman, Eckenrode, Cole, & Tatelbaum, 1998; Olds, Henderson, Kitzman, Cole, 1995).

The program has undergone three randomized studies using large sample sizes and up to 15 years of longitudinal follow-up (for the initial Elmira study). “Comparisons between women who were visited by nurses and those who were not demonstrated significant effects from nurse

visits on several measures of maternal health, maternal life-course development, child health and safety, and adolescent measures of delinquency” (Promising Practices, 2005). Results from the trial in the semi-rural area of Elmira, New York were very positive, showing improved pregnancy outcomes, better children’s health and development, and a positive impact on mothers’ economic self-sufficiency (Olds, Henderson, & Kitzman, 1994; Olds, Henderson, Kitzman, Eckenrode, Cole, & Tatelbaum, 1998; Olds, Henderson, Kitzman, Eckenrode, Cole, & Tatelbaum, 1999; Olds, Kitzman, & Cole, 1995).

Replication of the NHVP was done in Memphis, Tennessee, with a very different population (urban, primarily African American). In this effectiveness trial, there was a high rate of staff turnover due to a nursing shortage, only half of intended visits were completed, and consequently, results were more mixed between positive and negative (Olds, Henderson, Kitzman, Eckenrode, Cole, & Tatelbaum, 1998; Olds, Henderson, Kitzman, Eckenrode, Cole, & Tatelbaum, 1999).

The NHVP program in Denver, Colorado compared outcomes and services for families visited by nurses with those visited by paraprofessionals. While outcomes between the two groups were mixed, the research did show that services offered by paraprofessionals were different from those offered by nurses (Olds, Robinson, Pettitt, Luckey, Holmberg, Ng, et al., 2004). Nurses “concentrated on issues of personal health and parenting whereas paraprofessionals emphasized environmental health and safety, social supports, and the mother’s life-course development” (Promising Practices, 2005).

Benefits from NFP show that the program benefits the neediest families (low-income, unmarried women) by reducing rates of childhood injuries and ingestions that may be associated with child abuse and neglect, and helping mothers defer subsequent pregnancies and move into

the workforce. Three lessons can be learned from David Olds' work with the NFP: (a) only the original model yielded unambiguously positive results (fully implemented, no changes to model), (b) it is important to test a new service delivery idea before advocating its widespread adoption, and (c) it is important to stick with an idea for a long time (in this case, 30 years) (Alper, 2002; Olds, Henderson, Kitzman, Eckenrode, Cole, & Tatelbaum, 1998; Olds, Henderson, Kitzman, Eckenrode, Cole, & Tatelbaum, 1999; Promising Practices, 2005).

Parent Aide (National Exchange Club Foundation)

The National Exchange Club Foundation (NECF) coordinates the largest collection of Parent Aide programs with 79 centers in the U.S. serving 100 sites. Over the course of the past 20 years, the Exchange Club's Child Abuse Prevention network has provided home visitation services to 100,000 families at risk of abuse (Bartleson, 2003; National Exchange Club Foundation for the Prevention of Child Abuse, 2002). According to the National Parent Aide Network of the NECF, "Parent Aides are professionally trained individuals who become a friend and role model to parents who need help in dealing with life's daily challenges. Parent aides teach parents to be more loving and responsible to their children. They provide support and encouragement model normal ways of parent, provide genuine and caring friendships, focus on the good qualities of the parents, serve as an outside social control to stop abuse immediately, and address special needs of the family by referring them to community agencies when necessary" (National Exchange Club Foundation for the Prevention of Child Abuse, 2002).

The Parent Aide's involvement is family-centered, empowerment-based, and ecological in nature with services provided in the home. Families receiving Parent Aide services are referred by a variety of community sources. Families must have at least one child 12 years old or younger, be considered at-risk for abuse (either through presence of dynamics common in

abusive families or the presence of substantiated abuse or neglect), and be willing to participate in services. Families are matched with a professionally supervised Parent Aide who provides weekly home visits for 1 year. Closure is considered when a level of success occurs in four areas: child safety, problem solving, parenting skills, and social support (Evaluating the Work of Parent Aides, 2005).

Research on the Parent Aide model is scant but promising. One study on the Parent Aide program in Dallas, Texas, showed that parents who completed the Parent Aide program had fewer subsequent, substantiated reports to child protective services of child abuse or neglect than those parents who refused to participate or dropped out of the Parent Aide Program (Harder, 2005). This same study showed significantly lower parental stress, improved parenting skills, improved life skills, stronger social support network, and more of their basic needs met after completion of the Parent Aide program than they did at the completion of their assessment (Harder, 2005). Similar to the NFP study in Denver, this researcher examined differences of services and outcomes for families served by volunteers as compared to those served by professional case managers. Due to methodological constraints, the findings were not conclusive, but did indicate differences in engagement, attrition, close reason, and abuse recidivism (Harder, 2004).

