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ABSTRACT

The purpose of this paper is to summarize current trends in child abuse prevention and to provide program administrators and policymakers with guidelines for implementing successful new parent programs in their communities. Contents address: (1) the scope of the child abuse problem; (2) a theoretical framework or conceptual model for use in designing effective, new parenting services; (3) model program components for providing a mixture of therapeutic and supportive services; (4) empirical evidence on the effectiveness of programs designed to strengthen parents and reduce the likelihood of abuse and neglect through early intervention; (5) barriers to prevention; and (6) recommendations for the development of a comprehensive policy for local prevention advocates. (RH)

Intervening With New Parents:

An Effective Way to Prevent Child Abuse

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INTERVENING WITH NEW PARENTS: AN EFFECTIVE WAY TO PREVENT CHILD ABUSE

INTRODUCTION

NCPCA has placed a special emphasis on educational and support services for new parents in formulating its long range plan to reduce child abuse 20% by 1990.[1] Current shifts in the demographics of family life and in our understanding of the most effective methods for preventing child abuse, as well as the ongoing need to efficiently utilize scarce resources, all underscore the need to expand early interventions with new parents. The purpose of this paper is to summarize these trends and to provide program administrators and policy makers with guidelines for implementing successful new parent programs in their respective communities.

Unlike some policies and programs which have unfolded in the absence of empirical evidence or theoretical frameworks, new parent programs have a solid and expanding evaluative and theoretical foundation. Data suggest tha' the risk of child abuse or neglect can be significantly reduced if a continuum of supportive, educational and therapeutic services is made available to families around the time of birth.[2] While no single program is effective for all families under all conditions, areas of parental and personal functioning have improved following receipt of such diverse interventions as home visits, support groups, and parenting education classes.

When one talks about expanding parenting programs or establishing effective public policy to prevent child abuse, a number of questions come to mind.

SCOPE OF THE PROBLEM: What does the "at risk" population look like? How diverse are new parents or parents under stress? What are their presenting problems? What relative risk do these problems pose with respect to child safety?

THEORETICAL FRAMEWORK: What factors contribute to the parenting process and what skills and knowledge do parents need to best care for their children? What supports can the broader social environment offer to parents? What stands between good intentions and good parenting?

MODEL PROGRAM COMPONENTS: Given these factors or theoretical framework, what would a good parenting program look like? What are the key service components and key staff characteristics for successful programs?

EMPIRICAL EVIDENCE: What does the empirical evidence tell us about existing service models? Which are the most promising? And for whom?

BARRIERS TO PREVENTION: What are the fiscal impacts of prevention? Are some families

beyond help? Can parenting programs be voluntary and still capture the at-risk population? How intrusive do our programs have to be in order to protect children?

MODEL POLICY: What should local prevention advocates adopt as their approach to supporting first time parents and parents under stress?

The remainder of this paper addresses each of these issues in turn.

SCOPE OF THE PROBLEM

The structure of the American family has undergone tremendous change in the past several decades. Although the birth rate is declining, the number of births to teenagers and single, unwed women are on the rise. Of the 3.7 million babies born to women in this country in 1986, over 500,000 were born to teenagers and approximately half of these teens were unmarried at the time they gave birth. Seventeen percent of all births are to women who are not married.[3] Without making any moral judgments on the appropriateness of these births, fewer parental resources are potentially available to children in single-parent families than to those born into two-parent families. Further, the reality is that over 70% of all children in this country will face life in a single parent household at least some time before they turn 18 years of age. At any one time, almost a quarter of all families are headed by single parents.[4] The availability of full-time parental care is further limited by the growing number

of women entering the labor force. By 1995, two thirds of all preschoolers and 80% of all children 7 to 18 are expected to have working mothers.[5]

Children are the fastest growing poverty group in this country. While impressive gains have been made in the reduction of poverty among the aged, largely due to the passage of Social Security and Medicare, over one-fifth of the nation's children and over half of all minority children live in poverty.[6] Not only are more children being reared in households with limited financial resources, the social support systems in place to assist low-income families are declining. The real value of the average Aid to Families with Dependent Children (AFDC) benefit package declined 17% between 1979 and 1984.[7] Almost one-quarter of the women of child-bearing age do not have access to public or private health insurance. Medicaid reaches 20% fewer eligible families today than it did in 1975. Access to quality health care for young mothers is further limited by the fact that only slightly more than one-half of all practicing obstetricians will see Medicaid patients.[8] In addition to lacking access to basic primary and tertiary health care, many low income women and infants have poor nutrition. In 1984, the Federal Women, Infant and Children (WIC) food supplement program reached only one-third of all poor children.[9]

Without adequate access to prenatal and post-natal care, it is not surprising that our infants fare less well in the early years of life than children being born into countries where routine medical care around the time of birth and early infancy

is a given. The current infant mortality rate in this country of 10.6 per 1,000 live births is higher than virtually any other industrialized country. While marked reduction in the infant mortality rate was realized in the 1960's and 1970's, these gains have stalled in recent years, with black infants still having twice the mortality rate of white infants.[10]

