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Trauma Violence Abuse. Author manuscript; available in PMC 2017 May 26.

Published in final edited form as:
Trauma Violence Abuse. 2016 October ; 17(4): 363–365. doi:10.1177/1524838016661034.

The Public Health Model of Child Maltreatment Prevention

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Child maltreatment remains an area of concern for child advocates, policy makers, service providers, and researchers across the globe and presents an enduring threat to public health (Herrenkohl, Higgins, Merrick, & Leeb, 2015). In 2013, over 3.5 million referrals were made to child protective services in the United States and over 2 million cases, a rate of almost 29 per 1,000 children in the U.S. population, were investigated out of concern for the health and safety of the children involved (U.S. Department of Health and Human Services [U.S. DHHS], 2016, maltreatment). This figure rises substantially to more than 10% of all U.S. children, when children are asked directly to report their experiences of abuse and neglect (Finkelhor, Turner, Ormrod, & Hamby, 2009).

In other Western countries, the picture is much the same. According to one report from the United Kingdom, nearly 20% of all young people between the ages of 11 and 17 experienced high levels of abuse and neglect prior to adulthood (https://www.nspcc.org.uk/services-and-resources/research-and-resources/2013/how-safe-are-our-children-2013/). In the past decade, the number of children on child protection registers has risen in all four jurisdictions of the United Kingdom and, in Australia. The Australian Institute of Health and Welfare (AIHW, 2016) reported a 35% increase in the number of substantiated maltreatment reports between 2010–2011 and 2014–2015. This pattern is highly concerning because current levels of demand in ''statutory'' child welfare/protection systems surpass reasonable case load expectations and budgetary affordances. Driven by awareness of the challenges experienced by child welfare agencies overwhelmed and unprepared to accommodate the demand for assistance, many in the social service sector and research community have called for a new model of child welfare—one that places a much stronger emphasis on prevention (Herrenkohl et al., 2015).

The need for prevention is reflected not only by a growing demand for child welfare services but also evidence of the long-term effects of child abuse and neglect. For example, research

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The findings and conclusions in this report are those of the authors and do not necessarily represent the official positions of the Centers for Disease Control and Prevention, the Australian Government, or the Australian Institute of Family Studies.

Declaration of Conflicting Interests
The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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shows a strong connection between the experience of having been maltreated and the risk for chronic and sometimes life-threatening conditions, such as heart and lung disease, diabetes, and certain forms of cancer (Leeb, Lewis, & Zolotor, 2011; Middlebrooks & Audage, 2008). While the mechanisms that link child abuse and neglect to these outcomes remain under investigation (Min, Minnesa, Kima, & Singer, 2013; Shonkoff, Boyce, & McEwen, 2009), what we know of the detrimental effects of highly stressful environments is reason to move programming efforts forward while also remaining vigilant of new findings as they are received (Zimmerman & Mercy, 2010).

The escalating costs of child welfare services provide yet another reason to act immediately (Fang, Brown, Florence, & Mercy, 2012). In federal fiscal year 2015 alone, approximately US$8 billion was distributed to U.S. state and territory child welfare agencies to be used for child welfare services and foster care (Stoltzfus, 2015). These services focus on securing the safety of children, providing supports to vulnerable families, and managing housing and other essentials for those in need. In that the most vulnerable families are also those who repeatedly come in contact with the child welfare agencies, costs are driven upward by a relatively small segment of the overall population (AIHW, 2016). Further, abused children can concurrently encounter a range of other adversities including exposure to violence between adult caregivers, parental substance use, and mental illness, which add costs and complicate the process of matching services to need (Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008).

The rising number of referrals and rereferrals to child welfare systems (AIHW, 2016; U.S. DHHS, 2016) is a clear indication that the current tertiary or reactive response framework that characterizes child welfare services is unlikely to reduce the prevalence of child maltreatment in the population as a whole. In that only a fraction of all child maltreatment cases are actually reported to child protection workers and that the impacts of abuse and neglect are experienced whether or not child welfare agencies becomes involved (Herrenkohl, 2011), the goal of engaging families through prevention may require fundamentally changing the system to be more proactive and focused on early identification and risk reduction or positioning programs outside the child welfare system.

