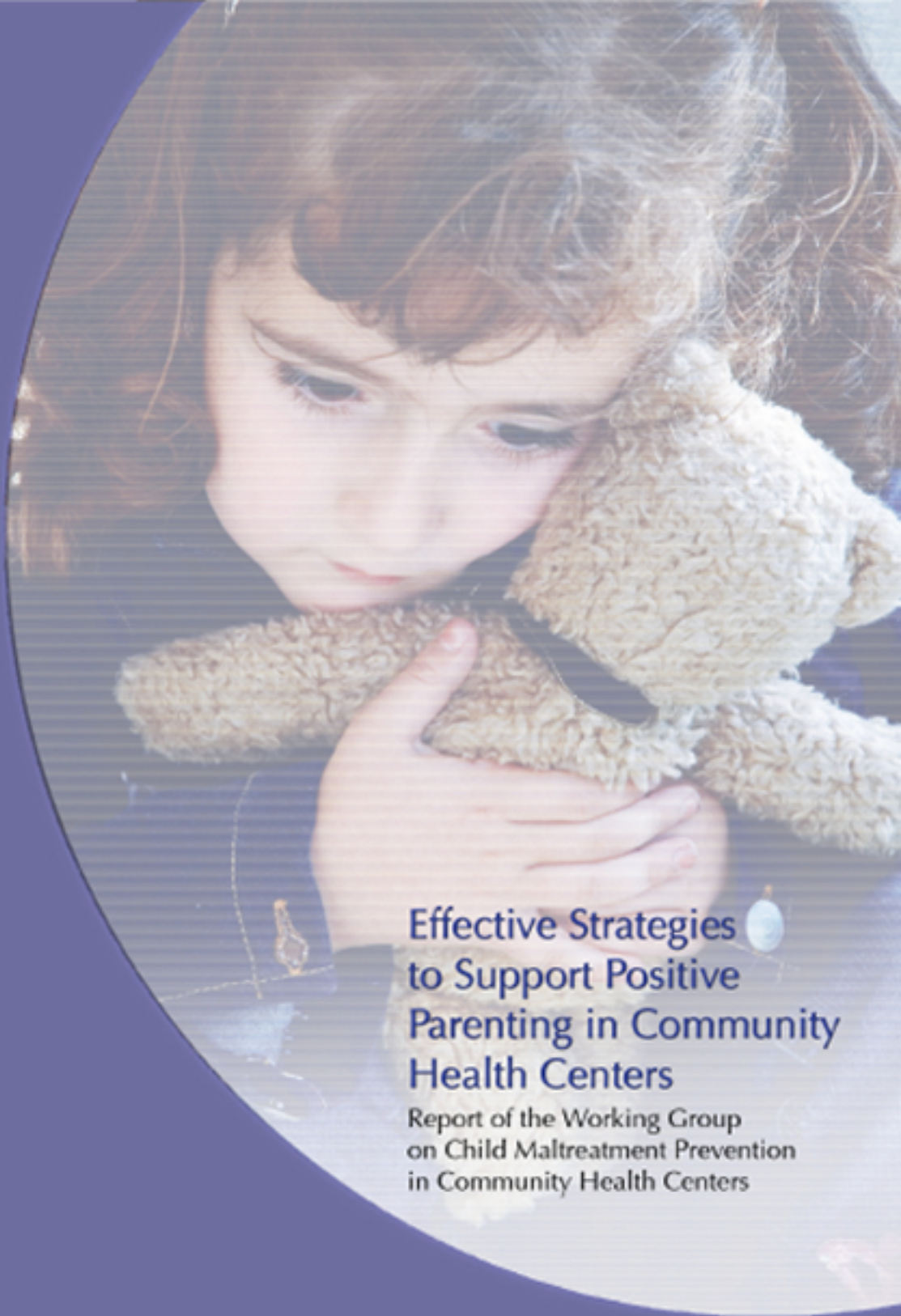

Effective Strategies to Support Positive Parenting in Community Health Centers

Report of the Working Group on Child Maltreatment Prevention in Community Health Centers

Executive Summary

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Introduction and Background

Our nation's future depends on the well-being of its children. Today's children are tomorrow's citizens, workers, and parents. Yet child abuse and neglect are serious public health problems in this country. In millions of families in the United States, children's caretaking and development are faltering and, in many households, failing altogether. Fortunately, we are in the midst of a remarkable expansion of knowledge in neuroscience and genetics, child development and early childhood intervention, and economics, which collectively creates common ground for public health strategies to prevent child maltreatment and promote healthy, positive development for all children. The resulting body of knowledge offers the public, policymakers, and civic leaders an unprecedented opportunity that did not exist even a decade ago to catalyze the creation of effective, science-based policies and practices to prevent child maltreatment.