Lack of adequate financial and health resources are only one set of problems faced by a growing number of children. Violence and substance abuse are almost commonplace in many American families. Seven out of ten adults in this country drink and nine million are problem or alcoholic drinkers.[11] Of every 1,000 couples, 158 pushed, slapped, threatened or used a gun or a knife on each other. Over 620 of every 1,000 children ages three to 17 experience this type of violence every year.[12] Perhaps reflective of this conduct is the fact that reports of child abuse have increased steadily, exceeding 2.2 million in 1986.[13] Similar to the mismatch between supply and demand observed in other social service areas, average child welfare budgets increased just 2% between 1981 and 1985, although reports of child abuse rose 51% during this same period.[14]

One of the most alarming statistics concerning the welfare of children is the recent increase in reports of child abuse and neglect related fatalities. Between 1985 and 1986, reported child abuse fatalities increased 23%. An estimated 1,300 children were identified in 1986 as fatal victims of severe physical abuse or neglect.[15] The actual number of child abuse fatalities, however, most likely exceed this figure. For a

variety of reasons, the determination of the immediate and situational cause of deaths involving young children are difficult to determine. Whether a death is classified as a child abuse fatality, homicide, SIDS death (Sudden Infant Death Syndrome), or accidental death often depends on the nature of the investigation and whether or not siblings are in the family. Unfortunately, increases exist in all of these categories. In 1985, 665 children nine years of age or younger were murdered, 90% of whom were killed by a parent at home with a blunt instrument.[16] Last year, 7,000 children were diagnosed as SIDS victims and another 3,000 victims were classified with condition similar to SIDS.[17] In 1983, over 8,000 children under the age of 15 died in accidents including motor vehicle accidents, drownings, fires, ingestion of poisons or falls.[18] Certainly, some of the deaths were unavoidable. However, a careful look at these cases suggest that in certain instances parental neglect, although often not intentional, was a contributing factor. For example, death scene investigations and autopsies in a sample of SIDS cases suggest that some small percentage of these deaths, perhaps 5%, are the result of poor care or poor environmental conditions.[19] Similarly, 20% of all child fatalities caused by fire occurred when children were either unattended or unsupervised. Over one-third of all fires in which children die are caused by children playing with matches.[20]

In short, the conditions under which some children live in this country are not optimal. Expanding programs which assist parents in dealing with these issues are essential in order to

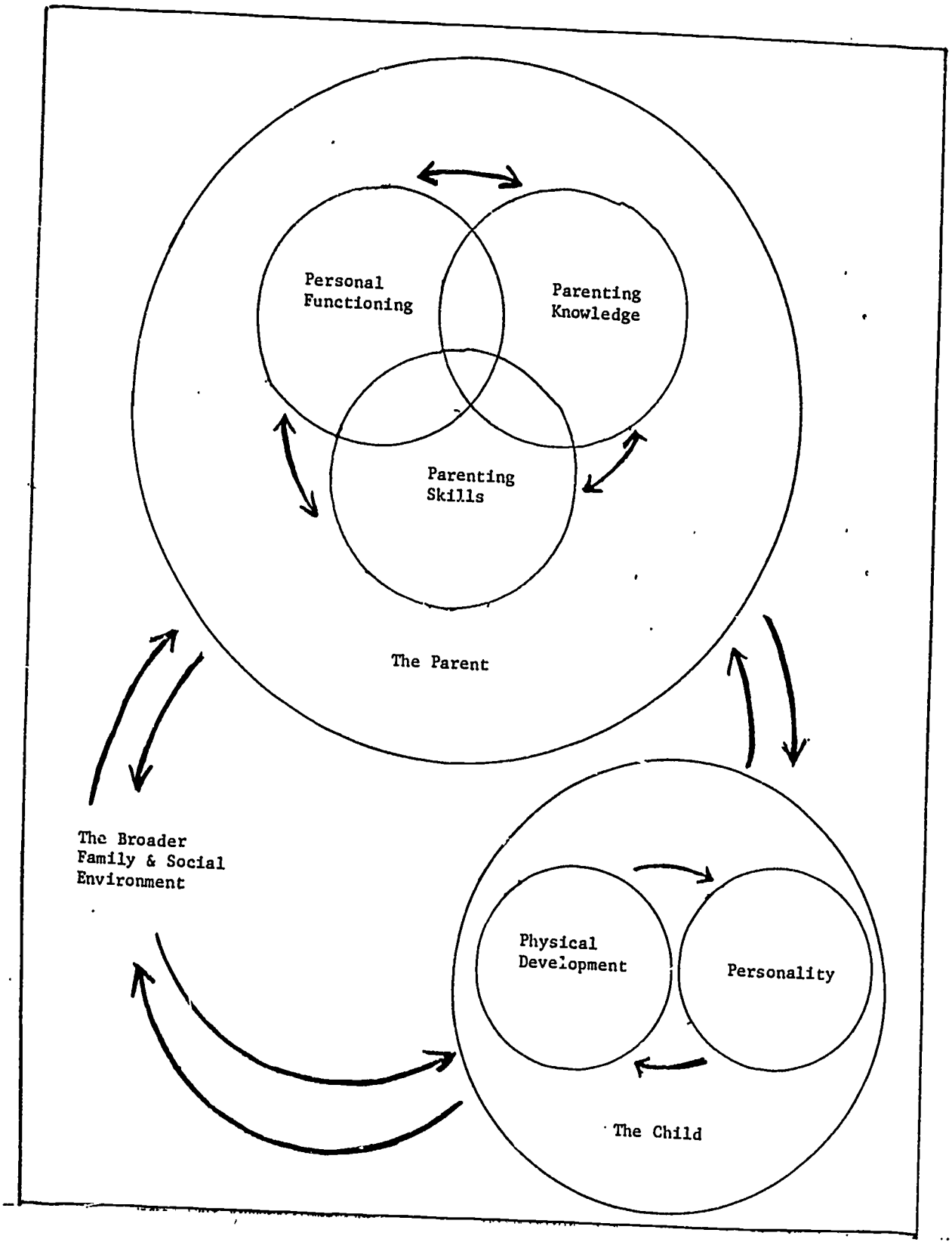
significantly reduce the rate of child abuse and neglect. Such services need to address, among other factors, the issue of adequate health care, housing opportunities and the elimination of violence.

