

Preventing Child Maltreatment in North Carolina

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Child-maltreatment prevention has become more robust in North Carolina since the North Carolina Institute of Medicine Task Force convened in 2005. The commitment by state governmental and nongovernmental leadership and funding agencies has been instrumental to this achievement. This commentary highlights several successful approaches used to prevent child maltreatment in the state, although there is much work to be done.

North Carolina has a long history of robust prevention of child maltreatment. In 2005, the North Carolina Institute of Medicine, under the leadership of Prevent Child Abuse North Carolina and the North Carolina Department of Health and Human Services, hosted a 6-month task force to determine the direction and agenda of child abuse prevention in the state. North Carolina has been home to many exciting prevention activities in the intervening 6 years. This commentary, in no way a comprehensive view of all the important work to prevent child maltreatment, will highlight several examples of universal, selective, and indicated approaches to child maltreatment prevention. The work in child maltreatment prevention in North Carolina is due to the coalescing of goals and values from government agencies, nongovernmental organizations, academia, and private funders.

The Numbers

Child maltreatment, broadly conceived, occurs when a parent or caretaker commits an act or fails to prevent an event that results in harm or risk of harm to a child. In North Carolina, during 2008-2009 there were nearly 68,000 reports to child protective services, for a rate of 3 reports per 100 children. Of these, 7.4% were substantiated as involving abuse, neglect, or dependency. An additional 35% of reports resulted in services being provided or offered, reflecting improved flexibility in assessing and adjudicating reports and in serving families during the past 6 years [1]. In 2007, there were 25 homicides due to child abuse and 139 child deaths attributed to neglect [2].

Universal Prevention

Universal prevention programs target every member of a group of interest, such as newborns. Universal prevention

programs tend to be challenged by limited resources, owing to the need to reach large numbers of families. For example, a home visitation program that seeks to serve all residents of a county may be able to visit each family only once. In contrast, a program that seeks to serve individuals at highest risk might identify 5%-10% of families with the greatest need and offer them 10-20 visits focusing on maltreatment prevention for the same cost. Furthermore, because population-based maltreatment rates are low (ie, 3 reports per 100 children), demonstration of the program's impact is difficult. It is for these reasons that there is much less evidence to support universal interventions. However, North Carolina is leading the way in developing and testing universal interventions to prevent child maltreatment.

Durham Connects. As part of the Durham Family Initiative, the Center for Child and Family Policy and the Center for Child and Family Health are working toward a universal home visitation program in Durham County, known as Durham Connects. This program will engage every family in Durham after the birth of a new child, identify family circumstances that place the child at risk for maltreatment, and connect the family to other resources. This program is designed to visit each family 1-3 times to assess their need and to link them with resources, but not to serve as a long-term service delivery model. It has been initially rolled out by targeting babies born every other day, so that babies born on alternate days can serve as a comparison group for evaluation. Previous limited-scope universal home visitation programs, although offering other benefits, have not been shown to reduce child maltreatment. However, this program is structured to include an evaluation based on the domains of risk for maltreatment; it is flexible, with 1-3 visits, depending on the need; and it is developed within an integrated system of care for children and families [3].

The Period of PURPLE Crying. The Period of PURPLE Crying: Keeping Babies Safe in North Carolina program (available at: <http://www.purplecrying.info/index.php?loc=mb1r3p6>) is a statewide, multimodal approach to prevent abusive head trauma. This intervention was created by a pediatrician with more than 30 years of experience in crying research, in partnership with the National Center on Shaken Baby Syndrome. The premises of the program are that all babies cry, some crying is unsoothable, crying peaks at 2-3 months of age,

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some healthy babies cry for more than 5 hours per day, and the only potential negative consequence of excess crying for the baby is abusive head trauma. This approach has been extensively tested in focus groups, among pilot subjects, and, more recently, among 4,000 families in Vancouver, Canada, and Seattle, Washington, in randomized, controlled trials. These studies showed changes in important knowledge and behaviors associated with shaking but were underpowered to detect a difference in abusive head trauma [4, 5].

