The Role of the Family and Family-Centered Programs and Policies

Lawrence M. Berger and Sarah A. Font

Summary

Families influence their children's health in two ways that are amenable to public policy—through their financial and other investments in children, and through the quality of care that they provide. In general, children who receive more resources or better parenting are healthier than those who don't. Public policies, therefore, might improve children's health either by giving families more resources or by helping parents provide better care.

When it comes to financial resources, write Lawrence Berger and Sarah Font, the research is straightforward—programs that add to disadvantaged families' incomes, whether in cash or in kind, can indeed improve their children's health. The Earned Income Tax Credit, for example, has been linked to higher birth weights and greater cognitive achievement.

When it comes to programs that target quality of care, however, the picture is more complex. At the low end of the spectrum, poor parenting shades into neglect or abuse, which can seriously harm children's health and development. Thus we might expect that the child protective services system, which has the power to intervene and protect children in such cases, could also improve children's health in the long run. But Berger and Font find that the system's ability to affect children's health is limited, largely because it becomes involved in children's lives only after damage has already occurred.

Other programs, however, have the potential to improve parenting, reduce maltreatment, and thus enhance children's health and development. Home visiting programs show particular promise, as do large-scale, community-level primary prevention programs.

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Childhood health is associated with a wide variety of outcomes throughout the life course, from ongoing physical and mental health to disability, mortality, and socioeconomic status. Families bear the primary responsibility for making direct investments in children, as well as for regulating and allotting other public and private investments. That is, families provide the caregiving context in which most children grow and develop; they also provide and allocate resources to children. In this way, families play the primary role in promoting child health and development. Thus, any effort to promote child health must necessarily involve families. Yet the quality of the family environments in which children are raised varies considerably; in particular, not all families provide safe, stable, and high-quality care.

In this article, we first explain how families are believed to influence children's health. In particular, we focus on family context (structure, composition, and access to resources) and parenting behaviors. We consider health in a broad sense, including physical, social-emotional, behavioral, cognitive, and mental health and development. Second, we describe the role of the child protective services (CPS) system in protecting children from familial harm and intervening with families where child maltreatment has occurred. We conclude that CPS has limited ability to influence child health, because it primarily intervenes only after harm has occurred and because a combination of resource constraints and a relatively narrow mandate means that CPS focuses on only a small proportion of children and families. Third, we review other policies and programs that can influence family contexts and behaviors before harm has occurred. We highlight

several promising programs—including economic support, community-level interventions, and home visiting programs—that have the potential to improve the quality of care children receive, reduce child maltreatment, and positively influence child health and development.

How Do Families Influence Child Health?

Families are thought to influence child health through three primary mechanisms: biological and genetic endowments, financial investments (goods and services purchased), and behavioral investments (caregiving quantity and quality).[1] Specifically, given their knowledge about a child's health from birth onward, parents make decisions about the quantity and quality of their financial and economic investments in their children. Wealthier parents can afford more and higher-quality goods and services than their lower-income counterparts. Likewise, within a given budget, more highly educated or skilled parents may make higher-quality caregiving choices than do less-educated or less-skilled parents. Parents' own health and mental health are also likely to affect the quantity and quality of their investments. Finally, family structure, complexity, and fluidity are linked to the financial and behavioral investments that parents provide.

Biological and Genetic Endowments
Genes affect physical and mental health, and predispositions for many health conditions are heritable. Because genetic predispositions are not malleable to public policy, we don't cover them in this article. Instead, we focus on how children's caregiving environments—which may be influenced by public policy—can influence their health. We emphasize, however, that children's genetic

attributes and predispositions interact with their environments to determine their physical and mental health.[2] Indeed, strong associations between parents' and children's health appear to be driven largely by shared experiences and behaviors—both in the womb and after birth—regarding the adequacy of material resources, stress, exposure to environmental stimulation and/or toxins, sleep and nutritional habits, parental behaviors and decision making, and parenting styles with regard to discipline, monitoring, and emotional support. In short, biology is far from destiny.

Financial Resources and Investments

Financial resources let families purchase goods and services that promote children's healthy development. These include basic material needs, such as food, shelter, and medical care, as well as things that support social and cognitive development, such as schooling, books, and toys. Children from low-income families have poorer prenatal health and poorer birth outcomes than do their higher-income counterparts; these disparities persist throughout childhood and, indeed, their entire lives. In addition to exhibiting poorer overall health and higher rates of a host of specific health problems, low-income children receive fewer and lower-quality medical and related services for their health problems, and their families are less able to manage these problems and provide compensatory and supportive environments.[3] Furthermore, stressful experiences associated with growing up in a context of limited economic resources may adversely affect children's neurological and biological development, thereby adversely influencing their physical and mental health, as well as their cognitive and social-emotional development.[4]