THEORETICAL FRAMEWORK

A theoretical or conceptual model of parenting is critical in designing effective new parenting services. Creating a "theory of parenting" imposes an order and prioritization of problem areas and service strategies. It helps program planners identify the attitudes, behaviors, and conditions which may pose barriers to effective parenting and may limit the program gains. It also prevents policy makers from placing too much hope in a single intervention or strategy. When operating with a theoretical framework, program managers can more easily identify the unique contributions of individual policies and service components to a client's success as well as those areas of personal functioning which require multiple interventions.

Figure A presents one approach for considering factors at play in parenting. This model has governed the development of a number of evaluation strategies and is a common approach taken by child development specialists and those fostering an ecological theory of child abuse prevention and family functioning.[21] It is an interactive model. Each of the five identified components both influence and respond to the other four. Before outlining specific new parent programs, it is useful to consider the unique issues and questions raised by each of these components.

Figure A
A Conceptual Model of Parenting



The most essential component in formulating any relationship is the capacity to love or respond to another. At the most basic level, parents need to have this capacity in order to relate to their children. Often adults who were abused as children, who were raised without the nurturance or support of an identified primary caretaker or whose initial observations of adult interactions were scenes of extreme violence lack this basic capacity. Parents who exhibit a lack of emotional attachment to their children are generally very poor candidates for parenting services. These individuals may require substantial therapeutic intervention and support to understand their own psychological make-up and difficulties before being able to address their relationship with their children. Fortunately, a relatively small percentage of even an abusive population suffers from this degree of personal dysfunctioning, suggesting that the majority of parents have at least this minimal requirement for adequate parenting.[22]

Second, it is important for parents to know, in at least general terms, the differing cognitive and physical abilities and needs of children at different stages of development. For example, a parent with a new infant needs to know how to feed a baby, what a baby should be fed and when the infant needs medical care. As the child develops, other practical knowledge is needed such as how to child-proof the house, how to provide support and direction for the child, and how to discipline the child. Parenting education programs are well suited to filling this type of informational gap either through written material, group

presentations or individual home instruction. In many respects, conveying this type of basic knowledge to parents may be the easiest task in improving parenting potential.

Beyond providing parents with general information, however, lies a more difficult task, that of helping parents translate knowledge into behavior. For some parents, the transition will be a natural extension of having received the information or of having observed appropriate caregiving. For other parents, the transition will be significantly more difficult. Identifying and addressing the barriers parents face in meeting their baby's needs can be a complex and time consuming task for practioners. Modeling the implementation of basic parenting information is one of the most effective ways to assist parents in integrating their newly acquired knowledge into how they care for their children. Parents who experienced healthy care as children or who observed or perhaps assisted their parents in the care of younger siblings will have less difficulty in making use of the knowledge parenting education resources offer than will parents who lack concrete experience. For the latter group of parents, service providers may need to spend several hours demonstrating basic child care techniques to first time mothers or assisting them in securing necessary support services such as medical care or day care.

A critical actor in the parent-child dyad is the child himself. Some babies are more difficult and temperamental than others. Low birth weight babies, premature infants or developmentally delayed children can be particularly

challenging.[23] Further, as with all relationships, some mothers and babies are simply more compatible and better suited to each other.[24] If the infant reminds the mother of someone she particularly dislikes, most commonly the baby's father, she may have difficulty providing the care she knows her child needs. In working with new parents, therefore, it is essential that attention be paid to the characteristics of the child and the manner in which the child and parent temperaments complement or disrupt the parenting process.

Finally, all of these factors operate within a broader context of the parent's personal and social environment. The ability of a young mother to adequately care for her child is influenced not merely by her own psychological make-up, her level of parenting knowledge and skills and the characteristics of her baby. Her parenting capacity also is shaped by the support she receives from her family and friends and her ability to master and effectively utilize other social institutions such as the local educational system, health care system, and welfare system. In addition, the total pool of resources potentially available to parents expand or limit their overall ability to meet the needs of their children. For example, communities which have a large number of quality day care facilities, schools, health care centers, housing and employment opportunities offer families greater resources to care for their children than do communities lacking these characteristics. Even the most knowledgeable and skillful parents will have problems insuring the health and well-being of their children if they are unable to find employment or

if their housing complex or community is riddled with crime. While most new parent programs do not address directly these broader social conditions, providers need to be aware of local conditions and service capacities in order to place realistic standards on their potential success.

