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Report to the Chairman, Subcommittee on Oversight of Government Management, Committee on Governmental Affairs, U.S. Senate

August 1992

CHILD ABUSE

Prevention Programs Need Greater Emphasis

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The Honorable Carl M. Levin
Chairman, Subcommittee on Oversight of
Government Management
Committee on Governmental Affairs
United States Senate

Dear Mr. Chairman:

This report, prepared at your request, reviews a variety of child abuse prevention programs, discusses their effectiveness, and describes funding and other obstacles to more widespread implementation of these kinds of programs.

The report contains recommendations to the Congress and a recommendation to the Secretary of Health and Human Services.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 7 days from its issue date. At that time, we will send copies to the Director, Office of Management and Budget; the Secretary of Health and Human Services; and other interested parties.

This report was prepared under the direction of Gregory J. McDonald, Director, Human Services Policy and Management Issues, who may be reached at (202) 512-7225 if you or your staff have any questions. Other major contributors are listed in appendix V.

Sincerely yours,

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

Executive Summary

Purpose

Reports of child abuse increased from 60,000 in 1974 to over 2.6 million in 1990. Of the cases reported in 1990, about 1 million were substantiated by social and health care professionals, including at least 1,200 fatalities and 160,000 serious injuries. Child abuse affects not only the well-being of children, but also the costs of care systems, such as child welfare, education, and health. Recent studies have found that abuse can result in lower academic achievement, more frequent school dropouts, juvenile delinquency, and higher rates of teenage pregnancy.

Federal funding efforts have been largely devoted to treating the consequences of abuse rather than preventing it from occurring. Federal matching fund reimbursements to states for foster care for abused children totaled over $1.8 billion in 1991. In contrast, the National Center on Child Abuse and Neglect (NCCAN), the federal focal point for abuse efforts, provides less than $60 million annually to address both prevention and treatment.

The Chairman, Subcommittee on Oversight of Government Management, Senate Committee on Governmental Affairs, asked GAO to determine

- the extent to which child abuse prevention strategies have been evaluated and shown to be effective;
- whether obstacles exist that inhibit program implementation and operation and, if so, whether there are alternative approaches that could overcome these obstacles; and
- the types of programs that provide families with services to prevent abuse before it occurs and the extent to which these programs are coordinated at the federal and state levels.

GAO studied child abuse prevention programs in eight states considered to be leaders in the field: California, Florida, Hawaii, Illinois, Michigan, New York, Oregon, and Washington. GAO conducted its work between February 1991 and March 1992.

Background

National awareness of child abuse began over 100 years ago, when an animal protection society served as a child's advocate in court because no child protection laws existed. In 1962 public concern was heightened by an article describing the "battered child." Since then, public and private organizations increasingly have focused attention on the prevention and treatment of abuse. Reports of abuse have increased substantially since 1962. However, it is unclear how much of the rise is due to increased

incidence and how much to heightened awareness and mandatory reporting requirements. Further, statistics include only reported incidents. The number of unreported cases—estimated by one study to be more than 6 million yearly—cannot be determined with precision (see p. 11).

In 1974, the Congress passed the Child Abuse Prevention and Treatment Act, which established NCCAN as the national focal point for child abuse prevention and treatment efforts. NCCAN provides research and program grants to states and organizations for abuse prevention and treatment. It is also required to provide information and technical assistance, and to facilitate communication about prevention and treatment efforts among federal agencies and states.

Results in Brief

Child abuse prevention programs have been shown to be effective. Evaluations indicate that some prevention strategies reduce the incidence of child abuse. Results from the few rigorous studies that have been done are promising. For example, a recent evaluation of a nurse home-visiting program showed that high-risk teen mothers who did not receive services had an abuse rate that was nearly five times the rate of those who received the services (see p. 19). Other studies suggest that prevention programs can also reduce the cost of long-term problems often associated with abuse, such as learning disabilities and chronic health conditions. One study estimates the cost of lost productivity by adults who were victims of severe abuse injuries as children to be as much as $1.3 billion annually (see pp. 24-25).

Available information indicates that federal funding for prevention—which is provided primarily by the Department of Health and Human Services (HHS)—is relatively low, often taking the form of short-term grants for demonstration projects. In contrast, the federal government provides billions of dollars annually to states to provide foster care and other assistance for children who have been abused (see p. 30).

Many programs GAO visited struggled to survive because they relied on multiple short-term funding sources. States provided limited central planning or coordination, and only one state GAO visited had a statewide prevention program. An independent advisory board established by the Child Abuse Prevention and Treatment Act recently reported that state plans for prevention are needed to help assure that resources are used effectively and efficiently (see p. 39). However, most states do not have such plans.

Principal Findings

Evaluation Results Support Prevention

Although rigorous longitudinal evaluations of prevention programs are few, they have shown promising results. For example, high-risk teen mothers who received services from a nurse home-visiting program had an abuse rate of 4 percent, compared with a rate of 19 percent for those not receiving home visits (see p. 19). The programs GAO visited generally demonstrated success with less rigorous evaluations—using such measures as parent-child bonding, parenting skills, and short-term reduction of abuse reports. For example, a California home visitor program evaluation showed an abuse rate of less than 1 percent in the families treated compared with estimates of as much as 20 percent among similar families nationwide (see p. 22).

Some studies indicate that prevention programs may pay for themselves. The few studies of costs and benefits done to date suggest that—over the long term—well designed prevention programs can reduce costs. One study showed that total federal costs of providing prevention programs for low-income populations were nearly offset after 4 years, and another estimated that prevention programs can yield significant additional savings beyond that period (see pp. 25-27). These longer term savings are based on reducing the costs of social problems related to abuse. For example, abused children have higher rates of juvenile delinquency and special health care needs than those who have not been abused.

Federal Support for Prevention Limited

The monies available for child abuse prevention programs cannot be readily determined because the funds are widely scattered among many agencies and not always labeled as abuse or prevention related. However, prevention funding appears low compared to foster care and other placement for abused children. Compared with the $1.8 billion provided for out-of-home placement in 1991, NCCAN provides $60 million annually for both treating and preventing child abuse. Challenge Grants, the only NCCAN grants reserved solely for prevention, assist states in setting up prevention funding mechanisms and comprise about $5 million of this amount. (see p. 28).

Titles IV-B and XX of the Social Security Act are additional funding sources available for prevention activities (see p. 30). The portion spent on abuse prevention cannot be determined for all states; however, 25 states

responding to a 1989 GAO poll estimated that they spent less than $17 million of nearly $3 billion in Titles XX and IV-B funds on abuse prevention.

States GAO visited were interested in expanding their prevention efforts to reduce future abuse treatment and foster care costs. However, budget constraints at the federal and state levels limited their ability to do so.

Prevention Programs Struggle to Survive

Programs GAO visited used a variety of prevention approaches, including home and center-based services. They often targeted specific populations, such as teen parents, ethnic groups, low-income families, or disabled children. Many said they struggled to meet funding needs with yearly grants from multiple sources, which increased their administrative burdens because of application and reporting requirements (see p. 36).

Typically, no individual or institution at the state or local level coordinates all efforts to avoid gaps in service. The U.S. Advisory Board on Child Abuse and Neglect, legislatively mandated to make policy recommendations to the Congress and HHS, has recommended state planning and coordination. However, states GAO visited have not assessed their abuse prevention needs and developed comprehensive prevention plans. Only Hawaii has begun a statewide prevention program (see pp. 39-42).

Recommendations to the Congress

To give states incentives to implement and sustain child abuse prevention programs, GAO recommends that the Congress amend Title IV of the Social Security Act to give the Secretary of HHS authority to reimburse states, at foster care matching rates, for the costs of implementing prevention programs. The reimbursements would be provided to states where prevention programs have been demonstrated, through sound evaluations, to pay for themselves by reducing the incidence of child abuse and the related foster care placements (see p. 46).