Families vary in their access to financial resources as well as the extent to which they invest available resources in children. Specifically, higher-income families make greater and higher-quality investments in every area.[5] This may partly reflect the fact that low-income and poor families have fewer options when choosing neighborhoods, housing, food, medical care, child care and schooling, and a host of other goods and services. However, financial resources are intertwined with other social advantages, most notably higher levels of education and social status. Consequently, along with constrained choices, low-income parents may have less knowledge to guide them in selecting the healthiest environments for their children.[6] Parental characteristics, including physical and mental health, education, and intellectual capacity, are also known to influence parenting behaviors and are thereby thought to affect children's health.[7] Parents' mental health problems may be particularly worrisome. Research has shown, for example, that maternal depression is associated with both low-quality parenting and with poor health and development among children. It may also make mothers less willing or able to take advantage of available services.[8] Regardless of parents' financial resources, education, or intentions, however, the level and quality of goods and services that a child receives can be conceptualized along a continuum ranging from extremely high investments in child health and development to serious material deprivation, which is closely associated with child neglect. As we discuss below, economic support policies can affect family resources and may thereby influence the amount of resources invested in children.

Behavioral Investments

Behavioral investments in children's care are equally important for their health. Such

investments include the full range of care-giving environments and activities to which children are exposed, taking into account both quantity and quality. High-quality child rearing requires that parents be accessible and available to children, engage with them, take responsibility for their safety and well-being, and use developmentally appropriate monitoring, management, and discipline strategies.[9] Parents also serve as role models. Each of these tasks requires forethought, collaboration, and coordination. Furthermore, parents' behaviors may directly influence child health by protecting children from or exposing them to a variety of health-related risks both before and after birth. Parents' health behaviors and exposure to toxins, both before conception and during pregnancy, may directly influence children's initial and ongoing health.[10] After birth, parents' decisions affect children's nutritional intake, physical activity, health care, supervision and safety, sleep routines, emotional support and stimulation, and exposure to secondhand smoke and other environmental toxins, each of which can affect children's health. Parents' behaviors may also influence their children's health indirectly, in that parents may model healthy or unhealthy behaviors or lifestyles.[11]

There are no commonly established thresholds for high-quality parenting. However, authoritative parenting, which combines supportive engagement with productive discipline, is thought to be the most developmentally stimulating parenting style. Children benefit most when parents are warm, responsive, affectionate, nurturing, and supportive; when they impart information and skills in a productive and positive manner; and when they exercise appropriate monitoring, control, and discipline so children recognize that their actions have consequences. Children raised by authoritative

parents exhibit higher levels of self-esteem and less depression and anxiety, and they engage in fewer antisocial behaviors such as delinquency and substance use, than do children raised by authoritarian (harsh, cold, and controlling) or permissive parents.[12] Like financial investments, the level and quality of behavioral investments in a child can be conceptualized along a continuum ranging from those that strongly promote health to those that create serious health risks. At the low end of this continuum, substandard care may, at the extreme, cross a threshold into child abuse or neglect.[13] Furthermore, just as public policy may influence the economic resources available to children, so, too, may policies and programs influence parental behaviors and the quality of the caregiving environments in which children are raised. We discuss several such policies and programs below.

Child Maltreatment

Child abuse and neglect pose a significant health risk for a large number of children. The Fourth National Incidence Study of Child Abuse and Neglect, which aimed to estimate child maltreatment beyond only those circumstances known to CPS, suggested that each year, between 1.7 and 4.0 percent of U.S. children are maltreated or at risk of maltreatment.[14] For both legal and policy purposes, states define child abuse and neglect differently, most notably with regard to children's exposure to domestic violence, parents' substance abuse, and the threshold (that is, the level of injury) for physical abuse.[15] However, in most states, four categories of behaviors are thought to warrant report, investigation, or CPS intervention. Child neglect refers to inadequate provision of basic necessities such as food, clothing, shelter, supervision, education, or medical care and, in some cases, a failure

to meet children's emotional needs. It is by far the most common form of maltreatment. Physical abuse consists of acts that cause bodily harm to a child or place a child at risk of bodily harm, often as a result of punishment or discipline. Sexual abuse is defined by a number of sexual activities involving children, ranging from direct sexual contact to sexual exploitation or exhibitionism. Psychological or emotional maltreatment (often termed "mental injury") is an umbrella term for actions or omissions that cause, or are likely to cause, psychological harm. Maltreatment behaviors may take the form of acts of commission (child physical abuse, child sexual abuse, some forms of psychological or emotional maltreatment) and acts of omission (child neglect, some forms of psychological or emotional maltreatment) on the part of either a permanent or temporary caregiver. In approximately 71 percent of confirmed maltreatment cases, a biological parent is the perpetrator.[16]

A recent comprehensive review and meta-analysis of the research identified 39 risk factors for child abuse and 22 for child neglect.[17] The strongest predictors of child abuse were parent anger/hyper-reactivity, family conflict, and lack of family cohesion; the strongest predictors of neglect were a poor parent-child relationship, parental perception of the child as a problem, parental stress, parental anger/hyper-reactivity, and parental self-esteem. In addition, growing evidence suggests that socioeconomic disadvantage is "the most consistent and strongest" predictor of involvement with CPS.[18] This may mean that economic factors directly or indirectly affect the probability of maltreatment. Moreover, among families reported to CPS, poor families have a greater number of risk factors than their better-off counterparts, and, among poor families, those that are reported to CPS

have more maltreatment-related risk factors than do families that are not reported.[19]