Findings from the research are clear. They are summarized below by the National Scientific Council on the Developing Child (2007):

- Early childhood experiences have lifelong effects. Childhood is a pivotal window of opportunity for positive and negative impact.
- The interaction of genes and early experiences shapes the brain over time and provides individuals with a strong or weak foundation for all future health, behavior, and learning.
- Severe and chronic stress in early childhood from maltreatment and exposure to violence is associated with persistent effects on the nervous system and brain chemistry that can lead to lifelong problems in health, behavior, and learning.
- Young children need nurturing, positive relationships, safe environments, and rich learning opportunities to thrive.
- Creating the right conditions for optimal childhood development is likely to be more effective and less costly than addressing problems at a later stage. Early prevention and intervention programs can enhance early development.

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The accumulated science provides the basis for a new national dialogue on the meaning of shared responsibility for children and strategic investment in their future (National Research Council and Institute of Medicine, 2000). Public policies that support growth-promoting experiences for children create an enduring foundation for lifelong economic productivity and responsible citizenship (National Scientific Council on the Developing Child, 2007).

History of the Working Group

With this knowledge in hand, the Division of Violence Prevention at the Centers for Disease Control and Prevention (CDC) convened a panel of experts to help establish national priorities and a common conceptualization of prevention as an effort to promote safe, stable, nurturing relationships for children and positive parenting practices. In September 2007, the CDC contracted with the American Psychological Association (APA) to convene a panel of experts to identify and recommend public health strategies based on the best available science to prevent child maltreatment by promoting positive parenting practices within the context of behavioral integration at community health centers. The seven-member Working Group on Child Maltreatment Prevention in Community Health Centers reviewed the relevant body of knowledge on the following topics:

I. Effectiveness of behavioral health integration in primary care settings;

II. Effectiveness of evidence-based positive parenting interventions to prevent child maltreatment; and

III. Viability of community health centers as a venue for child maltreatment prevention interventions.

This report summarizes the results of that effort. It describes the extent of the problem and then discusses the need for prevention, the effectiveness of parenting programs as child maltreatment prevention strategies, the value of community health centers as a venue for prevention initiatives, and the framework of behavioral health integration as a strategy for accomplishing that goal. The report concludes with recommendations, highlighting key factors necessary for their successful implementation.

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Understanding the Problem of Child Maltreatment[1]

Child maltreatment is a serious public health problem with lifelong consequences for individuals' physical and mental health and costs to society estimated to be in the billions of dollars annually. It is prevalent, damaging, and costly.

- In 2006, approximately 6 million children in the United States were referred to authorities because maltreatment was suspected; more than half of these cases were deemed worthy of an official response, and in over 905,000 cases, suspicions were substantiated. Conservative estimates suggest that 1,530 children died from abuse or neglect in the United States in 2006 alone; over three quarters were under the age of 4.
- Parents, either alone or with another person, are by far the most commonly responsible for children's maltreatment. Approximately half the maltreated children are from diverse ethnic minority backgrounds. Many families live in poverty, under high stress and low support conditions, with unequal access to physical and mental health care. In these circumstances, parental substance abuse, mental illness (especially depression), intimate partner violence, or harsh discipline place children at risk for neglect or abuse.
- A growing body of scientific research indicates that child maltreatment has pervasive, long-term physical and mental health consequences. It has been linked to risk for anxiety, depression, posttraumatic stress, the development of delinquency, acts of violence by youth, alcoholism, drug abuse, severe obesity, smoking, and suicide, as well as disease conditions in adulthood, such as pulmonary, heart, and liver disease, diabetes, and stroke.

[1] Strategies examined in this report are aimed at prevention of physical and emotional abuse and neglect. After surveying the literature, the working group determined that the evidence base for preventing sexual abuse through practices conducive to implementation in primary care settings was negligible.