To encourage states to develop and implement state prevention plans based on comprehensive needs assessments, GAO recommends that the Congress give the Secretary of HHS authority to direct any future increases in NCCAN Challenge Grants to states that are putting such plans in place (see p. 46).

Recommendation to the Department

GAO recommends that the Secretary of HHS provide funding incentives, such as through NCCAN, to encourage states to establish and rigorously evaluate programs with the potential for statewide implementation, and promote statewide adoption of strategies that have demonstrated effectiveness and cost benefits (see p. 47).

Agency Comments

HHS believed that GAO focused too heavily on home visitation programs and did not give adequate attention to the many federal health and social programs that can improve the well-being of families and reduce child abuse. It also disagreed with GAO's recommendation that the Congress authorize HHS to reimburse states for the costs of implementing prevention programs, and favored a recent administration proposal for providing states with more flexible funding for child welfare activities. (See app. IV.) GAO believes the report adequately discusses a variety of programs and approaches—among them home visiting—that are being used to help prevent child abuse. While the report does not advocate any one strategy, evaluations indicate that home visiting can be an effective strategy for preventing child abuse. Also, the U.S. Advisory Board on Child Abuse and Neglect has recommended that a universal home visitation program be developed. GAO continues to believe that its recommendation for encouraging states to develop and implement prevention programs is appropriate. GAO notes that while the administration proposal would provide states more flexibility to fund prevention efforts, the prevention programs would have to compete with programs that address abuse after it has already occurred. (See p. 47.)

Contents

Executive Summary		2
Chapter 1 Introduction		10
	Child Abuse and Neglect Are Major Social Problems	10
	Addressing Abuse Requires a Variety of Approaches	13
	Abuse Prevention Can Have Additional Positive Outcomes	14
	Federal Efforts Are Directed at Providing Grants and Information	14
	Objectives, Scope, and Methodology	15
Chapter 2 Evaluation and Experience Indicate That Prevention Works		18
	Rigorous Evaluations Are Few but Promising	18
	Less Rigorous Evaluations Also Suggest Success	21
	Evaluations in Process Should Produce Additional Information	23
	Studies of Costs and Benefits Are Limited but Encouraging	23
Chapter 3 Limited Federal Funding for Abuse Prevention Programs		28
	Federal Expenditures for Child Abuse and Neglect Come From Many Sources	29
	Federal Funding for Abuse Prevention Is Limited	30
	States Expressed Desire for Greater Flexibility in Federal Aid for Child Abuse Programs	31
Chapter 4 State and Local Prevention Efforts Experience Planning, Coordination, and Funding Problems		34
	Prevention Programs Vary in Terms of Target Groups and Range of Services	34
	Programs Have Difficulty Finding Information	35
	Funding Resources Are Fragmented and Unreliable	36
	State Efforts to Plan and Coordinate Prevention Efforts Have Been Limited by Lack of Resources	39

Chapter 5 Conclusions, Recommendations, and Agency Comments

43
Enhancing Program Evaluation 43
Modifying the Federal Funding Approach for Prevention Programs 44
Enhancing State Planning and Coordination 45
Recommendations to the Congress 46
Recommendation to the Secretary of HHS 47
Agency Comments 47

Appendixes

Appendix I: Hawaii's Healthy Start Program 50
Appendix II: The Elmira Prenatal/Early Infancy Project 64
Appendix III: Programs Contacted by GAO 72
Appendix IV: Comments From the Department of Health and Human Services 77
Appendix V: Major Contributors to This Report 83

Figures

Figure 1.1: Reports of Child Abuse Have More Than Tripled in the Past 15 Years 12
Figure 2.1: Elmira Project Costs for Low-Income Mothers Were Nearly Offset in 4 Years 27
Figure 3.1: NCCAN Grant Funding From 1981 to 1992 Much Less Than Title IV-E Foster Care Funding 28
Figure 4.1: Birth to Three Program Has Many Funding Sources 37
Figure 4.2: Webster Avenue Program Receives Grants of $20,000 or Less From 11 Foundations 38

Abbreviations

CAP	Child Abuse Potential Inventory
CAPTA	Child Abuse Prevention and Treatment Act
CPS	Child Protective Services
EID	early identification
HHS	Department of Health and Human Services
MCHB	Maternal and Child Health Branch
NCAST	Nursing Child Assessment Satellite Training
NCCAN	National Center on Child Abuse and Neglect
NCPCA	National Committee for Prevention of Child Abuse

Introduction

Each year, more than 800,000 substantiated cases of child abuse and neglect[1] occur in the United States. About 160,000 of these children suffered life-threatening injuries or long-term impairment in one year alone, and an estimated 1,100 to 5,000—most of them under 1 year old—die annually from the abuse they receive. State and local governments and interest groups have created a wide variety of programs and approaches for dealing with abuse. This report focuses on programs that have a common theme in their approach—preventing abuse before it occurs.

Child Abuse and Neglect Are Major Social Problems

Child abuse and neglect has become an increasingly serious problem in the United States. A study published in 1962 identified and discussed the "battered child syndrome" and estimated that, on the basis of surveys of hospitals and district attorneys across the country, the number of cases of serious abuse nationwide was perhaps in the hundreds.[2] In the 1970s, experts estimated that about 60,000 children per year received serious injuries as a result of abuse. More recent studies indicate that the problem is much more widespread, although they vary in their estimates of its size. For example:

- The American Humane Association reported that reports of child abuse nationwide totaled about 669,000 in 1976 and increased more than 300 percent to 2,086,000 by 1986. This represents an increase from about 10 children per 1,000 reported in 1976 to about 33 children per 1,000 in 1986.[3]
- A study sponsored by the Department of Health and Human Services (HHS) estimated that the number of cases of child abuse stood at 625,100 in 1980 and rose to slightly more than 1 million in 1986—an increase of 66 percent.[4] The study was based on recognized and reported cases of abuse provided by "community professionals" in a sample of 29 counties throughout the United States. The study found that the percentage of these cases that were substantiated or at least investigated further by social and health

[1]The Child Abuse Prevention and Treatment Act (P.L. 100-294, Apr. 25, 1988) defines abuse and neglect as the "physical or mental injury, sexual abuse, or exploitation, negligent treatment, or maltreatment of a child by a person who is responsible for the child's welfare, under circumstances which indicate that the child's health or welfare is harmed or threatened."

[2]C. Henry Kempe and others, "The Battered Child Syndrome," Journal of the American Medical Association, Vol. 181, No. 1, July 7, 1962.

[3]Highlights of Official Child Abuse and Neglect Reporting, American Association for Protecting Children, 1986.

[4]Study Findings, Study of National Incidence and Prevalence of Child Abuse and Neglect: 1988, National Center on Child Abuse and Neglect, Department of Health and Human Services.

care professionals also increased, from 43 percent in 1980 to 53 percent in 1986.