An Alternative to Tertiary/Statutory Responses: The Public Health Model of Prevention

An alternative to the current model of system engagement is one that positions public health prevention (Institute of Medicine, 1994) at the center of all activities rather than at the periphery. The public health model offers a unique structure to address population-level or pervasive health problems in a coordinated manner. The model relies on a large and multidisciplinary infrastructure to bring evidence-based primary prevention strategies to the public at a whole-of-population scale. At its core is a focus on early and comprehensive engagement (intervention) aimed at reducing risk factors and enhancing protective factors before problems first emerge (Herrenkohl et al., 2015). Although universal public health preventive interventions are often conceptualized as meeting a different need within a population than those of a more targeted nature (as in selective or indicated approaches),

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programs can be thought to exist along a continuum, with selective and indicated programs connecting with, and augmenting, those geared more generically to the population as a whole (Herrenkohl et al., 2015). A critical success component is to equip universal service delivery platforms—such as schools, early childhood education and care, maternal/child health, and broader health services—with the skills and resources to tailor services to meet the variety of needs as well as being a referral to more intensive services. Integration between such primary and secondary service systems is sometimes referred to as ‘‘progressive universalism’’ or ‘‘proportionate universalism’’ (Higgins, 2015).

The systems of care framework is one example of a coordinated public health prevention strategy. The framework is designed to encourage development of partnerships to create a broad, integrated process for meeting the multiple needs of vulnerable children and families and improving the efficiency of the U.S. child welfare system (Child Welfare Information Gateway, 2009). This framework embraces aspects of a public health-based, primary prevention model, and thereby represents a shift away from reactive strategies toward those that are more proactive and potentially less costly.

Articles in the Special Issue

In this special issue, we invited contributors to explore the theoretical, conceptual, and empirical foundations of the public health model, as it applies to child maltreatment prevention, drawing on the most rigorous science and proposing integrated models of practice and policy that have the potential to make a difference at scale. Programs and frameworks described herein offer a collection of core strategies structured around the public health model, with the most vulnerable families and their communities in mind.

The articles draw attention to the potential for efficacious and cost-effective family and community-based prevention programs designed to improve and sustain positive outcomes for the most vulnerable. In the first article, Jones Harden, Buhler, and Fernandez provide a comprehensive review of primary, secondary, and tertiary prevention programs designed for families of young children but also applicable to those who are older. In the article that follows, Molnar, Beatriz, and Beardslee emphasize importance of community-level prevention models and call for a three-pronged approach to public health prevention that focuses on knowledge development, community engagement, and program sustainability. Pickering and Sanders summarize evidence from trials of Triple-P, a widely used prevention system that reflects a multifaceted public health model of the sort we envision. Finally, Scott, Lonne, and Higgins focus on commonalities between the field of injury prevention and child maltreatment prevention, calling attention to what can be learned for community-level interventions and child welfare engagement. As a collection, these articles show the promise of public health prevention and touch on the challenges that must be overcome to successfully scale and sustain programs over time often with modest resources.

Acknowledgments

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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Biographies

Todd I. Herrenkohl, PhD, MSW, is a professor of social work and codirector of the 3DL Partnership at the University of Washington School of Social Work. His research focuses on the study and promotion of positive youth development and the amelioration of risk factors related to interpersonal violence through public health prevention. His funded projects and publications examine various health-risk behaviors in children exposed to child maltreatment, resilience and protective factors that buffer against early risk exposure in children, and approaches to promoting wellness by investing in the whole child. In his work with the 3DL Partnership, he and his colleagues partner with schools and community organizations to enhance learning opportunities for children and youth and to build capacity

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for sustained and mutually beneficial collaborations, professional development, and information sharing at the local and national levels.

Rebecca T. Leeb, PhD, is an health scientist in the National Center on Birth Defects and Developmental Disabilities at the Centers for Disease Control and Prevention. Her work focuses on the linkages between childhood adversity, foster care, disability, parenting, and healthy child development. She has authored/coauthored more than 25 scientific publications related to the surveillance and promotion of healthy child development and prevention of childhood trauma. She received her PhD in applied developmental psychology from McGill University in 1999 and completed a postdoctoral fellowship at the University of North Carolina at Chapel Hill, Department of Social Medicine in 2002. A 14-year-veteran of CDC, she began her career as an epidemiologist in the National Center for Injury Prevention and Control (2002–2010), where she led efforts related to the etiology and surveillance of child maltreatment and became a subject matter expert in child maltreatment prevention.

Daryl Higgins is an associate professor and deputy director (research) at the Australian Institute of Family Studies, where he has responsibility for the Institute's research program and its knowledge translation and exchange functions. The Institute undertakes a wide range of research, evaluation, and dissemination projects focusing on policy- and practice-relevant issues affecting families. He is a registered psychologist and is recognized for his research on child abuse, family violence, sexuality, family functioning, and past adoption practices and also an expert on public health approaches to protecting children. He is also an honorary principal fellow at the Melbourne School of Health Sciences, Faculty of Medicine, Dentistry and Health Sciences, the University of Melbourne.