Maltreatment during childhood is associated with a wide range of problems; these can be cognitive (executive functioning and attention, skills development, or educational achievement and attainment); mental health and social-emotional (attachment and behavior problems, emotional regulation, posttraumatic stress disorder, depression, suicidal thinking, criminal behavior, alcohol problems, or intergenerational transmission of maltreatment); physical (brain development, growth, obesity, or disease); and economic (earnings and income, job trajectory, occupation, or wealth).[20] It's not clear, however, that these associations are causal, because many of the family characteristics and behaviors that are associated with child maltreatment are also associated with poor health and development even in the absence of maltreatment.[21]

Substandard Parenting

Some children receive considerably lower-quality care than most other children do. We sometimes call this being exposed to substandard parenting or child maltreatment risk, which occurs when children receive a level of care that places them in the bottom end of the caregiving-quality distribution in one or more areas of parenting. These include parental warmth, emotional support, outings and activities, cognitive stimulation and access to learning materials, problems with the home interior (such as safety hazards, clutter, crowding, inadequate lighting, or inadequate heat), harsh discipline or frequent spanking, accidents requiring medical care, and access to routine medical and dental care. Notably, though low-quality behaviors in these areas are associated with child maltreatment, they do not necessarily

constitute maltreatment from a legal perspective. Nevertheless, substandard parenting indicates developmentally inappropriate caregiving and, at the extreme, may constitute or lead to maltreatment. For example, a lack of medical or dental checkups may be a marker of risk for medical neglect. Extremely low levels of parental warmth, emotional support, or cognitive stimulation may suggest that a family is at risk of physical or emotional neglect. Likewise, excessive spanking may indicate that a family is at risk of physical abuse.[22]

Substandard parenting and child maltreatment are also closely related. Abusive and neglectful parents tend to be more punitive and less responsive to their children than other parents, as well as less demanding of their children. Recent research also suggests that, after accounting for a host of other factors, substandard scores on widely used parenting assessments, such as the Home Observation for Measurement of the Environment and the Parent-Child Conflict Tactics Scales, are correlated with CPS involvement, as well as with other indicators of child maltreatment.[23] Furthermore, children may be at risk for adverse health and developmental outcomes if they are exposed to substandard parenting regardless of whether such behaviors constitute abuse or neglect. For example, our research has shown that measures of substandard parenting that don't meet the legal threshold for child maltreatment are equally or more strongly associated with children's later cognitive and social-emotional development than is maltreatment investigated by CPS.[24] Also, spanking, particularly in early childhood, is linked to a host of poor health and developmental outcomes.[25] Finally, low income and family complexity and fluidity appear to have similar associations with both substandard parenting and child maltreatment.[26]

Family Structure, Complexity, and Fluidity

Modern families come in a range of diverse and fluid forms. A large proportion, if not the majority, of U.S. children will experience one or more transitions in family structure and will have many types of caregivers and siblings. These transitions can provide opportunities to enhance investments in children's health, but they can also expose children to a variety of health-related risks.

Children who experience family complexity and fluidity tend to exhibit poorer average health and to have less access to regular health care.[27] In part, this reflects differences in parents' financial and behavioral resources; family complexity and fluidity are particularly common among poorer families.[28] Moreover, higher income is associated with lower levels of psychological distress, warmer and less harsh parenting, and higher-quality caregiving environments.[29] At the same time, the association between family complexity and fluidity and children's health may also reflect differences in how parents invest their financial and behavioral resources in their children.[30] Married two-biological-parent families, for instance, not only tend to be better off, they also tend to make greater average investments in children regardless of available resources. The reason may be that biological parents have greater incentives to invest in their children, that the institution of marriage encourages better parenting, and/or that individuals who choose particular family types differ in other ways as well. Higher-income and married biological parents also make higher-quality behavioral investments.[31] On average, children in lower-income and complex families (loosely defined to include families other than those consisting solely of a married couple and their joint biological

children) have poorer sleep routines, housing, nutritional intake, child care, home environments, schools, and neighborhoods than do children in higher-income and noncomplex families.[32] They also receive less monitoring and harsher parenting, and are exposed to more stress, conflict, and environmental toxins both in and outside their homes.[33] Each of these factors can adversely affect their health.