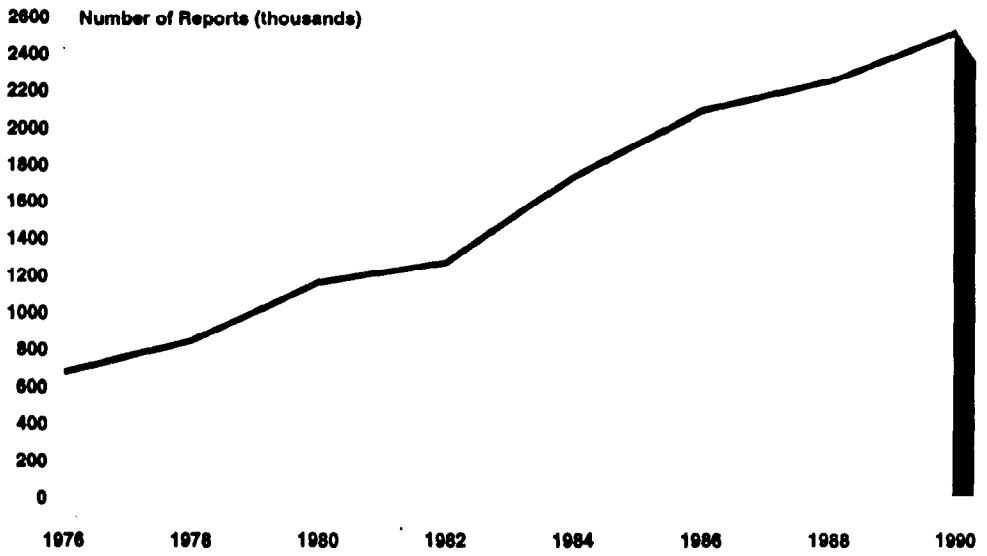
- An April 1992 survey by the National Committee for Prevention of Child Abuse estimates that in 1991 there were over 2.6 million reports of abuse. If just 40 percent of the cases were substantiated, the total number of abuse cases would exceed 1 million.[5]

While reports of child abuse have more than tripled in the last 15 years (see fig. 1.1), it is not clear how much of the increase reflects an actual rise in the number of abuse cases and how much represents a more complete reporting. The authors of the HHS-sponsored study suggested that the increase they reported was probably due more to a greater recognition of abuse than to an increase in its actual occurrence. This same study acknowledged, however, that reported cases are only the tip of the iceberg because many cases are never reported. Another study based on a survey of 1,146 nationally representative families states that the total number of incidents is at least 26 times the number estimated by the HHS study.[6]

[5]Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1991 Annual Fifty State Survey, National Center for Prevention of Child Abuse, April 1992.

[6]Murray A. Strauss, Family Patterns and Child Abuse in a Nationally Representative American Sample, University of New Hampshire, Durham, NH, Child Abuse and Neglect Second International Congress, London, September 12-15, 1978.

Figure 1.1: Reports of Child Abuse Have More Than Tripled in the Past 15 Years



Many children experience mental, physical, and social problems as a result of abuse. For example:

- Juvenile delinquency. Juvenile delinquency has been closely associated with abuse. A study comparing young males who had been abused or neglected as children and those who were from homes described by the authors as "loving" found that 20 percent of those from abusive or neglectful homes had been convicted of serious crimes, compared with 11 percent of those from loving homes.[7] Data from another study involving 297 families showed the percentage of adolescents who had spent time in prison was about twice as high among those who had been abused as among those in a comparison group.[8] A 10-year study of 411 boys found that by the time they had reached 18 years of age, 27 had been convicted of violent offenses. Of these violent delinquents, 62 percent had been

[7]Joan McCord, "A 40-Year Perspective on Effects of Child Abuse and Neglect," Child Abuse and Neglect, Vol. 7, pp. 265-270, 1983.

[8]Roy C Herrenkohl, Ellen C. Herrenkohl, and Brenda P. Egolf, The Relationship Between Early Childhood Abuse and Neglect and Adolescent Deviance, Center for Social Research, Lehigh University, Bethlehem, PA, September 1991.

exposed to harsh parental discipline, compared with 7 percent of the nondelinquent boys in the study.[9]

- Problems in school. Problems with academic performance and social adjustment at school are also associated with abuse. A study of 8,600 public school children found the academic achievement of maltreated children was significantly lower than that of a similar group of children who had not been maltreated. The effects observed across all grade levels included lower test scores and grades, as well as the increased likelihood of disciplinary problems, more tardiness, and a higher rate of suspensions.[10]
- Psychiatric illness and related problems. Studies also link abuse to high rates of psychosis, depression, developmental delays, violence and social aggression, and deficient social skills. For example, one study of abused children found that 40.6 percent exhibited self-destructive behavior (such as biting, burning, head banging, and suicide attempts), compared with 6.7 percent of the control group.[11]

Addressing Abuse Requires a Variety of Approaches

Dealing with abuse is complicated by the fact that no single cause for it has been identified. The personal or situational "risk" factors that have been linked to a higher probability of abuse include a variety of stresses, such as single and teenage parenthood, parental isolation, poor coping abilities, lack of social skills, drug and alcohol abuse, unemployment, and low income. A history of abuse in a parent's childhood may increase the likelihood of child mistreatment, although not all abused children become abusive parents.[12]

Efforts to address abuse can be described as a continuum of care. At one end of the continuum are activities to prevent abuse before the first incident occurs. Treatment for abused children and their families constitutes the next portion of the continuum. These efforts are typically the responsibility of local child protective services agencies. These agencies work with the children and families to solve their problems and, if appropriate, preserve the family unit. The remaining services on the

[9]D. P. Farrington, "The Family Background of Aggressive Youths," Aggression and Anti-Social Behavior in Children of Adolescents, Pergamon, 1978.

[10]John Eckenrode, Molly Laird, and John Doris, Maltreatment and the Academic and Social Adjustment of School Children, Cornell University, November 1, 1990.

[11]A.H. Green, "Self Destructive Behavior in Battered Children," American Journal of Psychiatry, May 1978.

[12]James Garberino, "Child Abuse: Why?", and N. Dickon Repucci, "Preventing Child Abuse: Problems and Promise," The World and I, June 1990.

continuum are those that involve removing children from dangerous abusive environments and placing them in foster care or adoptive homes.

Prevention programs, the first part of this continuum, include primary and secondary efforts. Primary prevention programs are aimed at the population in general. These could include a program available to all school children or a campaign to raise public awareness using radio or television messages. Secondary prevention is directed at specific populations identified as being at increased risk of becoming abusive (for example, single mothers or low-income families). Prevention programs are important because they aim at averting—rather than treating—the human suffering caused by abuse. They also aim at reducing the need for other types of programs that address the long-term consequences of abuse.

Abuse Prevention Can Have Additional Positive Outcomes

Abuse prevention programs often attempt to reduce parental stresses caused by risk factors, such as low self-esteem and poor parenting skills, as a way of preventing maltreatment of children. These programs can result in additional positive outcomes, such as increased parental employment and healthier children. In this way child abuse prevention programs are closely related to other types of prevention and family support programs, such as public health nurse visitation and center-based peer support activities. The shared goal is to strengthen and improve the general family environment rather than solving a specific problem. They promote family or individual well-being by helping to reduce or eliminate factors, such as social isolation and financial difficulties, that can limit it. For example, both types of programs may guide low-income families to appropriate financial aid and help families obtain needed health services. While the specific focus of the programs may vary, the similarity in approach can result in comparable outcomes. Additionally, although we know of no studies that evaluate their ability to prevent abuse, some programs, such as Aid to Families With Dependent Children and Head Start, can have the effect of improving family stability and reducing stress that is often associated with abuse.

Federal Efforts Are Directed at Providing Grants and Information

Federal activities directed specifically at child abuse prevention and treatment began in 1974 with the Child Abuse Prevention and Treatment Act (CAPTA). CAPTA established the National Center on Child Abuse and Neglect (NCCAN) to serve as the federal focal point for child abuse prevention and treatment efforts. NCCAN, part of HHS, currently provides about $60 million annually in grants to states and organizations for child

abuse activities. It is also charged with (1) maintaining and disseminating national information on the incidence of cases of child abuse and neglect and (2) establishing a clearinghouse for information on effective programs for dealing with abuse and neglect.

To help develop federal policy, CAPTA also required the Secretary of HHS to appoint an independent advisory board (The U.S. Advisory Board on Child Abuse and Neglect) of experts in the field. The board is required to report annually to the Secretary and the Congress and make recommendations encompassing all federal efforts to address child abuse and neglect. The Advisory Board issued reports in August 1990 and September 1991 that described child abuse as a national emergency and recommended federal planning and implementation of a universal voluntary neonatal home visitation program. In 1988, the Congress further required the Secretary of HHS to establish an interagency task force to encourage more prevention and treatment efforts and to coordinate those under way.