In North Carolina, we have developed a 3-dose approach that targets all families of newborns. During the first dose, all new parents receive their own DVD and booklet with information about the Period of PURPLE Crying while in the birth hospital or birthing center. The key messages are reinforced by brief bedside education from a nurse, and parents are told to share their informational materials with all substitute caretakers. The second dose, given during sick- or well-child visits to the child's family physician or pediatrician, involves distribution of materials to parents that reinforce the messages of the program. The third dose consisted of a 1-year sustained media effort, including the use of paid (mostly radio), earned, and social media outlets and platforms. A rigorous evaluation of this project is underway [6].

Selective Prevention

Selective prevention strategies serve children and families who have been determined to be at risk for maltreatment. These programs are among the best-studied strategies for maltreatment prevention and often include parent education, commonly in the home, and some system of screening and referral for more-serious problems. These programs tend to be more expensive to operate and provide a higher level of service to fewer families.

Nurse-Family Partnership. The Nurse-Family Partnership is among the most extensively studied and replicated models for preventing child maltreatment; its effectiveness has been demonstrated in 3 randomized, controlled trials and during many years of follow-up of subjects [7, 8]. This model has been shown to reduce child maltreatment, decrease emergency department use for treatment of injuries and poisonings, decrease adolescent arrests, and increase pregnancy spacing. In this model, nurses make home visits to identified at-risk families, starting in the third trimester of pregnancy, with follow-up for 2 years. This strategy was widely embraced by the North Carolina Institute of Medicine Task Force on Child Abuse Prevention, the North Carolina Division of Public Health, and funders in North Carolina and has been expanded to include 10 area programs [9].

Parents as Teachers. Parents as Teachers was designed as a universal program but, in North Carolina, is often administered to families with the greatest need, as identified by a local agency running the program. There are 77 local Parents as Teachers programs in North Carolina. As such, it may be the largest program in North Carolina for preventing child maltreatment. However, although the program offers more

flexibility in terms of its ability to target higher-risk groups, it was not specifically designed to prevent child maltreatment, and therefore there are fewer empirical data available to support its beneficial effect on child outcomes. The principles of the model include personal visits (every 1-4 weeks) by a parent educator, group meetings, health and development screenings and referrals, and development of a resource network [10].

Indicated Prevention

Indicated prevention programs serve children who have been determined to be victims of maltreatment. Many programs serve both selected and indicated populations on the basis of risk and program availability. Some professionals consider indicated programs appropriate for individuals at the highest risk, recognizing that highly vulnerable children may not fall neatly into a category of abused or not abused. Child protective services agencies in the United States have been the mainstay of identification, investigation, and provision of services for 4 decades. When indicated prevention strategies are being considered, the child and the caregivers may both be appropriate recipients, depending on the needs and goals relevant to their circumstances.

Trauma-focused cognitive behavioral therapy (CBT). This evidence-based therapeutic modality is for victims of traumatic events, such as child abuse, and studies have shown that at least 80% of children who receive CBT experience an improvement in their trauma-related symptoms. There are at least 170 therapists in 60 North Carolina counties with CBT training. Although CBT is not specifically designed to prevent maltreatment, it is designed to prevent the emotional consequences of maltreatment [11]. Additional information about the CBT model is available at the North Carolina Child Treatment Program Web site (available at: <http://ncctp.med.unc.edu/>).

Parent-child interaction therapy. This therapeutic model was originally designed and tested for children with conduct disorder. However, it has since been shown to reduce repeat maltreatment by physically abusive parents, who are taught specific skills in child-behavior management by a trained therapist [12]. The types of therapy and training in this modality are increasingly offered by child-serving agencies and mental health practitioners in North Carolina.

Conclusions

Child maltreatment prevention has become more robust in North Carolina since the North Carolina Institute of Medicine Task Force on Child Abuse Prevention convened in 2005. The commitment by state governmental and nongovernmental leadership and funding agencies has been instrumental to this success. In addition, the task force leadership wisely recommended the devotion of resources to evidence-based strategies, to promising strategies, and to new and developing programs that have a strong mechanism in place to facilitate collection and evaluation of new evidence [13].

Strategies such as the Nurse-Family Partnership and trauma-focused CBT have a strong empirical foundation. Programs such as Durham Connects and the Period of PURPLE Crying have rigorous designs in place to facilitate their evaluation. Future gains in maltreatment prevention will depend

on financial and in-kind support, leadership, research, and surveillance to monitor progress and identify strengths and weaknesses of the state's system of prevention [14]. **NCMJ**

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