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Likewise, compared with children in stably married, two-biological-parent families, children in other (heterosexual) family settings experience, on average, lower levels of parental support, supervision, and monitoring, as well as less consistent discipline. They also face greater levels of stress and parental conflict, and their parents have poorer psychological wellbeing. Each of these factors is associated with lower levels of parental support, engagement, and warmth, and limited parental attention to children's health and emotional needs.[34] These factors may be compounded when families experience fluidity and instability. For example, many children receive less child support (whether formal or informal) and direct caregiving involvement from nonresident fathers; these behaviors decrease further when mothers or fathers take a new partner or have new children.[35] Furthermore, children in married or cohabiting stepparent households tend to receive fewer financial and behavioral

investments, on average, than those in married two-biological-parent households; however, some recent research has found relatively high levels of stepfather involvement with children, particularly among married stepfather families.[36]

The Child Protective Services System

An estimated 13 percent of all U.S. children and 21 percent of black children will experience confirmed maltreatment at some point between birth and age 18.[37] In 2012 alone, CPS agencies received reports on 6.3 million children. Yet only a small portion of those children and their families received any compensatory services. About 62 percent of the reports received by CPS are screened in, meaning they receive an investigation or assessment, but the remaining 38 percent receive no formal response, and the families involved are often unaware that a report had been made.[38] Reports are screened out when allegations don't meet statutory definitions of maltreatment, or when the agency has insufficient information to start an investigation. The proportion of cases that are screened out varies substantially across states, however, giving reason to believe that these determinations are somewhat subjective and that the proportion of cases investigated likely depends on the availability of resources.

Once reports are screened in, whether children or families receive services tends to depend on the outcome of the investigation or assessment. Families most commonly receive services after CPS determines that a child has suffered maltreatment. Roughly 4.6 percent of U.S. children were reported to CPS in 2012, and maltreatment was confirmed for about 0.9 percent of children (19 percent of screened-in cases).

In the vast majority of CPS cases, children are determined not to be maltreatment victims; 70 percent of these children and their families receive no additional services. If a report is confirmed, CPS has several options: child victims and their families may receive no services (40 percent of confirmed cases), in-home services (36 percent), or out-of-home (foster care) services (24 percent). In all, in 2012, over 1 million U.S. children and/or their families received CPS-related services, including about 60 percent of children whom CPS had determined to be maltreatment victims.[39] Furthermore, as a result of CPS involvement, more than 250,000 children entered and more than 460,000 were living in some form of out-of-home placement.[40]

CPS Services to Parents

State and county CPS systems vary greatly in terms of the services they offer and how accessible those services are. In part, this reflects the fact that CPS makes referrals to and contracts with a range of community-based agencies that tackle problems such as substance abuse, mental health, economic hardship, domestic violence, and parenting behaviors. Most frequently, families receive parenting-related services that are similar to those available to the general public. They receive other types of services much less frequently. For example, despite the fact that substance abuse and mental health problems are common among CPS-involved families, intensive inpatient or outpatient services are not typically available to them, given budgetary constraints and limited capacity.[41]

Arguably, the two most intensive types of interventions that CPS offers are family preservation programs to prevent removal of a child and family reunification programs to facilitate a safe return home after an out-of-home placement. Family preservation

programs do little to prevent out-of-home placement or future maltreatment, though they have been shown to produce modest improvements in family functioning, parenting behavior, support, and child wellbeing. Moreover, family preservation efforts on the whole have not consistently provided high-quality services. Family reunification programs could both facilitate children's return home after a placement and ensure that the homes to which they return are safe and stable. Yet few reunification programs have been rigorously evaluated. Furthermore, children who spend time in foster care go back to foster care at relatively high rates after being reunified with their families. Specifically, between a quarter and a third of reunified children will return to foster care within 10 years. Thus we have little reason to believe that family preservation and family reunification services, in their current form, do much to promote the health and development of CPS-involved children.[42] (For a discussion of how the U.S. legal framework may influence the role of CPS in family life, see Clare Huntington and Elizabeth Scott's article in this issue.)

CPS Services to Children

CPS largely aims to promote child wellbeing by improving the quality of children's caregiving environments. For children who remain in their homes and those who are in an out-of-home placement but are expected to return home, the primary target of CPS intervention is most frequently their parents, rather than the children themselves. This focus is crucial for achieving safety and promoting permanency, but it may be short-sighted with regard to promoting child wellbeing more generally, because it may miss opportunities to tackle children's health and developmental needs head-on. This may be particularly true for children who remain in their own homes. Compared to children

in out-of-home placements, child maltreatment victims who remain in the home are less likely to have health insurance; to receive regular medical checkups and mental health screenings, referrals, and services; and to be up to date on their immunizations. They are also more likely to have their dental, physical, or mental health care needs delayed due to cost, as well as to be hospitalized due to illness or injury.[43] This, at least in part, reflects the fact that more resources are available for the care of children in out-of-home placements, and more prescriptive (and widely established) guidelines govern that care. However, children who are removed from the home, on average, have experienced more severe maltreatment than those who are not. As such, they are likely to exhibit more health and developmental problems and to need more services than do those who remain in the home.

Though foster care remains essential for children who can't safely stay in their homes, in its current form it is unlikely to produce meaningful improvements in children's health.

In short, CPS-involved children generally receive inadequate health services—even those in foster care, who are typically covered by Medicaid. Furthermore, although CPS caseworkers are expected to refer children for services when they identify physical, mental, or educational needs, it's not clear that workers have the tools and training to accurately

identify such needs. Indeed, studies that compare CPS caseworker assessments of children's health and developmental needs to assessments conducted using standardized measures suggest that caseworkers fail to identify behavioral/emotional, developmental, and substance use needs, respectively, in 35 percent, 46 percent, and 70 percent of cases in which such needs were identified by standardized assessments.[44] These facts limit our confidence that the CPS system, in its current form, plays a large role in promoting child health and development. Furthermore, CPS funding, caseloads, and the availability of community services that CPS can access all vary considerably by locality. More fully and evenly resourced CPS systems, in which caseloads allowed for intensive developmental assessments and caseworkers were adequately trained to identify children at risk for health and developmental problems, might play a significant role in identifying at-risk children and connecting them to services. However, this would require a considerable commitment of resources, as well as a shift in CPS priorities.