In February 1992, we testified before the Subcommittee on Select Education, House Committee on Education and Labor, that NCCAN was not meeting all CAPTA's requirements.[13] We noted that although NCCAN had recently filled some long-term staff vacancies, staff and budget shortages continued to impede it from fully carrying out its legislative mandates—particularly in the areas of technical assistance, program monitoring, and reporting to the Congress. We expressed concern that NCCAN would be unable to handle its extensive workload even with a full complement of staff. We are continuing to review NCCAN's progress and plan to report our findings separately.

Objectives, Scope, and Methodology

In a letter dated February 19, 1991, the Chairman, Subcommittee on Oversight of Government Management, Senate Committee on Governmental Affairs, asked that we look into the role of the federal government in addressing the increasing incidence and complex nature of child abuse and neglect in the United States. The Chairman expressed particular interest in gaining a clearer picture of how federal programs provide incentives for—or impediments to—effective intervention. Our objectives were to determine:

- The extent to which child abuse prevention strategies have been evaluated and shown to be effective (see ch. 2).

[13]Child Abuse and Neglect: Progress of the National Center Since May 1991 (GAO/T-HRD-92-14, Feb. 27, 1992).

- Whether obstacles exist that inhibit program implementation and operation and, if so, are there alternative approaches that could overcome these obstacles (see ch. 3).
- The types of programs that provide families with services to prevent abuse before it occurs and the extent to which these programs are coordinated at the federal and state levels (see ch. 4).

We focused our work on prevention activities that take place before the first instance of abuse.

To determine the extent to which programs have been evaluated and shown to be effective, we conducted a literature search in which we obtained reports and information on research projects and program evaluations. We supplemented this information with data obtained from programs we visited and from interviews with officials representing programs, state agencies, and private nonprofit organizations.

Our work focused on programs in eight states. In selecting the states, we surveyed officials across the country for recommendations on which states were considered leaders in the field with programs and activities in place. Based on the information provided—and to obtain a degree of program variety and geographic diversity—we selected California, Florida, Hawaii, Illinois, Michigan, New York, Oregon, and Washington. In each state, we interviewed state officials and chose specific programs for further review. In all, we visited 27 program sites and interviewed officials from 7 others. We examined budget documents, interviewed administrators, and reviewed other available program information. We did not independently verify the program cost information and evaluations.

We supplemented our work in these eight states by interviewing officials in Colorado, Maryland, Mississippi, and Oklahoma to obtain information on their prevention programs. We also conducted work at the New Mothers' Project in Memphis, where we interviewed the project's director and nurse home-visiting staff. We also interviewed officials at the National Committee for Prevention of Child Abuse in Chicago, the American Association for Protecting Children in Englewood (Colorado), the C. Henry Kempe Center for the Prevention and Treatment of Child Abuse and Neglect in Denver, and the Erikson Institute for Advanced Study in Child Development in Chicago. We also met with the NCCAN Director and other staff at NCCAN and HHS to discuss child abuse prevention activities nationwide.

We conducted our work from February 1991 to March 1992 in accordance with generally accepted government auditing standards.

Evaluation and Experience Indicate That Prevention Works

Program evaluations, along with nearly two decades of program experience, indicate that prevention programs can be effective. Rigorous evaluations measuring programs' impact on child abuse and neglect using control or comparison groups have been rare, but findings from those that have been done have been generally positive. The more common evaluations of the programs' short-term effects—such as on client satisfaction, parenting skills, and incidence of reported child abuse—have also shown positive results. Taken together with evidence provided by other studies and reports, the indications are that the programs are successful in preventing abuse.

Few studies have evaluated abuse prevention services from a cost-benefit perspective. The evidence from these studies suggests, however, that abuse prevention programs can save money by reducing future costs associated with abuse. Prevention programs often link parents with health and social services, such as employment services. Thus, they can also improve child and parent well-being in other ways, such as by helping to increase the employability of poor single mothers.

Rigorous Evaluations Are Few but Promising

Our review showed that the results from the few rigorous evaluations of prevention programs have been encouraging. We found several studies completed over the past 20 years, including one begun as early as 1971 and one published in 1981. In two more recent evaluations of prevention programs, researchers measured the program effects by comparing the behaviors of parents who participated in the programs with the behaviors of similar parents who received less extensive services. Not all of the evaluations we reviewed demonstrated significant reductions of abuse, but most provided evidence that abuse prevention works. The studies discussed below illustrate some of the prevention research that has taken place in the last 20 years.

University of Colorado Study

In 1971, a team of researchers at the University of Colorado began a study, using control groups, of 150 new mothers to predict which parents were at risk of becoming abusive and to determine how to prevent the abuse. The team published a report in 1979 discussing the feasibility of predicting the potential for child abuse and other abnormal parenting practices.[1] The team found that prevention services provided to parents who were at risk

[1]Jane D. Gray and others, "Prediction and Prevention of Child Abuse and Neglect, 1979," Journal of Social Issues, Vol. 35, No. 2, pp. 127-139.

of becoming abusive could significantly improve the infants' chances of avoiding serious physical injury requiring hospitalization.

Family Support Center in Yeadon, Pennsylvania

This evaluation—published in 1981—studied 46 families and their 74 pre-school-age children in Yeadon, Pennsylvania, participating in a program to reduce child abuse.[2] The families selected were considered at risk of abuse based on a stress index developed by the program. Services were provided on a voluntary basis. Families received a combination of services that began with weekly nurse or social work home visits—continuing for an average of 10 months. After the first 3 months of home visits, families joined a family education and activity group, which met at a community church twice a week for 14 weeks. At the conclusion of this activity, parents joined peer support groups, which met once a month in parents' homes. During the 10 months of the program, there were only four incidents of abuse or neglect. Using a comparison group of at-risk parents from a previous study, the program reported that this represented a reduction in the abuse rate from an expected 18 percent to about 5 percent.

Elmira Prenatal/Early Infancy Project

This research project at the University of Rochester is one of two recent studies providing particularly strong empirical evidence that child abuse prevention works. This project, which was completed in the early 1980s, evaluated a program of prenatal and postnatal visits by nurses to rural homes in the vicinity of Elmira, New York. The project reported that families who received home visiting had an abuse rate 50 percent lower than those who did not receive the services. Among the high-risk group of unmarried, low-income, teen mothers who received home-visiting services until their children were 2 years old, the abuse rate was nearly 80 percent lower than among those in a similar high-risk group that did not receive services. The abuse rate for this group was 4 percent compared to a rate of 19 percent for those who did not receive the home-visiting services.

The program is designed to begin during pregnancy and continue until the child is 2 years old. The home visits center on three major activities: providing parent education, enhancing social support by family and friends, and linking the family with other health and human services. In addition to reducing child abuse, the project reported improvements in the lives of the poor single mothers who received home visits. These included

[2]K.A. Armstrong, "A Treatment and Education Program for Parents and Children Who Are at Risk of Abuse and Neglect, 1981," Child Abuse and Neglect, Vol. 5, pp. 167-175.

an 82-percent increase in the number of months they were employed and a 43-percent reduction in subsequent pregnancies within the first 4 years after the birth of the first child.

The researchers report that their findings suggest that such programs have the greatest chance of success if they

- are based on a model that addresses the interaction of a variety of factors (for example, social, economic, psychological) that influence maternal and child behavior,
- are designed to intervene during pregnancy and early childbearing years with nurse home visitors who visit often and develop a professional rapport with the families, and
- target families at greater risk for problems due to poverty and lack of personal and social resources.

(For a detailed description of the Elmira Prenatal/Early Infancy Project, see appendix II.)