MODEL PROGRAM COMPONENTS

The above model suggests that programs which work on all of these areas either alone or in association with other community-based agencies hold the most promise for success. Based on the above description of factors which influence a parent's ability to parent, it becomes clear why the simple provision of parenting knowledge is in sufficient in effecting change or why an expansion in health care services does not always result in higher use by those eligible for care.

The model also underscores the need to offer new parents a variety of strategies in order to increase the likelihood that they will successfully receive the assistance they need. No matter how well structured a program, there are no guarantees that it will be successful with all of its clients. However, this model, as well as what we know about successful health care and social service practice, does suggest that the inclusion of certain components and the hiring of certain staff increase the odds of program success.

Much of what we know with respect to the individual causes of child maltreatment suggests that direct interventions with parents, preferably as close to the birth of their first child as possible, are excellent strategies for reducing levels of

physical abuse, neglect, and emotional maltreatment. Programs offering instruction in specific parenting skills such as disciplinary methods, basic child care and infant stimulation; child development education; familiarity with local support services; and linkages to other new parents in the community address a number of the interpersonal and situational difficulties for parents outlined in the above model. While the content and structure of these programs vary, critical service goals for new parent programs should include:

- o increasing a parent's knowledge of child development and the demands of parenting;
- o enhancing a parent's skill in coping with the stresses of infant and child care;
- o enhancing parent-child bonding, emotional ties and communication;
- o increasing a parent's skills in coping with the stress of caring for children with special needs;
- o increasing a parent's knowledge about home and child management;
- o reducing the burden of child care; and
- o increasing access to social and health services for all family members.[25]

On balance, programs which incorporate these objectives rely upon a mixture of therapeutic and supportive services. While there are no specific standards for structuring these programs, the most common service elements include routine health

screening and developmental testing for the child, instruction in or modeling of basic child care techniques either through clinic-based classes or regular home visits, identification and enhancement of the mother's system of formal and informal supports, and, if appropriate, case management and advocacy services at the client and system levels.

Further, research has shown that families involved in different types of maltreatment have different informational needs and respond more positively to different service settings. For example, group based parent education and training which emphasizes impulse control and alternative methods of discipline are particularly successful with physical abusers. In contrast, efforts to address child neglect are more successful when they rely more heavily on a one-on-one service system built around basic casework counseling or problem solving techniques. Parenting instruction with this population needs to address concrete child care tasks such as diapering and feeding an infant or managing a two year old. Successful prevention of emotional maltreatment includes group-based services which define non-physical methods of discipline; emphasizes the need for consistency in determining and implementing rules; and offers parents ways of demonstrating affection toward their children.[26]

Reflective of these differing needs, appropriate staffing patterns may include the use of multidisciplinary teams for both assessment as well as service delivery or may rely heavily upon the skills of a single service provider. This second approach is most common in those programs utilizing a home visitor approach.

In certain instances, the provider will need to be a health care professional or trained social worker. In other cases, specifically trained paraprofessionals can be utilized.

Independent of professional training or education, the provider's personal skills play a central role in engaging and retaining families in their programs. Among the characteristics considered most essential are an active interest in new ideas; an active interest in people and an ability to engage people socially; an ability to accept people's life situation without prejudging them; an ability to relate to a family's experiences without becoming enmeshed in the family's problem cycles; and relative stability in his or her own personal life.[27] These characteristics have been found to be particularly essential in working with teenage parents where the provider's value system may suggest that having children at a very young age does a disservice to both the youth and the infant. An analysis of provider attitudes in at least one teen parent program found that a staff member's expectations of themselves and of the families being served played a significant role in the extent to which material was accurately presented to the time and the extent to which the teen responded in a positive manner.[28]

Any advice or assistance offered to new parents must be tempered by the emphasis given in this country to parental rights. In a free society, the "correct" method of parenting is a personal decision, largely left to the discretion of each individual parent. However, when certain conditions, such as early pre-natal care, proper nutrition, and well-baby check-ups,

can be linked to healthier pregnancies and healthier infants, greater latitude exists in how forcefully the concepts can be presented. Further, by connecting the information offered parents to measurable and observable changes in their child's well-being, providers creates a more positive and objective service environment.

EMPIRICAL EVIDENCE

While this type of model program design is useful to improve the quality of how we serve parents, measuring the effectiveness of these types of interventions are dependent upon careful and repeated evaluations of actual programs. What does the empirical evidence say about our ability to strengthen parents and reduce the likelihood of abuse and neglect through early intervention? On balance, the evidence is quite promising.