Foster Care Services

Foster placement may promote children's health by protecting them from additional maltreatment. At the same time, foster care may disrupt familial and community ties and can thereby diminish mental and behavioral health. The effects of foster care placement itself are difficult to assess, given that children who enter care have generally experienced more severe maltreatment than children who remain in the home. Among children on the borderline of being placed in care, foster care placement is associated with worse academic and behavioral outcomes in early adulthood. However, it's unlikely that such foster care placements can be prevented in most cases, and research has found that

during childhood, maltreated children in foster care and those who remained at home have essentially equivalent cognitive and behavioral outcomes.[45] In sum, though foster care remains essential for children who can't safely stay in their homes, in its current form it is unlikely to produce meaningful improvements in children's health.

CPS and Child Health

Since 2001, state CPS agencies have been required to undergo federal Child and Family Services Reviews, which assess and monitor their progress toward promoting child wellbeing (in addition to safety and permanency). States are assessed in three areas related to wellbeing: (1) enhancing families' capacity to provide for their children's developmental needs; (2) whether children receive services that meet their educational needs; and (3) whether children receive services that meet their physical and mental health needs. (These measures assess only the availability and provision of services, and not whether the services are effective.) In the most recent round of reviews, no state achieved "substantial conformity" with outcomes 1 or 3, and only 10 achieved "substantial conformity" with outcome 2.[46] This largely reflects the fact that CPS systems are constrained by the quality and quantity of service providers in their regions as well as by limited resources with which to serve the large number of families that come to their attention. Nonetheless, the findings reinforce our conclusion that the services currently provided through CPS are unlikely to promote child health and wellbeing, other than perhaps through crisis management.

Family-Centered Programs and Policies

A range of family-centered policies and programs attempt to influence children's health and development either directly, or, by targeting families' financial resources and parenting behaviors, indirectly. Because this article deals with the role of the family, we don't discuss programs targeted directly at children. Rather, we focus on programs that may influence child health and development by improving family investments.

Programs Targeting Financial Resources and Investments

Many U.S. policies and programs aim to increase access to financial resources either by transferring income directly to families or by providing some of the goods and services that greater financial resources would allow a family to purchase. A recent review of empirical research linking economic support policies with child health and development concluded that policies and programs that reduce poverty or increase income positively influence child wellbeing.[47] The Earned Income Tax Credit (EITC), for example, is now the largest and perhaps the most generous antipoverty program in the U.S. It constitutes a refundable tax credit for low-income earners who work. The income subsidy that EITC provides has been linked to increased birth weight and thereby improved child health, as well as to greater cognitive achievement. It may also function indirectly to improve children's health by improving mothers' physical and mental health.[48] The Child Tax Credit, which provides a tax credit with a maximum of $1,000 per child (a part of which is refundable) to all working families to help offset the cost of raising children, and in particular its refundable component, the Additional Child Tax Credit, might be expected to operate similarly, though there has been less empirical work in this regard.

Although researchers have generally found positive associations between income

supports and child health and wellbeing, it's important to recognize that the outcomes that they've examined and the effect sizes that they've found vary across programs and policies, and, in many cases, by population subgroup. The timing and magnitude of transfers may also be important, as may additional conditions for receiving benefits, such as the work requirements associated with Temporary Assistance for Needy Families (TANF) participation. Furthermore, TANF is intended to be temporary and includes many behavioral requirements. Unlike the EITC, we lack substantial evidence that TANF participation is positively associated with child health.

Beyond direct public income transfers, child support enforcement promotes private transfers from noncustodial parents to custodial parents, and thereby increases the economic resources available to children. Additionally, a variety of fatherhood programs include education, job training, and employment components in an effort to increase nonresident fathers' economic contributions to their children. On the whole, these programs have produced only small improvements in earnings and employment; nonetheless, they have had some success at increasing child support payments.[49] In short, to the extent that such programs can meaningfully increase the financial resources available to children by increasing the child support received on their behalf, they could positively influence child health. However, research on the connection between child support and child health and wellbeing has been inconclusive.[50] Nor are we aware of any evidence that the employment and earnings components of fatherhood programs are linked directly to children's health and wellbeing. (For detailed discussions of how housing and nutrition programs affect child

health, see the articles in this issue by Ingrid Gould Ellen and Sherry Glied, and by Craig Gundersen, respectively.)

Programs Targeting Caregiving Quality

A variety of programs aim to help parents provide an optimal caregiving environment. When they target families that are not involved with CPS, such programs are generally considered preventive. They may function in one of two ways: to prevent a family's level of risk from elevating to the point at which child health or development is jeopardized, or to compensate for parent or family deficiencies. We focus on programs with the most promising evidence of effectiveness. (We also reviewed the evidence on couple-relationship and father-involvement programs and concluded that such programs are unlikely to play a substantial role in improving child health and development; thus we don't discuss these programs.)