National Committee for Prevention of Child Abuse Study

Another recent study that demonstrates the success of abuse prevention programs is an evaluation completed in 1992 by researchers at the National Committee for Prevention of Child Abuse. This 3-year project evaluated the effectiveness of 14 child abuse prevention programs in the greater Philadelphia area. The study used a pre-test/post-test design. Although somewhat less rigorous because of the absence of a control or comparison group, it combined data from individual program sites to compare program characteristics, such as intervention strategy and length of involvement.

The 14 programs represented a wide variety of service approaches. For example, they include home visitation services and community center services, targeted both to specific populations and to a more general public. All programs were designed to provide services to families before abuse had occurred. Nine of the programs served primarily low-income families.

Over 1,000 parents served by the program between March 1990 and July 1991 participated in the evaluation. The evaluation examined the extent to which the programs changed participant parenting practices, personal functioning, and parent-child interaction patterns. It measured parents' likelihood of becoming abusive using staff assessments and the Child

Abuse Potential Inventory (CAP). It focused on changes in parents' knowledge, attitudes, and relationships with their children during and after the delivery of services to determine if the risk level was reduced. Additionally, the study measured the program's impact on children's cognitive and social functioning, using the Denver Developmental Screening Test at program intake and at termination.

Researchers found that, as a group, the programs significantly reduced participants' levels of risk for maltreatment. On average, participants decreased their risk of becoming abusive by about 11 percentage points as measured by the CAP. For clients scoring in the highest CAP risk category, the average reduction in risk was about 17 percent. In terms of specific behavior, parents were less likely to use corporal punishment, to provide inadequate supervision, or to ignore their children's emotional needs. The study also found that the potential to be abusive continued to decline between program termination and a follow-up interview 3 months later.

The study reports that children as well as parents benefited from participation. Overall, the percentage of children scoring in the normal range on the Denver Developmental Test increased from 69 percent at the beginning of services to 87 percent at the end.

Less Rigorous Evaluations Also Suggest Success

While rigorous, controlled evaluations are the more accurate way to measure the effectiveness of prevention efforts, less rigorous evaluations provide at least some indication of whether the services provided are beneficial. Most of the 27 programs we visited lacked the funds and expertise to perform rigorous, long-term evaluations, but some performed assessments of the programs' short-term effects. These less rigorous evaluations support the argument that prevention programs work. Of the 18 programs with short-term evaluations, 13 reported positive benefits, such as improved parenting skills, increases in parental self-esteem and knowledge of child development, and reduced numbers of abuse reports. The results of several of these evaluations are summarized below.

Webster Avenue Family Resource Center (New York)

This Rochester, New York, center provides a variety of programs, including parent education and support, social events, child care, and counseling. The programs are aimed at improving parenting skills and reducing risk factors, such as isolation and low self-esteem, which are often associated with child abuse. Webster Avenue Center periodically evaluates its programs and staff from the perspective of its clients. The

center has collected and analyzed parent feedback since 1988 using a questionnaire that is completed by participants from a cross section of center activities. Responses are periodically summarized. Examples of some of the questions are:

- Have the center's programs helped you to better understand your child?
- Have the center's programs helped you to feel better about yourself as a parent?
- Since you have been coming to the center, did you meet a new friend?

The seventh questionnaire summary, covering January to June 1991, includes responses from 223 clients. It reports a very positive client view of program results. For example, 84 percent of the clients stated that the programs helped them better understand their child a lot or quite a bit, 88 percent said the programs helped them feel a lot or quite a bit better about themselves as parents, and 97 percent said they met at least some new friends.

Birth to Three (Oregon)

Birth to Three is a center-based parent support program in Eugene, Oregon, that has been in operation since 1978 and is open to the public. Under an evaluation requirement imposed by the state, which helps fund the program, a random list of 100 participants per quarter is submitted to the state's Child Protective Services (CPS) office and compared to the names on reports of abuse. The program director said that, of the most recent 600 names submitted, only 1 had been reported to CPS for child abuse—an incidence rate of about 0.17 percent. This rate is less than one-tenth the estimated average national reporting rate, according to the 1988 National Incidence Study published by HHS.

Family Support Program (California)

The Family Support Program in Sacramento, California, provides volunteer mentors and parenting education to families at risk of abuse. Mentors make weekly home visits to provide parenting and nutrition suggestions, respite child care, and transportation. They also teach parents about the development and growth of their children. Most participating families volunteer to receive services and, according to the program director, 80 percent have incomes below the poverty level. The program director said that, as part of the evaluation of the program, staff check all program participant names against CPS reports of abuse. Fewer than 10 percent of all program participants have later been reported to CPS, and fewer than 1 percent of those who receive a mentor later become involved

with CPS. Some studies have estimated the rate of abuse among at-risk populations to be as high as 18 to 20 percent.

Evaluations in Process Should Produce Additional Information

We identified several program evaluations in process that should produce additional information about the extent to which various types of programs are effective in preventing child abuse and neglect.

- The principal investigator for the evaluation of the nurse visitation program in Elmira (see p. 19), has begun a similar program in Memphis to assess the effects of this strategy in an urban setting.
- Hawaii has plans to conduct an evaluation of the lay home visitor services the state provides to at-risk new mothers. This study will assess the effects of providing such services for the first 5 years of a child's life, using areas of the state not yet incorporated into the program for comparative purposes.
- NCCAN has funded nine 5-year programs to plan and develop model comprehensive community-based child abuse prevention programs. NCCAN will coordinate data collection and program evaluation.
- A 5-year family support program funded by HHS/Headstart is aimed in part at reducing family stress factors associated with abuse by providing comprehensive support services. The program director said that, although reducing child abuse is not the program's major thrust, the preventive nature of the programs should reduce abuse. There are 24 demonstration sites nationwide and, according to the director, 10 more have been funded. Evaluations of the program's effectiveness using comparison groups will be performed by a third-party contractor.
- Michigan is promoting more rigorous program evaluation by providing for longitudinal evaluation of selected projects receiving state-administered grants. An official of the Michigan Children's Trust Fund—the state organization that supports local child abuse prevention programs—said that beginning in 1991, two new programs supported by the trust fund will receive extensive evaluation involving a randomly assigned control group, pre- and post-testing of participants, and collection of data on the participants for 3 to 5 years.

Studies of Costs and Benefits Are Limited but Encouraging

The effectiveness of prevention activities must also be viewed from the perspective of their cost. Very little analysis has been done to estimate the total cost of preventing child abuse or the long-term social costs of not preventing it. We identified three studies that suggest that although prevention can be costly, it can pay for itself in the long run.

The cost of preventing abuse may be best demonstrated using a specific program as an example. Hawaii's Healthy Start is a home visitation program—the most comprehensive statewide effort in the nation—that screens new births and offers services to families exhibiting risk factors associated with abuse. Program projections indicate that in 1993 the cost to provide the full 5 years of service to a family would be about $7,800. However, the total cost of preventing one case of abuse through the program is about $38,800.[3] It is possible this cost may be justified in cost-benefit terms because child abuse can be an expensive outcome. The cost of child abuse includes, but may not be limited to, the costs of the immediate consequences of child abuse, such as hospitalization and foster care. A hospital official in Hawaii said that the cost of hospitalizing an abused child for 1 week would range from $3,000 to $15,000. A Hawaii social services official said that providing foster care for 1 year would cost more than $6,000. Adding the costs of the potential long-term consequences of abuse could raise this amount substantially. For example, the Hawaii program estimates the cost of incarcerating a juvenile for 1 year at about $30,000, the cost of providing foster care to an abused child to age 18 at $123,000, and the cost of institutionalizing a brain-damaged child for life at $720,000. However, not all abused children will incur costs at this level.

In addition to the benefit of reducing the direct cost of abuse, the program delivers other benefits. Potential savings resulting from improved family health and improved education and employment opportunities for the parents—goals of the program that can benefit not only those who would have become abusive, but the other participants as well—increase the likelihood that the total savings can offset total costs.