Comprehensive programs which have incorporated the program objectives and staff characteristics outlined above into intensive, one to three years of weekly contact with participants generally have been found to produce the most positive gains. Both home-based programs as well as center-based programs have demonstrated a wide range of positive client outcomes. Specific gains have included improved mother-infant bonding and maternal capacity to respond to the child's emotional needs[29]; demonstrated ability to care for the child's physical and developmental needs[30]; fewer subsequent pregnancies[31]; more consistent use of health care services and job training opportunities[32]; and lower welfare use, higher school completion rates and higher employment rates.[33] In identifying the types of

parents most likely to benefit from these educational and supportive services, several have noted particular success with young, relatively poor mothers [34] and with mothers who felt confident in their lives prior to enrolling in the program. [35]

At least one ten-year longitudinal study suggests that comprehensive parenting services not only produce initial gains but that these gains are strengthened over time. Seitz and her colleagues successfully tracked, ten years later, 15 of 17 matched sets of families, half of whom had received a coordinated set of medical and social services, including day care for their children. While not specifically identified as being at risk of maltreatment, these families all had household incomes below the federal poverty level and were expecting their first child. Following the birth of the baby, the team pediatricians saw the mother and the baby daily in the hospital and scheduled an initial home visit following discharge. Each family received 13 to 17 well-baby visits; an average of 28 home visits by a social worker, psychologist or nurse; and two to 28 months of day care services over the entire treatment period. Families were enrolled from pregnancy through 20 months postpartum.

Although the sample is small and was limited to first-time mothers, repeated follow-up studies on the treatment families noted a steady improvement from termination, to five years later, to the current ten-year post-termination study. Specific differences were noted between the two groups in the mother's level of education, the family's financial independence and the child's school performance. Average educational achievement for

treatment mothers was 13.0 years while the control sample had an average of only 11.7. The study team found 13 of the 15 treatment families had at least one full-time wage earner or full-time equivalent between both adult partners in the home, a situation which was found in only eight of the 15 control families. Significant differences also were noted in the school performance of the two groups of children. Only four of the 15 control children were judged by their teachers to have good school adjustment, a rating given to ten of the 16 treatment children. [36]

On balance, these findings show a slow and steady increase in the economic growth of the treatment families and a static picture for the controls. Translating these gains into social service savings, the authors noted that an additional $40,000 in welfare costs and documented school services were needed by the 15 control families in the single year in which the ten-year follow-up study was conducted. While not specifically documenting a reduction in abuse or neglect, the study clearly demonstrates the elimination of certain factors associated with higher rates of maltreatment and the positive effects early family-based interventions can have on both parents and children.

While such studies are useful in advancing our understanding of how best to enhance general parenting skills, the work of David Olds and his colleagues has provided some of the best empirical evidence to date that the provision of a specific service model does indeed reduce the incidence of child abuse and neglect.[37] The participants in this study, all of whom were

first-time mothers, were randomly assigned to one of four conditions in which the most intensive level of services involved regular pre- and postnatal home visits by a nurse practitioner. The nurse home visitors carried out three major activities: parent education regarding fetal and infant development; the involvement of family members and friends in child care and support of the mother; and the linkage of family members with other health and human services.

Of the 400 women participating in the program, 47% were younger than 19 years of age, 62% were unmarried, and 61% were low socioeconomic status. Those who received the most intensive intervention had a significantly lower incidence of reported child abuse over the two-year postbirth study period. While 19% of the comparison group at greatest risk for maltreatment (i.e. poor, unmarried teens) were reported for abuse or neglect, only 4% of their nurse-visited counterparts were reported. Of these cases, 50% involved reports of neglect only and 50% involved reports of neglect and physical abuse. Although these results were not true for older program participants, the dramatic gains realized with first-time, teen mothers suggest that this group may benefit particularly from prevention services. In addition to having a lower reported rate of child abuse, those infants whose mothers received ongoing nurse home visits had fewer accidents and were less likely to require emergency room care. The mothers also reported less frequent need to punish or restrict their children.

The use of home visitors has been identified by others as achieving notable gains in parent-child interactions and in improving the child's developmental progress. For example, Project 12-Ways, a multifaceted home-based service program in central Illinois, provides intensive services to families who have been reported to the State Department of Children and Family Services (DCFS) for abuse, neglect, or being at risk of abuse or neglect. Educational and support services are provided to program participants in their homes by advanced graduate students in the Behavior Analysis and Therapy Program at Southern Illinois University. The specific topics covered during these home visits include parenting skills, stress management, self-control, assertiveness training, health maintenance, job placement and marital counseling. Repeated evaluation of the program has documented significantly fewer repeated abuse and neglect incidents among program recipients than among DCFS clients not receiving this intervention. While enrolled in the program, only 2% of a randomly selected number of Project 12-Ways's clients were reported for maltreatment compared to 11% of the control group. In the year following termination of services, 10% of the treatment families and 21% of the non-treatment families were reported for maltreatment.[38] Subsequent evaluations of this approach has found similar differences between treatment and comparison samples, although the effects of program involvement tends to diminish over time.[39]

Similar gains have been noted with this model when lay volunteers were used as the primary service provider. The C.

Henry Kempe National Center for the Treatment and Prevention of Child Abuse and Neglect pioneered the use of lay home visitors with at risk mothers. Evaluations of their efforts have consistently found this method to result in a reduction in child abuse potential and an enhancement of mother-infant relationships.[10] While not measuring a reduction in child abuse and neglect directly, the Ford Foundation's Child Survival/Fair Start initiative suggests that well trained community volunteers offer a unique opportunity to successfully engage at-risk mothers, particularly those who lack the ability to trust anyone aside of their immediate family. Targeting specific high risk communities and populations such as migrant farm workers and public housing residents, the program had four primary objectives: to promote simple health care practices and personal hygiene; to encourage the appropriate use of the health care system; to strengthen parent-child relationships; and to strengthen parental coping skills. All services were provided in the home by a lay worker chosen from the community and supervised by specially trained professionals.