Primary Prevention Programs

Primary prevention programs address parenting and developmental risk for children and families outside the context of CPS. Whereas traditional efforts were most often focused at the family level, these programs increasingly also target the role that communities and institutions can play in enhancing or constraining parental choices. The principle that guides many such programs is that optimal caregiving occurs when families' environments are conducive to positive parenting choices. As such, these programs tend to focus on enhancing protective factors, strengthening cohesion (trust, informal support networks, social organization, or norms regarding helping behaviors), and reducing structural barriers (economic conditions, crime and victimization, or limited availability and quality of human services) at the community level.

Primary prevention programs tend to have both universal (community-level) components and targeted components (more intensive interventions for at-risk families). Universal components include public awareness campaigns on issues of parenting, child maltreatment, and child development (for example, sleeping in the same bed, spanking, or exposure to secondhand smoke). These programs frequently also include screening and community involvement efforts aimed at identifying high-risk families and increasing informal support networks. When families are identified as at risk, they are referred for more intensive services. Rather than offering a specialized set of services, many primary prevention programs aim to strengthen the capacity of existing community services to better assist local families, as well to help families access existing community support services, such as home visiting or respite care. Indeed, the fact that community-level primary prevention efforts tend to make optimal use of existing services and structures has been widely touted as one of their most appealing characteristics.[51] In terms of child health, many such programs explicitly encourage parents to take up parenting and health insurance programs for which they are eligible.

Systems of Care

Large-scale community-level prevention efforts vary considerably in the extent to which they emphasize universal versus targeted components. At one end of the spectrum are system-of-care models; the Durham Family Initiative (DFI) in North Carolina is a prime example. The DFI constituted a universal effort to identify and intervene with at-risk families. It aimed to improve community social cohesion and resources, as well as the capacity and accessibility of the service delivery system, by promoting cooperation

among agencies, engaging communities via outreach workers, and working to reform policies and practices by developing innovative service models to help families meet their children's needs. It focused specifically on reducing child maltreatment rates, identifying families at risk for maltreatment through universal screening of pregnant women. Despite positive results, the program was ultimately scaled down under a new name, Durham Connects, and now primarily offers nurse home visiting for all newborns and their families; those found to be at risk of maltreatment or child development problems are referred to appropriate services.[52]

System-of-care approaches like DFI are difficult to evaluate experimentally. Compared to otherwise similar counties in North Carolina over the same time period, however, Durham County experienced a relative decline in substantiated child maltreatment and maltreatment-related hospital visits after DFI began. Evidence also suggests that DFI may be associated with decreases in spanking, parental stress, and substandard parenting and maltreatment behaviors, as well as improvements in parental efficacy and warm and responsive caregiving.[53]

Another promising model, the Los Angeles Prevention Initiative Demonstration Project (PIDP), takes a similar approach to DFI in its scope and aims. However, PIDP was designed to vary across communities. It also focuses more intensively than DFI did on improving families' economic resources through activities like financial literacy training, educational and employment training, and free tax preparation to increase the number of families who take advantage of the EITC. Evaluations of whether PDIP has decreased CPS involvement have produced mixed results, although there is some

evidence that it has reduced the chances that a child will be referred to CPS more than once, and increased the chances of timely reunification for families who have children in foster care.[54]

Social Learning Approaches

The social learning approach to primary prevention is best exemplified by the Triple P—Positive Parenting Program, which calls itself a "comprehensive public health model of intervention." Its current incarnation consists of a "system" of parenting interventions that includes universal public education, as well as a range of voluntary parenting advice seminars, skills-training sessions, and tailored group and individual services offered in a variety of settings. It also supports coordinated efforts by local service providers to promote key aspects of healthful, developmentally appropriate parenting activities. These services primarily target the family. They emphasize self-regulation, self-sufficiency, and personal agency, and they seek to improve caregiving by influencing how parents view and respond to children, using a range of techniques grounded in developmental science. Triple P interventions, which are designed to meet the unique needs of at-risk families, operate at varying levels of intensity. At the most basic level, Triple P gives the public information on parenting through media campaigns; at the most intensive level, parents participate in 10 or more sessions that teach an array of parenting skills, such as mood management, partner support, and recognizing unproductive parenting behaviors.

Triple P delivers its services in many formats, including individual sessions, group sessions, media-based materials, self-directed modules, and telephone consultations. This flexibility allows parents who otherwise might have difficulty scheduling sessions to access information and training on their own time. Moreover, media-based materials and self-directed modules cost considerably less than individual or group sessions. The combination of tailored levels of intensity and modes of delivery indicates the program's ambitious scope. In multiple experimental evaluations, Triple P has demonstrated improvements in child behavior, parenting skills, rates of substantiated child maltreatment and removal from the home, and hospital admissions for child injuries. Although the size of these effects varies based on the module and whether the outcomes were measured by parents' self-reports or by clinical or teacher observations, on average, the effects are considered large by conventional standards. For example, in a randomized study of 18 South Carolina counties, Triple P was associated with reduced rates of substantiated maltreatment, out-of-home placement, and hospital admissions for child injuries on the order of 25 percent or more.