The most thorough analysis we found of the immediate and long-term monetary effects of not preventing abuse was published in 1988.[4] This study examined research on a variety of outcomes of abuse, such as juvenile delinquency and the need for special medical services and educational programs. Using conservative estimates of abuse and treatment prevalence rates from separate studies, it calculated the

[3]Hawaii's estimated 1993 program costs are about $7,800 for the full 5 years a family can participate in the program. This $7,800 figure, however, is not a true measure of the actual cost of preventing abuse through the program, because the abuse rate for an at-risk population has been estimated to be as high as 20 percent. This means that on average, 80 percent of the program's expenditures are for families who would not have abused or neglected their children. A better estimate of the total cost of preventing abuse is $38,800—the cost for the one family in five where abuse or neglect would occur plus the cost for the other four where abuse or neglect would not occur.

[4]Deborah Daro, Confronting Child Abuse: Research for Effective Program Design, New York: The Free Press, Macmillan, Inc., 1988.

potential dollar costs resulting from abuse. For example, assuming a 20-percent delinquency rate among adolescent abuse victims, the study estimated that it would cost over $14.8 million if these youths required an average of 2 years in a correctional institution. It estimated that if 1 percent of severely abused children suffered permanent disabilities, the annual cost of community services for treating developmentally disabled children would increase by $1.1 million. Finally, it estimated that the cost in future lost productivity of severely abused children is $658 million to $1.3 billion annually, even if their impairments limited their potential earnings by just 5 to 10 percent.

The Michigan Children's Trust Fund recently compared the costs of preventing child abuse with the costs resulting from maltreatment. The analysis estimated the annual state cost of a child abuse prevention program that starts prenatally to educate and support parents, and works intensively with them during the first year of their child's life. It noted that this kind of program not only reduces abuse, but can also help children come into the world healthier, creating additional cost savings by reducing the number of low birthweight babies. The analysis estimated the annual state costs to address the results of maltreatment, which included the costs associated with medical treatment for injuries sustained by abused children, special education, foster care, adult and juvenile criminality, adult psychological problems, and lost productivity. The study showed that providing a year-long parent education and home visitor program to every family having its first baby in the state of Michigan would cost about $43 million per year. In contrast, the estimated total state costs of dealing with the results of abuse and low birthweight babies exceed $823 million annually.

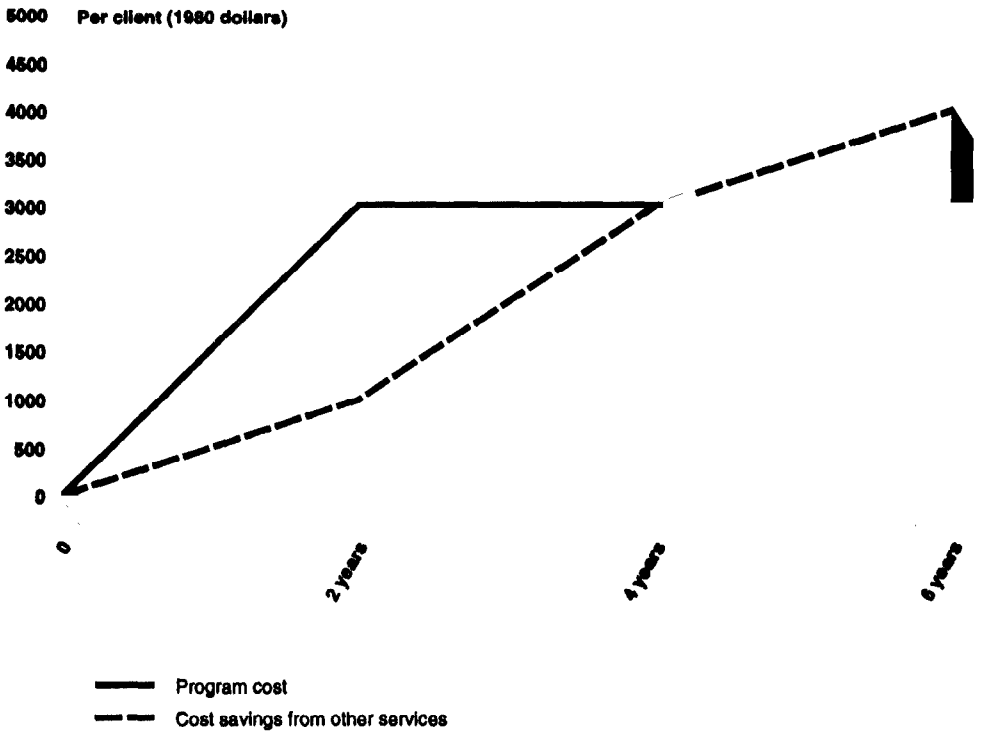
Another recent cost study suggests that prevention can pay for itself. A 1990 report on the Elmira Prenatal/Early Infancy Project—discussed earlier—suggests that program costs can be offset in a relatively short time.[5] The study concluded that the program's cost of $3,017 per low-income family (in 1980 dollars) could be nearly offset within 4 years. According to the principal investigator, even if the rate of cost savings is reduced by one-half over the next 2 years, the program will have more than paid for itself for low-income children before they enter school. The study suggests that frequent home visitation by nurses during pregnancy and the first 2 years of the child's life can significantly reduce many health and social problems—including child abuse—commonly associated with

[5]David L. Olds and others, "Effect of Prenatal and Infancy Nurse Home Visitation on Government Spending" (Presented at the 1990 Annual Meeting of the American Pediatric Society and Society for Pediatric Research, May 9, 1990). (See appendix II for a more detailed description of this study.)

childbearing among adolescent, unmarried, and low-income parents. For example:

- Home visits reduced instances of prematurity and low birth weight, excess use of the health care system, child abuse and neglect, and developmental delay. They also reduced the number of subsequent pregnancies during the 4 years following the birth of the first child. These reductions in turn cut the need for public expenditures for health care and social services. Treating low-income families resulted in an average 4-year savings of $468 per family in Medicaid payments and costs of social services resulting from child abuse.
- The program helped to improve the employability of clients. Women who had not finished high school returned to school more rapidly than their counterparts who did not receive nurse visits. After they had their children, poor unmarried mothers who received nurse visits were employed 82 percent more of the time than poor unmarried mothers who did not receive these visits. On average, over 4 years, each low-income home-visited family received $1,637 less in public assistance and $770 less in food stamps. Their increased employment also resulted in increased tax revenues of $137.

Figure 2.1: Elmira Project Costs for Low-Income Mothers Were Nearly Offset in 4 Years



The Elmira study points out that a prevention program can be cost beneficial because of a wide-ranging set of positive effects—including reducing abuse and neglect. Some researchers have suggested that cost-benefit studies of abuse prevention programs would need to encompass a wide sweep of potential benefits in order to fully measure what the programs accomplish. For example, two researchers addressing abuse prevention concluded that there is good reason to expect that well-designed home visitor programs will significantly improve the mother's general child-rearing skills, and consequently improve the cognitive, social, and emotional growth of many children.[6] Two other researchers concluded that the cost of prevention programs should be understood in terms of all the things they prevent. They cite such additional benefits as fewer premature births and a lower incidence of accidental injuries.[7]

[6]Michael S. Wald and Sophia Cohen, "Preventing Child Abuse—What Will It Take?" Family Law Quarterly, Vol. XX, No. 2, Summer 1986, pp. 281-302.