Evaluations of these efforts found that for many of the families, the home visits were sufficient to resolve the majority of their situational and personal difficulties. Many multi-problem families, however, required additional, more directed professional assistance in the areas of health care, child care, and mental health services. The conclusion drawn by at least one evaluator of these services is that more comprehensive and technical training needs to be provided to lay service workers or

the professional service community needs to be better sensitized in order to improve the direct access of these systems by high-risk families.[41]

A number of parenting enhancement models utilizing a center-based service delivery method also have produced positive gains in overall parenting skills and in the use of community resources.[42] Many of these programs are school-based initiatives. For example, the New Futures School in Albuquerque, New Mexico reports a very positive response of teen mothers to their school-based educational and support program. A 1981 follow-up study on youth who were served by the program between 1974 and 1980 found that over 80% of the teens had completed high school and as a group they had a repeat pregnancy rate one-third the national average.

One of the most widely disseminated group based models is the Minnesota Early Learning Demonstration (MELD), an intensive two-year parenting education and support program. Since its inception in 1975, six specific programs have been developed: MELD for New Parents; MELD for Young Moms; MELD Plus for growing families; LaFamilia/MELD for Hispanic families; MELD Special for parents of children with specific needs; and HIPP/MELD for hearing impaired parents. Each program's purpose is to provide the most useful information available in the most supportive environment that can be created. MELD's mission is to get families off to a good start and to eliminate the potential for maltreatment by never letting abusive or neglectful patterns begin. The MELD staff believe that there is no one right way to

parent and participants are encouraged to make the childrearing choices that are appropriate for them and their children. The program demonstrates that if participants are supported in their efforts to be good parents, if they are exposed to good information and alternative ways of addressing childrearing issues, they will be able to make the choices that enhance their children's well-being as well as their own.

A typical MELD group includes 10-20 mothers who meet for two to three hours weekly. While the program lasts for two years, the meetings are scheduled in four six-month phases that include 20 meetings each and are lead by extensively trained parent volunteers. The topics discussed during these meetings include health issues, child development, child guidance, family management and personal growth. Specific techniques incorporated into the program include large group discussions; small group discussions; brainstorming; demonstrations; homework; role-playing; mini-lectures; films; outside resources; facilitator presentations; parent presentations; sharing of experiences; and informal socializing during the meal provided at each meeting. All participants are provided with transportation assistance and child care to facilitate attendance at the meetings.

Although the program has never been evaluated in terms of child abuse prevention, the immediate outcomes demonstrated by program participants are encouraging. A recent evaluation of the MELD Young Moms program conducted by the Child Welfare League of America noted that 80% of the participants had finished or were completing high school compared to an overall school completion

rate of only 20% for the general adolescent parent population. Also, while 25% of all teenage mothers experience a repeat pregnancy within a year of their first birth, MELD Young Mom participants have a repeat pregnancy rate of only 10-15%. Changes also were noted in the parents' use of discipline, where the percentage of parents who spanked their children decreased from 56% at the start of the program to only 12% at the conclusion of services.

By way of grounding these findings, it is informative to consider the history of a group of 2,800 young women in Illinois who were enrolled in AFDC prior to their 18th birthday because they were pregnant. These young women did not have the advantage of any special educational or supportive services. Eighteen months after being placed on welfare, 72% had dropped out of school with no plans to return. Forty percent already had a second child and an additional 7% were pregnant. Finally, only 25% had any employment history and almost 90% were still receiving welfare.[43] Statistics such as these underscore the difficulty low income teen mothers face and the low probability they have of becoming self-sufficient in the absence of any educational or supportive services.

The collective results outlined above underscore the difficulty in addressing the myriad of issues associated with an increased risk for maltreatment under the rubric of a single service framework. Offering services in a client's home has a number of distinct advantages, particularly when the objective is to reduce the likelihood of maltreatment. Such services offer

the provider an excellent opportunity to assess the safety of the child's living environment and to work with the mother in very concrete ways to improve parent-child interactions. The method also affords the client a degree of privacy and the practitioner a degree of flexibility difficult to achieve in center-based programs. Individuals who may be reluctant to attend weekly sessions at a community-based service center or local hospital either because they are uncomfortable about sharing their experiences with other parents or because they find it difficult to travel to the center find home-based services a welcomed alternative.

The method, however, is not without drawbacks. The costs of these programs can be quite significant, particularly if, as in the case of the Olds study, the home visitors are nurse practitioners or clinical social workers. Even if trained paraprofessionals or volunteers are used, the strategy is highly labor-intensive and involves considerable transportation costs. Also, the one-to-one service model places a tremendous burden on the individual provider. The home setting makes it potentially more difficult to focus on parent-child relationships or on a given set of parenting skills. Often, clients are not prepared for the worker's visit although these appointments may be longstanding.[44] A clinician may need to spend considerable time focusing the mother on the issues or tasks to be addressed during the visit and away from the normal, daily distractions found in home settings. Children crying, the telephone ringing, or an unexpected visitor are distractions which are more readily

controlled in an office setting. Also, the method itself does not afford the practitioner the opportunity to draw on the benefits of a group service model, as discussed below, nor the clients to work through his or her difficulties with others in similar circumstances. Further, although these clients initially will have tacitly agreed to participate in the program, having a stranger actually enter one's home can be extremely threatening. Consequently, clients may be particularly resistant to the home visitor during the first several contacts. In addition, these clients may be less outer-directed and socially skilled than those women who choose to attend parenting programs held outside their homes. Practitioners involved in this method of service delivery, as described earlier, need to be sensitive to these fears and limitations and to work with these clients in developing a gradual nurturing, personal relationship with the mother. Several initial visits may be required to develop this level of trust such that the client is able to openly and honestly discuss her parenting concerns and accept specific child care suggestions.