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- Estimates of costs to society range from $94 billion to a more conservative $24 billion for the associated legal and health care costs. Short-term costs include hospitalization or emergency room visits for medical treatment of injuries from physical abuse; out-of-home placement alternatives to remove children from abusive or neglectful families; programs and services to address mental health issues and substance abuse; and child protective services and investigations. Although difficult to estimate precisely, there are also long-term, downstream costs, such as lost productivity, poor physical and mental health in adulthood, and antisocial behavior.

Preventing Child Maltreatment

Focus on Primary Prevention From a Public Health Perspective

- The public health model is an applicable framework that goes beyond the identification of risk and protective factors and moves the field forward to focus on the prevention of maltreatment and on the promotion of healthy family functioning and child outcomes generally.
- Analogous to other national public health strategies universally encouraged for all families—such as vaccines, car seats, and breastfeeding—primary prevention efforts such as those focusing on positive parenting practices can have a far-reaching impact on children, families, and communities, ultimately challenging normative patterns.

Focus on Parenting Practices and Community-Centered Initiatives

This report describes a promising pathway to the prevention of child maltreatment by addressing the problem from a public health perspective and a community-centered model. The approach centers on prevention (i.e., before any maltreatment occurs) and promotion of healthy family functioning universally (i.e., to the entire population), but it also includes focused efforts in selective settings, in this instance, poor neighborhoods served by community health centers, given the additional risks present in such communities. Recommendations focus largely on improving the environments in which children are raised—the quality of parent–child interactions, caregivers' child-rearing practices, and the

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behavioral/mental health problems of parents—through improvements in the behavioral health care families receive in primary care settings.

Because parents, caregivers, and other relatives are responsible for a clear majority of child maltreatment and because patterns of abuse take root when children are infants or young children, caregiver-focused strategies that address parenting skills, especially (but not limited to) when children are young, would seem to be a promising mode of intervention to prevent child maltreatment. Also, parenting practices are amenable to change, given reasonable efforts, and are the subject of a considerable body of accumulated scientific evidence including proven change strategies.

The recommended strategies include the following:

- Universal parent training programs, well grounded in science, adapted to families of all backgrounds, offered at community health centers, based on strategies that may enhance parenting broadly, with maltreatment prevention being one indicator of such broad improvement; and
- Integration of behavioral health care activities and workers into primary care settings to identify and address parental risk factors that preclude optimal parenting and refer them to the appropriate interventions, such as preventive positive parenting programs.

Focus on Building Safe, Stable, Nurturing Relationships for Young Children

- Efforts that promote safe, stable, nurturing, and stimulating home environments early in a child's life can significantly and positively affect the child's developmental growth trajectory for years to come, with benefits for the child, family, and society at large.
- The focus on promoting key relationships in children's lives is well grounded in theory and science.
- Although no single factor explains why maltreatment occurs within families, certainly parental mental health problems, family chaos, stress related to social and economic conditions, cultural issues, and other risk factors all play a part. However, a substantial portion of the risk for maltreatment is evident in the parent–child relationship and the continuous flow of daily parent–child interactions. When children's caretaking demands exceed parents' coping resources or when stressful, volatile, and hostile parent–child interactions out-

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number positive, safe, and nurturing interactions, the likelihood of maltreatment is heightened.

- Promoting protective factors by helping parents form stable, secure attachments with children, develop warm, positive relationships with children, and use positive discipline strategies is a promising approach to maltreatment prevention.

Prevention Can Be Cost Effective

- Prevention makes sound social and economic policy. Prevention of child maltreatment is cost effective. Initiatives that promote safe and supportive relationships for vulnerable children are wise investments in the future because they can result in significant reduction of child maltreatment, with resultant cost savings associated with child welfare, health and mental health services, foster care and residential placements, and adult dependence on welfare, incarceration, and health and mental health care systems.

Taking Prevention to Primary Care Settings

Primary health care is an existing setting that is widely and regularly accessed by parents and children, where a range of prevention strategies can be implemented.

- Parents and children attend regularly scheduled checkups at each stage of a child's development in primary care settings. Psychosocial concerns are raised in the vast majority of visits.
- Health care professionals are well positioned to promote healthy parent–child interaction, to strengthen child-rearing practices, and to intervene before precursors escalate into abuse or neglect.
- Health care professionals have a unique opportunity to observe the quality of parent–child relationships over time, allowing for early identification of risk factors, such as harsh discipline and hostile parent–child interactions.
- Physicians and others are likely to be the first to notice the stress-related mental health problems in parents, such as

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depression and substance abuse that often set the stage for later neglect or family violence.