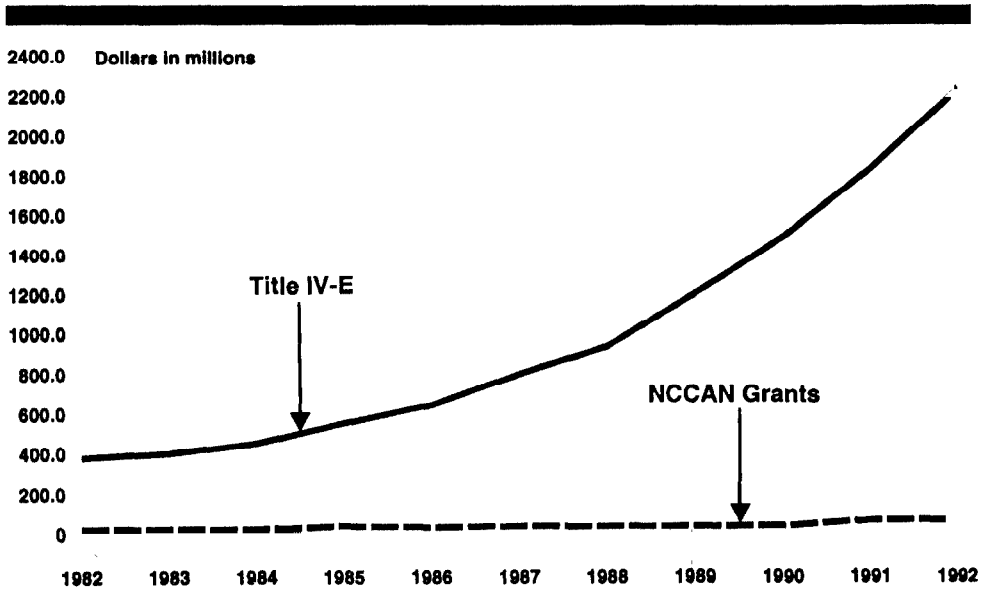
[7]James Garberino and Kathleen Kostelny, Public Policy and Child Protection, Erikson Institute, Chicago, IL, 1988.

Limited Federal Funding for Abuse Prevention Programs

Funding for prevention programs is a relatively small portion of federal funds available for child abuse and neglect efforts. Most federal expenditures are for programs that intervene after abuse has occurred. More specifically:

- Most federal funding goes for foster care and other out-of-home placements. Federal expenditures for foster care alone have more than doubled in the past 4 years, rising from about $800 million in fiscal year 1987 to about $1.8 billion in 1991. Over the past 10 years, foster care expenditures have increased five fold (see fig. 3.1).
- NCCAN grants are the primary federal source of funding for prevention programs. During each of the past 4 years, NCCAN provided $30 to $60 million in grants. Much of this grant money, however, also goes to programs that intervene after abuse occurs. About $5 million per year was specifically set aside for prevention. Available evidence indicates that a substantial portion of the remainder is spent on programs other than prevention.

Figure 3.1: NCCAN Grant Funding From 1981 to 1992 Much Less Than Title IV-E Foster Care Funding



Federal funding for foster care is an uncapped entitlement. That is, states are reimbursed on average for about 56 percent of the costs their foster care programs incur for children from families eligible for Aid to Families

With Dependent Children. The cost of this reimbursement has almost doubled in the past 4 years. Future growth will continue to result in increased expenditures at both the federal and state levels.

Most of the children who are placed in foster care have been victims of abuse or neglect. Recent legislation before the Congress has addressed the need to reduce foster care by intervening sooner to provide family preservation services to troubled families. Preventing abuse and neglect from occurring in the first place is an even earlier intervention strategy to reduce the need for foster care and other treatment for maltreated children. Officials in five of the eight states we reviewed said they would like to have more flexibility to finance prevention activities, for example, with federal funding now specifically earmarked for foster care.

Federal Expenditures for Child Abuse and Neglect Come From Many Sources

The total amount of federal funds being spent on child abuse and neglect prevention cannot be precisely determined. One reason for this is that such federal funding is spread among many agencies. In 1989, an interagency task force[1] chaired by the NCCAN director surveyed 41 federal agencies and offices and found 28 that reported specific activities pertaining to child abuse and neglect. These activities included service delivery, research, demonstration projects, staff activities, and grants for social and other services. In addition, although the other 13 agencies did not provide specific activities for child abuse and neglect, they reported activities directed toward understanding or ameliorating other problems that may be related to child abuse—for example, substance abuse.

NCCAN's 1991 Guide to Funding Resources for Child Abuse and Neglect and Family Violence confirms the broad participation among federal organizations. It cites eight federal departments and numerous offices and bureaus within those departments that provide funds for child abuse and neglect efforts.

A second reason for the difficulty in determining precisely how much federal money is being spent on child abuse and neglect programs is that expenditures for this purpose cannot always be separated from expenditures for other purposes. In its 1989 survey of federal agencies, the Interagency Task Force attempted to collect data on the amount of funding that supported the activities reported by federal agencies. The task force reported that it could not accurately represent the total funding

[1]A 31-member task force established under the Child Abuse Prevention and Treatment Act to coordinate federal efforts for addressing child abuse and neglect.

because some agencies' mechanisms for defining budget categories made it impossible to break out actual costs for activities specific to child abuse and neglect.

Federal funding to states and other organizations for child abuse services comes mainly from four sources:

- NCCAN grants. NCCAN administers several categories of grants to states and other organizations. During the most recent 5 fiscal years (1987-91), total funding for these grants was about $180 million. Grants rose during that period from about $30 million in 1987 to about $60 million in 1991.
- Foster care matching funds. HHS provides these funds to the states under Title IV-E of the Social Security Act. This is an entitlement to provide foster care and other out-of-home placements for children who are eligible for Aid to Families With Dependent Children. During the most recent 5 fiscal years (1987-91), total funding was about $6.2 billion. Funding rose during the period from about $800 million in 1987 to an estimated $1.8 billion in 1991.
- Child welfare services. HHS provides matching grants to states for child welfare services to families irrespective of income under Title IV-B of the Social Security Act. Total funding during the last 5 fiscal years (1987-91) was about $1.2 billion. Grants rose during that period from about $223 million in 1987 to an estimated $274 million in 1991. The amount spent on abuse prevention is not known.
- Social services block grants. HHS provides these grants to the states under Title XX of the Social Security Act. States can use these grants for a variety of purposes, including programs related to child abuse and neglect. During the most recent 5 fiscal years (1987-91), grant money available has remained at about $2.7 billion annually, totaling about $14 billion over the period. The amount spent for child abuse programs is unknown.

Other smaller HHS programs with child abuse treatment and prevention aspects include Family Violence Prevention Services, Temporary Child Care and Crisis Nurseries, Abandoned Infants Assistance, and Adoption Opportunities. The 1991 funding for each of these programs was less than $13 million.

Federal Funding for Abuse Prevention Is Limited

Funding earmarked specifically for abuse programs is limited largely to NCCAN grants, which are available for preventing abuse as well as for treating abused children. About $5 million of each year's grant money is set aside for Challenge Grants, which must be used exclusively for abuse

prevention activities. This grant program was created as an incentive to states to establish and maintain trust funds or other funding mechanisms to support abuse prevention efforts. Several states we visited had used Challenge Grants to support children's trust fund organizations, which raise additional funds using such strategies as license fees, income tax checkoff, and sales of keepsake birth certificates. Some of the trust fund organizations also provide information and technical assistance to prevention programs in their state.

Much of the remaining grant money appears to go for programs that treat abuse after it happens. NCCAN officials do not have a breakdown of how the remainder is spent, but 17 states responding to a previous GAO survey reported spending $1.9 million of their grant money—apart from Challenge Grants—on prevention programs in fiscal year 1989.[2] About $25 million in such grants was available to states in fiscal year 1989.

Funding for prevention programs forms an even more limited part of the expenditures from Titles IV-B and XX of the Social Security Act. Because states are not required to separately account for and report monies spent on abuse prevention, the total amount of these funds spent by states on prevention is unknown. However, in our May 1991 report, we noted that the 25 states able to identify the source and amount of federal funds used for prevention under these titles collectively spent $14.9 million in 1989, while total funding available to all states under these titles was about $3 billion.