Comparison of Home Visitation Models

The three home visitation models discussed here have several important similarities and differences. All three models embrace an ecological approach, acknowledging the role of factors such as poverty, substance abuse, domestic violence, and mental health. They all serve families at-risk for abuse, however, the Parent Aide model generally serves a higher risk population (69% of those served have had involvement with Child Protective Services) (Evaluating the Work of

Parent Aides, 2005). HFA and Parent Aide both use paraprofessionals, while NFP utilizes public health nurses. The NFP enrolls only first-time mothers, whereas HFA serves mothers of all ages without regard to number of children. Parent Aide serves pregnant and new parents, but also initiates services families with children up to the age of 12 years. All three models intend to visit families once a week, but they vary in length of services offered: NFP offers services from prenatal through 2 years old, HFA enrolls families from prenatal to 3-5 years old, and Parent Aide serves families for up to 1 year. All three of these programs struggle with client engagement, client attrition, and uniformity of services offered.

Deborah Daro has over 20 years of experience in evaluating child abuse treatment and prevention programs. In *Public Health News*, Dr. Daro stated that effective programs intervene with children and families prenatally or at birth, are long term and intensive, and offer parents help with finances, health care and mental health issues. “Effective programs also limit the caseloads for child abuse prevention program staff to no more than 15 families per worker, hire staff with strong relationship-building skills and provide ongoing training and supervision (*States using evidence-based methods*, 2004, p. 1). Similar to what others have stated, Dr. Daro adds the caveat that not all programs work all the time for all families.

In his book, *Stopping Child Maltreatment Before it Starts: Emerging Horizons in Early Home Visitation Services*, Guterman (2001) lists core elements of service for home visitation services. These include: clear focus and roles, curricula with clear objectives, moderate to intensive delivery of services, and to initiate services with families prenatally.

Recommendations

Again, we must face the disappointing reality that we do not yet know how best to prevent child abuse and neglect. Additional research is needed to more adequately answer this

crucial question. We must acknowledge that different services will work with different populations, depending on:

- Level of risk for child abuse;
- Type of abuse or neglect;
- Parent characteristics: age, gender, race, intellectual level;
- Children's characteristics: age, special needs (i.e. developmental delay, disabilities, physical and mental health); and
- Other risk factors: poverty, substance abuse, domestic violence, mental health (especially maternal depression).

Due to the dearth of research and clear answers, it is important that whatever approach is chosen that evaluation protocol are instituted as early as possible, ideally, from the very beginning (including the use of valid and reliable measurement tools, and deliberate and standardized data collection).

When considering the adoption of a home visitation model, these are important elements to consider:

- Provide intensive training (both initial and ongoing) for staff and supervisors. This training must emphasize:
 - Recognizing child abuse and neglect;
 - Thorough knowledge of child development and the ability to teach this to parents;
 - Enhanced ability to engage and build alliances with families which includes being nonjudgmental, strengths-based, and able to empower parents; and
 - Recognizing and responding to risk factors, such as substance abuse, domestic violence, and maternal depression.

If volunteers or paraprofessionals are chosen as home visitors, they must receive intense training (including shadowing) (see above for topics), ongoing training, and effective supervision.

- The initial engagement and ongoing nurturing of relationships with families are critical to the success of any program.
- Provide parent training to influence their knowledge, attitude, and behaviors.
- Engage in ongoing maintenance of the program to assure integrity of the model (especially frequency of home visits) and to maintain focus. It is easy for home visitors to get side-tracked with multiple, chronic crises experienced by the family (i.e. eviction, threats of violence, need for concrete services). Responding to these issues is critical, but must not keep home visitors from the tasks of teaching and role-modeling appropriate parenting. The use of a parenting curriculum can help to bring focus to the relationship.
- Acknowledge the role of family context, including poverty, substance abuse, domestic violence, and mental health. Also housing, employment, education, health, and childcare. The provision of case management services are an important component of any effective child abuse prevention program.
- Consider augmenting home visitation services with center-based services to ease social isolation and build social support as well as to teach important parenting skills and child development knowledge.

While this report focuses mostly on home visitation, other types of prevention activities are also viable, including public awareness campaigns, skills-based curricula for children (especially for sexual abuse), parent support groups (such as Circle of Friends), and respite and crisis care programs.

The prevention of child abuse and neglect is both important and complex. The answers are not clear, but the problem is compelling. With the reality of child deaths and mounting caseloads for our CPS workers, we must invest our time, energy, and money in working to protecting our child before it is too late. I commend the State of Nebraska and Prevent Child Abuse Nebraska for standing up to the task.

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