In contrast, parenting services offered through a community-based family service center or health care facility provide participants with an opportunity to share childrearing and personal problems with other parents in similar situations. This exchange serves an important validation function for parents, allowing them to acknowledge their difficulties and stresses while accepting peer suggestions on how best to cope with the demands of young children. Strategies such as the MELD program

establish an ongoing support group for parents to draw upon during and outside the actual service delivery process, further reducing the level of isolation. Often the physical location of the group meetings can become identified as a general support center for all parents to utilize in addressing a wide range of issues. In this sense, the strategy serves as a foundation for a more universal child abuse prevention effort in which parents seeking assistance need not first be identified as requiring "special" services.

The major difficulty these programs face is the organizational demands they place on group participants. Regular attendance at weekly group meetings requires a good deal of motivation and structure on the part of a young mother. Evaluations of these efforts suggest that only a fraction of participants are able to demonstrate this level of control. Drop-out rates of as high as 40 to 50% have been noted by several program reviewers.[45] Unlike the home-based models, continued participation in a center-based program is contingent upon a parent's willingness to cope with the transportation and child care demands inherent in attending any event outside of one's home. Also, weekly participation requires that these young mothers introduce a level of consistency and scheduling into their daily lives which generally has been absent. It is logical to assume that parents exhibiting this motivational level will be predisposed to taking full advantage of the support and educational benefits offered by center-based programs. However, parents lacking this motivation and who may be among those at

greatest risk for maltreatment will be unlikely to sustain involvement long enough with these programs to achieve the most positive outcomes.

Reaching the full spectrum of the "at risk" population clearly requires some combination of both methods as well as the provision of crisis intervention services and respite care. Center-based services, particularly if they are associated with local junior high and senior high school programs for adolescent parents, offer excellent opportunities for a highly motivated teenage mother not only to improve her parenting skills but also to continue her education and to establish a stable life for herself and her infant. Home-based programs, with their more individualized and flexible service delivery system, will be particularly useful with a more isolated population and with those mothers lacking the interest or motivation to participate in a group program. Augmenting both of these strategies needs to be crisis intervention and respite services to function as a safety valve for new parents.

BARRIERS TO EFFECTIVE PREVENTION PLANNING

Before developing a specific local service plan, it is useful to consider some hard realities those interested in expanding new parent services must face. First, none of the solutions being debated will be cheap to implement. Even the most modest programs, those involving short-term informational services to first time parents, would require significant funding. Simply supplying all new mothers with $5 worth of printed material, with no individual explanations, could cost

$18.5 million annually.[46] If every women giving birth received one hour of parenting advice and information, the costs would exceed $52 million each year.[47] While the costs of new parent services can be minimized through integration with existing service systems and through the use of paraprofessional staff and volunteers, significant expenditures are inevitable.

In the long run, prevention is cost effective. The work of Seitz cited above illustrates that initial spending on health care and day care services around the time of birth can result in significant system savings in local welfare and special education budgets. Considering the broader prevention network, it has been estimated that even if such services were successful in reducing the level of serious physical abuse by only 20%, some $362 million would be saved each year in reduced foster care costs, hospitalization and medical costs, rehabilitative services, juvenile court costs, and lost future productivity.[48]

Unfortunately, policy rarely is made with an eye toward long term savings. Calls for a balanced budget makes legislatures uncomfortable with even moderate spending now if savings cannot be realized in the same fiscal year. For at least some period of time, it is reasonable to assume that significant dollars need to be placed in both treatment and prevention. While prevention dollars spent today eventually will lead to a reduction in the demand for treatment services, the increasing number of current victims as evidence by higher reporting and child fatality rates suggest that this transfer point has not been reached. Being committed to the provision of new parent services means being

committed to devoting professional energies and fiscal resources to the planning and implementation of an intervention which may not produce aggregate, measurable cost savings for some time. Such strategies, however, offer the only possible hope of ever being able to reduce treatment costs not because the problem is being ignored but rather because the problem is being conquered.

Second, the health and welfare of the nation's children is influenced by a myriad of sociological and demographic trends which in turn influence both the potential for child abuse as well as our capacity to prevent it. Divorce, women in the labor force, teen age pregnancy, domestic violence, school failures and drop-out rates, drug use, a mismatch between the skills of the workforce and the jobs that are available, the lack of affordable housing, and an erosion of the social service safety net add stress to the parenting process and place a growing number of families at an elevated risk for maltreatment.