- Health practitioners are perceived by patients as caring and knowledgeable; their rapport and credibility provide a unique opportunity to normalize parent help-seeking and make it possible to refer and engage families in parenting programs with minimal stigma.
- Mounting empirical evidence suggests the usefulness of establishing prevention programs in primary care settings. Prevention efforts in pediatric practices have resulted in an array of positive outcomes, including fewer child injuries, reduced child exposure to violent media, and increased safety of home firearm storage. Innovative programs have shown promising results.
- Leaders in science, practice, and policy have called for transformations in the health care system that promote healthy social and emotional development as part of healthy child development for all children, creating fertile ground for this approach. Models of infrastructures that are consistent with this report's recommended approach have been promoted by the U.S. Surgeon General's Report on Children's Mental Health, the President's New Freedom Commission on Mental Health, the CDC, the American Academy of Pediatrics, the APA, and the World Health Organization, among other groups.

Implementing Child Maltreatment Prevention at Community Health Centers

The existing network of community health centers (CHCs) is a promising venue for launching family-centered initiatives to prevent child maltreatment.

- CHCs are the largest national network of primary care safety net providers in the United States, serving more than 15 million individuals across all 50 states every year. Economic harsh times are likely to increase the demand for services at the CHCs. They provide family-oriented, comprehensive primary and preventive health care to inner city and rural communities regardless of the patient's ability to pay.

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- CHCs serve a highly diverse population, two thirds of whom are ethnic minorities, and "hard to reach" families. This population overlaps extensively with the families at highest risk for maltreatment, because it often occurs in the context of poverty, parental substance abuse, interpersonal violence, parental mental illness, and limited access to services and resources.
- The population served by CHCs is primarily young and female, necessitating a strong focus on pediatrics, family medicine, obstetrics and gynecology, and mental health, all contexts well suited for identifying warning signs and intervening with young families before situations reach critical levels.
- Governed by patient-led community boards, these neighborhood clinics have a long-standing commitment to prevention, reduction of disparities in access to care, and cost savings.

Over the last decade, CHCs have steadily increased their attention to behavioral health issues.

- Seventy percent of centers have on site mental health services and 50% have onsite substance abuse treatment services.
- Mental health and substance abuse together constitute the leading reason for visits to CHCs, with health supervision of children under 12 a close second.
- Many centers have mental health and substance abuse screening, diagnosis, and treatment as well as patient education, self-help support groups, and group counseling on site.

CHCs undoubtedly face a number of challenges, including serious financial stressors and gaps in capacity.

- Centers struggle to access capital funding to address aging structures, respond to equipment needs, or adopt promising innovations because federal funds are intended primarily for direct services.
- Centers have difficulty recruiting and maintaining qualified staff because they are located in less desirable or remote areas and have difficulty offering competitive salaries.
- New initiatives in child maltreatment prevention at CHCs will require a serious commitment to workforce development and

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training, given the overall shortage in mental health professionals trained to work with children and families nationally.

- Any new initiatives in child maltreatment prevention at CHCs could not be funded from existing resources.

Integrating Behavioral Health in Primary Care Settings

The integration of behavioral health workers and services in primary care settings is a promising framework for promoting a family-centered approach to preventing child maltreatment.

- Behavioral health integration is a holistic approach that aims to provide seamless, cost-effective care as well as prevention and better management of problems through immediate access to mental health care.
- When integrated in primary care settings, behavioral health care workers (e.g., psychologists, social workers, behavior management specialists) can implement evidence-based positive parenting initiatives adapted to the needs of a local diverse population. As members of multidisciplinary teams, they can provide the triage, curbside consultation, screening, crisis counseling, assessment, treatment, and referral necessary to create a sustainable, collaborative health care system in which to embed preventive parenting initiatives at primary care settings.
- The feasibility of integrated care has been amply demonstrated in a range of settings, including treatment of common mental health problems in pediatric offices and "hard to reach" populations, such as homeless mothers and children. Studies show improvements in service utilization and greater confidence in referrals by general practitioners.
- Rigorous research on patient outcomes, cost, and consumer satisfaction is limited, and further research is clearly indicated. Thus far no single model has been found to be superior. Research has been hindered by the fact that programs are often embedded in disorganized, inefficient systems of care, making it difficult to tease out independent contributions of innovative models.