In short, based on the few comprehensive and well-implemented interventions, best represented by DFI and Triple P, the evidence for social learning approaches is quite encouraging. These programs are associated with improved parenting behaviors and decreased child maltreatment, both of which should positively influence child health and development. Furthermore, Triple P is associated with decreases in child behavior problems, a key indicator of social-emotional adjustment. On the whole, however, because these programs tend to be universal in nature, they are difficult to implement and rigorously evaluate. Moreover, given their high cost (DFI, for example, cost about $1 million per year), few communities have

initiated and sustained integrated systems of care, despite the fact that their large effect sizes suggest that the economic benefits of such programs may outweigh their costs.[55]

Secondary Prevention Programs

Secondary prevention programs target families that have been identified as at risk for substandard parenting, child maltreatment, or adverse developmental outcomes for children, but that are not (in most cases) being served by CPS. Factors that might lead a family to be identified as at risk include teen birth, low income or material hardship, parental psychosocial problems, or having children with special needs. In many cases, families are identified via a primary prevention program.

Home Visiting Programs

Home visiting has arguably become the most touted means of delivering services to parents. Such programs take many forms, but they generally target socioeconomically disadvantaged mothers with infants or young children. Intervention often begins (or is intended to begin) during the prenatal period. Despite the fact that they primarily target low-income mothers, these programs do not predominantly focus on providing material or economic resources; rather, most of them focus on parenting education and skill building. Home visitors may be nurses, other professionals, or paraprofessionals.

Home visiting programs tend to focus fairly narrowly on parenting competency, while acknowledging that individual behavior is not simply a function of personal pathology but rather exists in the context of familial, social, cultural, and community characteristics and processes. Thus, most programs aim to help parents master their role, in part by helping them access informal and formal supports; the programs also model and teach parenting behaviors, such as warmth, responsiveness, sensitivity, and appropriate discipline, that encourage child-parent attachment.[56]

Overall, research suggests that well-targeted home visiting programs relying on a tested model that has been implemented with fidelity (that is, staying true to the original program design) are a promising approach to improving parenting behaviors and children's cognitive and social-emotional outcomes. Evidence on whether home visiting reduces child maltreatment has been inconclusive, however. There is only weak evidence that home visiting prevents child maltreatment as measured by official maltreatment records; however, there is strong evidence that many home visiting programs are associated with reductions in substandard parenting and maltreatment-related behaviors. Among home visiting programs that have assessed child health, at least one reported decreased emergency room visits; the evidence on whether such programs increase regular doctor and dental checkups is inconclusive, and there is little to no evidence that they improve immunization rates.[57]

Research suggests that well-targeted home visiting programs relying on a tested model that has been implemented with fidelity (that is, staying true to the original program design) are a promising approach.

Not all home visiting programs are of equal quality. Several models have been rigorously evaluated, but these results may not apply to generic home visiting programs, or to programs that are not implemented and delivered with fidelity to tested models. To date, the Nurse Family Partnership (NFP) model has been the most heavily and rigorously evaluated via random assignment experiments with diverse populations in Elmira, New York; Memphis, Tennessee; and Denver, Colorado. On the whole, results suggest that the program substantially improves maternal parenting behaviors, reduces child maltreatment and child injuries, and improves children's social-emotional functioning.[58] Several other models, including Healthy Families America (HFA), may also hold promise. HFA has been experimentally evaluated in a number of states. A meta-analysis of HFA studies suggests consistent positive effects on parenting attitudes and parent-child interaction, and smaller effects on parent-reported child maltreatment. The program appears to have mixed effects on children's health. It is most consistently linked to higher birth weight and reduced birth complications; there is less consistent evidence of a link to improved cognitive functioning and regular doctor visits, and no evidence of increased immunization rates.[59]

An additional benefit of home visiting programs is that they may present an excellent opportunity to screen parents for mental health problems, link them to appropriates services, and, in some cases, directly provide preventive treatment, or support services.[60]

Parent Training Programs

In addition to home visiting, a variety of individual and group parent training interventions are offered outside families' homes. These programs differ widely in their theoretical underpinnings, the types of families and functional problems they target, levels of intensity and duration, modes of service delivery, types of services provided, and the skill and education levels of providers, making direct comparisons difficult. A recent meta-analysis loosely grouped these programs along three dimensions.[61] First, programs were defined as either behavioral or nonbehavioral in orientation. Behavioral programs focus on how parents' reinforcement and punishment choices affect the development and maintenance of children's behavior; nonbehavioral programs focus on interactional styles in areas such as parent-child communication and problem-solving. Second, programs were identified as focusing on the parent only, the parent and child, or multiple systems. Finally, they were categorized as having group, individual, or self-directed modes of service delivery.

