

# WORKING P A P E R

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## Preventing Child Abuse and Neglect in the United States

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CHILD POLICY

**If you had \$5 million to spend each year for the next five years to prevent child abuse and neglect in the United States, how would you spend it?"**

By Mary Carrasco, MD

The system of care for suspected victims of child abuse and neglect in the United States was developed at a time when child abuse, even in its severest forms, was not openly acknowledged as occurring. At that time, we had no public infrastructure for intervening in child abuse, so the vital first step was to enlist police, hospitals, and local government in stopping the most dangerous forms of child abuse. In doing so, we created a system that was so weighted toward the most severe cases of abuse that our resources were thrown into the end stage of the continuum of maltreatment—millions of dollars for court hearings and billions of dollars in child protective services and foster care. The fact that there is a range of child maltreatment calling for different approaches along that continuum is something that gradually took hold as an idea. However, our distribution of resources has never caught up with this understanding. State and federal requirements that mandate certain levels of intervention continue to make it difficult to employ child abuse funds in what could be more useful ways.

The child welfare system has evolved to begin caring for less-severe abuse, but the system of interventions has not adjusted adequately; we have kept incentives aligned with *tertiary intervention* rather than *prevention*. We have made the same mistakes in our child welfare system as we have in our health care system: Our investments are well after we could have prevented crises; and the responsibility and reimbursement for prevention, evaluation, and child abuse intervention do not necessarily reside in the same agency or share incentives.

Even when we do invest in prevention services, those that we label “proven” tend to be very expensive and are most commonly based on one-to-one interventions that require a highly trained professional *intervening* – as opposed to *facilitating growth* of a subject. We assume that the qualities of the intervention can be captured in a document that can then be replicated with the same or similar effects in another setting, without accounting for personal variation in delivery. Little emphasis is given to the fact that some practitioners will never acquire the skills necessary to assist families regardless of the amount of training they receive. That fact in and of itself negates some of the assurance provided by a randomly controlled trial that has demonstrated effectiveness because it will necessarily have the same result under a different set of conditions with different staff. Another problem with most of the “proven” interventions is that the families who agree to participate and persist in the study interventions are often the least likely to be those with the highest risk of negative outcomes.

Use of one-to-one interventions are unlikely to lead to marked declines in child abuse rates or improved parenting or child well-being for the population as a whole for a number of reasons, the most compelling being cost. The nation will never have enough funds to rely on one-to-one interventions by specially trained personnel in the field of child abuse, even if some funds are moved from intervention services to prevention. And while there are efforts at welfare reform under way, these are not bold enough to truly effect change at the population level in prevention of abuse because most are still focused on secondary and tertiary prevention.

If I were able to direct \$5 million every year over the next five years to effect this shift, I would recommend investing the funds in leading an effort toward community engagement using a public health approach rather than the traditional programmatic approach. The public health approach begins by looking at the issue as one of greater child well-being rather than prevention

that takes place one social worker or nurse at a time, although these services may be needed for some families. It is often possible to engage high-risk families if the parents are first encountered in a nonthreatening and nonadversarial way and without conveying they are bad parents. This approach can then be used to screen and engage many more high-risk families than can the traditional approach.

What is needed is a shift to a public health model of child abuse prevention, which focuses on changing community environments rather than targeting only those deemed to be at risk in the same way that even partial immunization of the public lowers community risk. To reduce abuse and increase child well-being, we need to promote a sense of community responsibility for children, families, and neighbors. We need to empower people in the community to know how to be helpful when they see a parent or caregiver under duress and to convey to all parents in a community that they can reach out for help when they need it and that they will get the help they need without penalty.

In high-risk communities, this kind of change often requires outside assistance. A neighborhood family support center based on a public health model could be the focus of the intervention, but those at the center must feel a responsibility toward everyone in the community, not just the center's initial users. There must be a special focus on engaging nonusers and making them feel welcome. Many early family support centers started out this way, as an alternative to categorical programs, but over time many have, in an effort to demonstrate effectiveness, become focused more exclusively on those users willing to commit to long-term interventions rather than the broader community, including many of the higher risk who may be reluctant to engage in that way. The success of the program should be judged by indicators for the whole area served and not just for the users.

We would begin by assembling a national group of thought leaders from government, nonprofit organizations, and the private sector to jointly agree upon the changes to the system that we wish to support in a limited number of community demonstration sites. The members of this group can also assist in determining how federal and state requirements should be changed.

We need to identify a small number of demographically varied geographic areas that can demonstrate that they are ready for change and can obtain federal and state waivers from binding regulations so that the local sites may use funds more flexibly and demonstrate the effectiveness of prevention efforts in an entire, significantly sized population—not just for the willing program participants we so often see in controlled studies.

National staff would develop criteria for choosing sites and for soliciting proposals. They would then assist demonstration sites with planning their strategies for change and obtaining state and federal waivers, and they would oversee local sites' implementation of new programs, documenting their effectiveness at the community level. Many sites that have the potential ability to conduct effective programs do not have either financial resources or the expertise needed to do so.

An important element in the prevention efforts we fund is an awareness of the qualities of the people providing the service, including their ability to engage hard-to-reach populations—not just their “credentials,” such as amount of training they have received, whether or not they are licensed, etc. Successful interventions often depend on a few individuals with special abilities to connect with and inspire others, and identifying such people requires special efforts.

There also needs to be a national public awareness component for the program to help change the environment in which abuse develops. One example of this approach would be the “One Kind Word” program. In addition, part of this public awareness effort should focus on a

broader cause of the diminished well-being of some children in our society: the sexualization of young girls. Girls cannot miss the messages the media delivers, the sum of which tells them that their value depends on their sexual appeal or behavior to the exclusion of other qualities. I would like to see that, as part of their work to promote the well being of all children in their communities, the demonstration sites join together with a national program to organize an effort to counter the media's message—from helping to organize protests against television, ads, and other media that engage in the sexualization of children to advocating for laws that clarify public standards for messages involving children.

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