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Improving Parenting Practices by Addressing Parental Risk Factors

Efforts to identify and address the risk factors that impair healthy family functioning and preclude optimal parenting will complement strategies to strengthen families and enhance parenting.

- The behavioral health integration model provides an opportunity to identify and help address psychosocial problems that place families at risk for maltreatment, especially parental mental health risk factors, such as maternal depression, substance abuse, and intimate partner violence.
- Frequently, health care professionals are in a position to identify and confront these psychosocial problems facing families.
- An integrated care model that includes mechanisms for identification and referral of parental risk factors could help prioritize limited resources, leverage impact, and meet specific needs of individual families. For example, some risk factors, like maternal depression, could be tipping points in multiproblem families. Identifying and addressing a mother's depression may be a tipping point enabling her to find work and function better in a variety of ways that protect against the development of abuse or neglect.

Improving Parenting Practices With Evidence-Based Interventions

Evidence-based parent training is a promising strategy for preventing child maltreatment.

- There is a substantial body of well-designed controlled trials and other scientific research showing that parenting programs can produce significant and durable positive changes, in terms of increasing healthy family relationships, changing parenting behavior, reducing child behavior problems, and reducing future rates of child maltreatment.

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- Meta-analytic reviews of programs tend to produce positive but small to moderate effect sizes; yet even with small effect sizes, promoting parenting efforts in communities could result in significant reductions in the prevalence of child maltreatment and cost savings.

Programs vary dramatically in terms of the scientific evidence for their effectiveness. Not all programs are effective.

- Although a multitude of programs have been developed in the name of child abuse prevention, and many implemented widely, the vast majority are not evidence based and either have not undergone scientific evaluation or have failed to show effective prevention when rigorously evaluated.
- In contrast, the accumulation of evidence for a comparatively smaller number of programs has reached an important turning point, with at least one program showing preventive impact on child maltreatment at the population level with large effect sizes and numerous programs showing lasting effects on parent and child behavior in rigorous randomized controlled trials.

Effective programs share core elements and content.

- Effective programs tend to focus on parents; teach positive parenting practices; provide skills training, parent education, social support, and/or crisis intervention; and use standardized curricula delivered by trained professionals and others with strong quality control mechanisms.
- The content of programs with the largest effects includes having parents practice new skills during training sessions and understand the importance of parenting consistency, as well as teaching parents how to have positive parent–child interactions, use emotional communication skills, and replace punitive punishments, criticism, and negative commands with timeouts, praise, and positive communication.

Communities need to be selective in locating promising programs for implementation and matching the model to the needs of a particular site and population.

- Effective programs vary in terms of their mode of delivery (e.g., center based or home visitation, individual or group format), intensity, cultural fit, and intended population.

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- Some models are better suited to changing serious parenting problems but are less suited to mass delivery, whereas others may be suited to economical mass delivery but are designed for parents with fewer serious problems.

Programs with positive outcomes have well-trained staff, are intensive and implemented with fidelity and strong quality controls, and are evaluated regularly and improved continuously. Yet achieving such capacities requires resources and time.

- Cost–benefit studies suggest that high-quality early interventions are likely to produce better outcomes than remediation efforts later in life; the up-front costs of high-quality programs for vulnerable families generate a strong return on investment.

In summary, there are a number of promising parenting programs described and reviewed in the report that could be incorporated into CHCs. No single program is a panacea. Nonetheless, there are both center-based programs and home visitation programs with a sufficient evidence base to warrant being tested in demonstration projects within the CHC model.

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Overarching Recommendations

From the public health perspective, the child maltreatment prevention field has seen scientific progress in understanding the problem and developing some efficacious intervention models, but knowledge of dissemination and implementation on a broad scale has remained limited. Demonstration projects evaluating evidence-based preventive parenting programs by integrating behavioral health care into primary care settings at CHCs is a logical next step.

The Working Group on Child Maltreatment Prevention in Community Health Centers offers the following recommendations, with the intent to spur future action:

I. Promote safe, stable, nurturing relationships for children through positive parenting with the integration of behavioral health in primary care settings.