The meta-analysis suggests that behavioral parent training programs are associated with moderate improvements both in parenting and, particularly, in child behaviors in the short term, but that these effects fade to the extent that they are either no longer statistically significant or are very small in magnitude by about one year after the intervention. Nonbehavioral programs, which have been less rigorously evaluated, show less evidence of effectiveness, though some short-term positive associations have been found for parental stress and attitudes about parenting. Furthermore, a recent systematic review of the effectiveness of group-based parenting programs concluded that behavioral and cognitive-behavioral group-based parenting programs are associated with short-term improvements in parental wellbeing in areas such as stress, depression, anxiety, anger, guilt, self-esteem, and satisfaction with romantic partnerships.[62] Again, however,

these effects were found to be short-lived—none persisted over the course of a year.

On the whole, parent training programs, particularly when delivered outside a community-level framework such as those provided by DFI and Triple P, seem to have limited utility for improving caregiving practices and home environments and, thereby, promoting child health and development. Nonetheless, programs that teach parents hands-on skills that they can practice in the presence of service providers may hold some promise. Both Incredible Years (IY) and Parent-Child Interaction Therapy (PCIT) exemplify this approach. IY is a group-based parenting program that focuses on developmentally appropriate problem-solving, self- and child-management, discipline, and communication strategies; participation is associated with less harsh and more responsive and cognitively stimulating parenting, as well as decreased child behavior problems. PCIT coaches parents to manage their children through developmentally appropriate attention, feedback, and discipline; participation is associated with improvements in parent-child interactions and decreased child maltreatment.[63] Finally, given that parental education and health are strong predictors of child health, interventions that increase parents' education and improve parents' health, including two-generation programs, may hold promise for improving child health, largely by their positive influence on health behaviors within families.[64]

Conclusions and Recommendations

Our review suggests that financial resources and investments, along with the quality of caregiving behaviors and environments to which children are exposed, are two primary mechanisms through which families influence child health and development. The quantity and quality of investments in each of these areas tend to be greater among more stable and better-off families than among more complex, fluid, and poorer families. As such, policies and programs that increase family financial resources or improve caregiving behaviors have the potential to positively influence child health and wellbeing, particularly for disadvantaged families. That is, to the extent that economic support policies successfully increase family resources, they are likely to positively influence child health both directly and, through improved caregiving environments, indirectly. Thus, cash or in-kind transfers, whether public or private (for example, child support), are one promising approach to promoting child health.

The CPS system has a clear role in protecting abused and neglected children from maltreatment, as well as in promoting permanency for children who have been removed from their homes. To the extent that it accomplishes these objectives, CPS should have positive implications for child health and development. Unfortunately, however, existing family preservation and reunification efforts have not been particularly successful. In addition, most children do not receive CPS services until they have already been abused or neglected—that is, the system is compensatory rather than preventive. As such, many referred children will already face health and development problems by the time they come to the attention of CPS. Enhanced prevention efforts may therefore be a more sensible approach to promoting child health, although some degree of compensatory help for maltreated children will always be necessary. It is important to

recognize, however, that individual CPS systems operate in the context of a state's or county's broader approach to intervening with children and families. Indeed, CPS relies extensively on existing community services. Community efforts with a holistic orientation to meeting the needs of children and families may be more successful at both preventing CPS involvement and serving CPS-involved children and families than would efforts that take a more fragmented approach.

A wide range of primary and secondary prevention programs are intended to improve children's caregiving environments. They vary widely with regard to the rigor with which they have been evaluated and the extent to which empirical evidence demonstrates their efficacy. Large-scale community-level primary prevention efforts such as DFI and Triple P offer a coordinated and holistic approach to promoting high-quality caregiving and supporting healthy child development—in stark contrast to the fragmented array of programs that are available in many communities. The evidence suggests that such large-scale efforts have considerable potential to help children and families. At the same time, however, they are difficult to implement and require large amounts of coordination, collaboration, and resources.

Turning to secondary prevention efforts that target at-risk families, we conclude that home visiting programs, such as NFP and HFA, if implemented and delivered with fidelity to their tested models, hold particular promise for improving parenting and, thereby,

children's health and development. Again, though, implementing these programs with fidelity on a large scale is an intensive and expensive proposition, although the benefits of doing so are likely to well outweigh the costs. Home visiting programs have gained traction in recent years, and the Affordable Care Act includes funding to expand them, with an emphasis on the NFP model. One important mechanism through which these programs may benefit child health and development is screening parents for mental health problems and linking them with services; this area is ripe for additional research and program exploration. In contrast, individual- and group-based parenting programs are considerably less expensive and have greater capacity to serve a large number of families. However, though a few programs, such as IY and PCIT, show promise, we are much less sanguine about the potential for these programs to produce lasting effects on parents and children.

In short, we believe that efforts to promote child health by improving the caregiving behaviors and environments to which children are exposed are most likely to be successful when they comprise a coordinated package of prevention, intervention, and treatment services and emphasize identifying and engaging at-risk families, offering adequate access to both preventive and compensatory services, and helping families acquire financial resources. To this end, we endorse the proliferation of large-scale community-level primary prevention efforts as well as the expansion of evidence-based home visiting programs.

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