One challenge facing those concerned with prevention is selected from among these issues, those trends they will try to reduce and those they will accept as a given. This selection process reflects different ideological points of view and different concepts of family structure. Policies whose success depend upon an increase in two parent households where one parent remains home to care for the child face a tough battle. Whether one prefers this type of family structure is a question of personal taste and values. The reality, however, is that few families resemble this model and prevention efforts need to be successful in an environment where many children are raised by a

single, often working, parent or by two, full-time employed parents. The most effective prevention planning will be that which begins with a profile of families as they are, not as one might want them to be.

Finally, a chronic criticism of prevention services is that the only parents who use them are the ones who would most likely not abuse or neglect their children. Parents who recognize the need to seek out parenting services, the argument goes, are exactly the type of parents one would expect to successfully engage in service. Given this self-selection pattern, it is not surprising to find the notable gains cited above among prevention service participants.

To a certain extent the voluntary nature of prevention services do allow the most violent and most seriously dysfunctional families to avoid early intervention. For example, a recent review of the types of teen parents electing to participate in Parents Too Soon, an educational and support program in Illinois, confirms this theory. Those youth who had ever held a job, perceived work as better than welfare and saw themselves as having problems were three times more likely to enroll in the program than youth with none of these characteristics.[49]

While such findings may indeed suggest a self-selection process, this process may not be detrimental to the efficient use of prevention resources. Simply put, severely dysfunctional families may not be good candidates for prevention services. In analyzing his most recent family violence data, Straus and his

colleagues noted that roughly 4 to 6% of the households interviewed demonstrated severe violence toward their children irrespective of the child's age.[50] One interpretation of this finding is that physical violence in these families is not a result of a lack of child development knowledge or unrealistic expectations for children. Families in this group appear to communicate through violence and to cope with stress and disappointment by physically mistreating each other. Simply providing parenting education services and support groups to these families has little chance of breaking this very severe pattern of violence.

Protecting children who live in these types of violent environments may well require non-voluntary programs and coercive interventions. On the other hand, prevention services, almost by definition, have an inherent voluntary quality to them. The minute a program shifts from voluntary to mandatory it shifts from social support to social control. One of the major dilemmas facing the prevention field is how to reach down into those families at highest risk without altering the supportive and positive image of prevention.

The existing health and educational systems offer a number of opportunities for capturing an increasingly larger segment of the total population. Further, the use of these systems helps cast new parent programs not as a means of helping parents avoid negative behavior but rather as an means of helping parents achieve the best possible relationship with their children. What would these integrated policies look like? At the national

level, Medicaid coverage could be expanded to include all pregnant women, thereby insuring that pre and postnatal health care was affordable and accessible to all women having children. Further, local health care facilities could be more explicit in addressing parenting and child development education in the context of regular pre and post natal care, well-baby check-ups and general family practice visits. All hospitals could adopt a policy of providing parenting information and referral services to all women delivering at their institutions and local school districts could include mandated parenting and family life education for junior and senior high students. Public housing complexes could include on site day care, parenting education classes and health care services for residents. Finally, a high priority of all city governments could be an ample supply of quality housing for all families with children, located in communities which were safe for children to play outdoors.

Even if all of these reforms were instituted some families would continue to fall between the cracks. They may continue to ignore prevention services or simply not benefit from the services they do receive. Over time, however, such strategies would significantly increase the percentage of the population receiving early intervention and would reach out to those young parents who, if left unserved, may well become the chronic neglectful and seriously abusive parents of the next decade.

ESTABLISHING A COMPREHENSIVE POLICY

Development of new parent programs, therefore, will occur in a context of limited resources, changing family and social

dynamics, and some number of reluctant participants. Given these parameters, at least four strategies should be pursued in all local communities. First, prevention advocates need to work with all local hospitals with maternity wards to develop education and supportive services around the time of birth for all women delivering at these institutions. Initially these services might be limited to first time parents, gradually expanding to include all births.

Second, prevention advocates need to work with all local junior and senior high school administrators to integrate parenting and family life education into the standard curriculum. Further, all high school districts should develop and implement a comprehensive educational and support program for pregnant and parenting teens. Key services to include in such a program would be day care, vocational training, support groups, and financial planning.

Third, prevention advocates need to integrate parent enhancement services into the broad range of organizations with which parents interact. Both home visitor programs as well as center based education and support groups need to be established, thereby providing a network of services for parents with different personal skills and needs. Local churches, recreational centers, housing associations, day care collectives and civic organizations all must be engaged in supporting parents in their local community either directly, through the development and implementation of a new parent program, or indirectly, through contributing volunteers or funding to existing efforts.

Finally, prevention advocates need to take stock of their progress, noting the number of families they are serving and the changes their efforts produce. If a program is not successful in a given community, those who operate it should be the first to identify the problem and to take corrective action. Improving the effectiveness and efficiency of new parent programs will depend upon those involved in these programs having the courage to learn both from their successes and their failures.

Comprehensive prevention efforts will not eliminate all child abuse. Child abuse and neglect will continue to exist in our society as long as there are families with fewer personal and environmental resources than they need to adequately raise their children. Just because we cannot be 100% successful, however, does not mean that prevention is not worthwhile. The implementation of quality new parent programs throughout all communities can make a sizable dent in those maltreatment episodes which result from a parent's lack of knowledge, lack of skills or lack of support. Further, this approach offers the most empirically and theoretically sound avenue open to policy makers and program administrators committed to stopping the hurt before it begins.

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