II. Promote universal access to evidence-based, preventive, positive parenting programs at CHCs for families from diverse socioeconomic, cultural, racial, and ethnic backgrounds.

III. Promote interdisciplinary, interagency, and cross-systems collaboration to implement child maltreatment prevention initiatives at CHCs.

IV. Develop national efforts across CHCs to prevent child maltreatment.

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Key Considerations for Implementation of Recommendations

Successful implementation of these recommendations requires attention to a number of key considerations. The effort to move evidence-based programs from research to wide-scale adoption is in a nascent stage. Successful implementation must be conducted (a) in a systematic fashion that follows the limited scientific findings to date about strategies and quality improvement processes; (b) through a network of demonstration projects evaluated to determine effectiveness; (c) with an understanding that the evaluation results will feed ongoing efforts to retool and revise original models; and (d) with adequate funding and support from key stakeholders. The working group has identified the following key areas to consider in implementing the proposed model:

Local adaptation of evidence-based programs. Standardized, evidence-based parenting programs will need to be adapted to meet the needs of local, diverse populations and ensure that interventions are culturally compatible; diversity training will ensure that providers are culturally competent.

Stakeholder buy-in and support. Challenges to implementation at local health centers are many and will require stakeholder "buy in" and support from CHC staff, administrators, patients, patient-led CHC governing boards, community leaders, and the public. Embedding child maltreatment prevention initiatives in larger community-wide prevention efforts is propitious; highly visible community-wide efforts have been far more effective than single-component initiatives in other preventive public health initiatives.

Use of technology. In order to promote cost-effectiveness, to overcome barriers to access, and to achieve the broadest reach, the highest levels of technology available will be needed to identify problems early (e.g., instruments administered in waiting room kiosks), train parents (e.g., video lending libraries), and provide parenting advice (e.g., cell phones for 24/7 counseling).

Multilevel research and evaluation of new program effectiveness. Transportation of evidence-based parenting programs to widespread service delivery should begin with the evaluation of a limited number of demonstration projects before moving toward national study of variability in

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programs, adaptation strategies, and resources. Results of this evaluation will help determine how best to adapt programs and take them to scale nationally.

Workforce development plan. A strategy will be needed to develop a well-trained, multidisciplinary, tiered (doctoral and nondoctoral) workforce that includes behavioral health specialists. Such a strategy needs to take into consideration the shortage of professionals trained to work with children and families, the difficulties of recruiting and retaining skilled workforce in remote or undesirable locations, and the lack of focus on prevention in behavioral health education.

Collaborative networks of centers. Given the wide variation across local health centers, collaborative networks of participating centers will help collapse costs and reduce inconsistencies in training, tracking and monitoring, and evaluation.

Engagement and retention strategies for parents. Incentives and strategies for engaging and retaining diverse at-risk families in parenting programs will be necessary given the many barriers to access that exist and the fact that dropout rates are exceedingly high in this population.

Fidelity, quality control, accountability, and evaluation. Moving experimental programs from science to wide-scale adoption requires quality controls and evaluation to ensure fidelity to program models, given that behavioral health workers will adapt programs to the needs of diverse local populations and that centers may implement core components but not necessarily whole programs.

Adequate funding. Supporting primary care system transformation and implementation of effective interventions through demonstration projects should be a priority. Existing funds are not adequate to support the implementation of the evidence-based model recommended in this report. New resources will be required.

Role for CDC. The CDC should have a critical role in the implementation and evaluation of demonstration projects at CHCs to prevent child maltreatment. As the nation's leading public health agency, the CDC National Center for Injury Prevention and Control is the logical choice as the home for research and service initiatives to prevent child maltreatment from the public health perspective. In addition, the CDC has defined child maltreatment as one of its top priorities and has been involved in several projects

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related to parenting interventions.

Contribution of psychology. Psychologists can make an important contribution in primary care settings to the prevention of child maltreatment. The field of psychology can make a unique contribution to the efforts to prevent child maltreatment through its expertise in research, training, and practice. Psychologists can contribute through behavioral triage and screening, psychosocial assessment, on-site treatment, referral, consultation, case management, workforce training, and program adaptation and evaluation. In addition, the APA can contribute by promoting training of psychologists to embrace prevention and behavioral health integration in primary care settings, by advocating for further research, and by encouraging a national effort to make child maltreatment prevention part of the primary care setting's portfolio of services.

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