States Expressed Desire for Greater Flexibility in Federal Aid for Child Abuse Programs

In five of the eight states we visited, officials said they were interested in using a portion of federal foster care funds for abuse prevention programs. Some officials said they believed such programs could reduce both the need for foster care and federal and state foster care costs. At present, foster care funds cannot be used in this way, even if states were to demonstrate that the prevention programs reduce child abuse and resulting federally funded foster care placements.

Michigan already has an initiative that diverts state foster care monies to provide funding for family preservation programs that reduce the need for foster care.[3] According to state officials, the state negotiates performance

[2]Child Abuse Prevention: Status of the Challenge Grant Program (GAO/HRD-91-95, May 9, 1991).

[3]Family preservation services are directed at families that are on the verge of having a child removed because of abuse or neglect. In contrast, the programs we focused on in this report are targeted at families that have not yet experienced an instance of abuse.

agreements with county social service agencies specifying the number of foster care placements that will be avoided because of treatment by a family preservation program. The counties then contract with private agencies to provide family preservation services using state funds that would have been used for foster care. Officials there said they would like to use the same strategy to fund child abuse prevention.

The states that expressed an interest in using federal foster care funds for prevention programs said they were interested in doing so partly because they were likely to have more state-level support for programs with federal matching funds. They said that given their current budget environments, they were not optimistic about being able to invest more resources in prevention programs for which they receive no federal matching funds.

The other three states we visited indicated that they had not yet considered diverting foster care monies to fund prevention programs. However, they said they would like to be able to increase their child abuse prevention efforts.

At the federal level, several bills have been introduced that would increase flexibility for federal funding of certain types of programs for child abuse and neglect, but most are not aimed at preventing abuse before it starts. The Congress has considered several proposals to amend the Adoption Assistance and Child Welfare Act (P.L. 96-272) that would provide additional federal monies for programs to reduce foster care. These programs are targeted at families with abuse or neglect problems so severe that foster care is the next step. The proposals include:

- S.4, which would authorize a new capped entitlement associated with Title IV-B of the Social Security Act. The new entitlement would be for "innovative services." Eligible activities would include intensive family preservation services, respite care, and family support services. The entitlement would start at $150 million in 1992, growing to $400 million in 1994. S.4 would also authorize a demonstration project that would allow 10 states greater flexibility to use Title IV-B and Title IV-E funds to design child welfare activities.
- H.R.3603, which would add Title IV-G to the Social Security Act. This new title would allow states on an open-ended basis to fund intensive family services to prevent the need for foster care.
- S.2809/H.R.5316, which would amend Title IV of the Social Security Act to authorize states to use federal funds for family support, reunification, placement, and assistance in those instances where child abuse has

already occurred or is suspected. Total funding would begin at $1.3 billion for fiscal year 1993 and rise to $2.2 billion for 1997.

These proposals do not extend increased funding flexibility to prevention programs targeted at families in which abuse has not yet occurred. Rather, they are directed at families where abuse or neglect are already occurring.

One bill before the Congress, H.R.1244—the Healthy Beginnings Act—would provide grants to public and private organizations to establish nurse home-visiting services in medically underserved areas. Services are intended to improve the overall well-being of high-risk women and their young children and would include activities associated with abuse reduction, such as educating mothers in parenting skills, building an emotional support network for mothers, and linking families with social and health services.

State and Local Prevention Efforts Experience Planning, Coordination, and Funding Problems

The eight states we visited had a wide variety of child abuse prevention programs offering different approaches and services. Programs often originated at the community level and struggled for financial resources. Program officials frequently had difficulty finding information on how to establish or improve a program. Most programs relied on multiple, short-term funding sources, such as grants, which caused uncertainty about program survival and added to their administrative burden. Additionally, grant money often went to start new programs, with little funding available for maintaining established ones.

Although states offered a wide range of programs, most were not well coordinated at the state or local level. Several states were attempting to assess and plan their prevention needs, but efforts were limited, in part because of budget constraints. In our view, comprehensive needs assessments and knowledge of existing programs are needed in order to develop and implement prevention plans that avoid gaps and overlaps in services.

Prevention Programs Vary in Terms of Target Groups and Range of Services

The 27 programs we visited varied in several ways. They varied in the length of time they had been operating, the locations where services were provided (center-based activities or home visitation), and the clientele they were targeting (all parents or only those that met specific criteria). They varied in size from fewer than 100 to several hundred clients per year. Some programs hired only professionals, such as nurses or social workers, while others hired paraprofessionals or used parent volunteers.

The prevention programs visited often started at the local level to meet a particular need. Some programs were open to any parent of a newborn. Others were geared specifically to teen parents, minorities, or those considered to be especially vulnerable because of such stress factors as low income, employment problems, and low education level. For example, Birth-to-Three in Eugene, Oregon, began as a support program for new parents in the community. Over the years it has expanded services to include programs specifically for teenage parents and for severely stressed parents of older children.

Another effort, the Early Parenting Program at San Francisco General Hospital, is a home visitor program specifically for families who have a child born at the hospital or who receive their pediatric care there. Families typically exhibit certain social risk factors, such as an inadequate

support system; education, housing, or employment problems; and mental health or substance abuse problems.

Programs Have Difficulty Finding Information

Officials at some programs said information on prevention approaches and strategies was difficult to find, citing as examples information on starting a program; identifying the kinds of programs that work best; funding, staffing, and advertising; and locating program literature. Staff at two programs that targeted Hispanic families said they had difficulty finding parenting information that was culturally specific. They were not aware of other Hispanic programs in operation and could find little information that was culturally sensitive. Officials said that cultural sensitivity is important to help parents understand how the concept of appropriate child rearing applies to their specific background. Program staff said that in several weeks, they could locate only sketchy information that was inadequate to develop their program. Ultimately they had to adapt information from non-Hispanic programs and tailor it to their clients' needs.

Officials from a few programs also said that they had problems locating and sharing information about the activities of other programs, the types of services they offer, and any lessons learned about what has worked and what has not. Some program officials said they lack sufficient funds to attend conferences, such as the National Conference on Child Abuse and Neglect, sponsored by NCCAN. Conferences like this can provide opportunities for program officials and staff to learn about program strategies and share information with others on what works under which circumstances.

Several information sources are available to programs. However, some of the programs we visited were not aware of these sources or the information they could provide. NCCAN sponsors a clearinghouse to provide information on child abuse prevention and treatment, but several program officials we spoke with did not know it existed. Some programs we visited were not aware of information resources available from the National Committee for Prevention of Child Abuse (NCPCA)—a private nonprofit organization—and one program did not know about information available from the Children's Trust Fund in its state. Children's Trust Funds are state organizations that were started to provide funding for abuse prevention and to administer NCCAN Challenge Grants. NCPCA and some of the state Trust Fund organizations provide program guidance and information on child abuse prevention. All 50 states have NCPCA chapters, and 47 have a Trust Fund or Challenge Grant organization as a prevention

focal point. In some states these two organizations work closely together, as in Washington and Michigan.

In addition, the NCPCA chapters and Children's Trust Funds did not always have complete information on what programs existed in the state. Several officers said they lacked sufficient resources to gather comprehensive program information and disseminate it throughout the state. Some organizations had efforts underway to solve this problem. In one state the Children's Trust Fund organization has prepared a directory that lists by county the name, address, and telephone number of child abuse prevention programs. However, the directory does not describe the programs or differentiate between prevention services and intervention services. According to a Children's Trust Fund official, it would be useful to have such information, but scarce resources prevented them from developing it.

An NCPCA chapter in another state had collected some information about programs in the state, but the chapter director said that he had no way to assure that the directory contained complete and up-to-date information. They said that when programs closed, the chapter sometimes did not find out until it called the disconnected phone. They expressed interest in developing a document for dissemination to the community, but lacked the resources to do so.

As discussed on page 15, we are reviewing NCCAN's progress in meeting its legislative mandates in such areas as technical assistance and program monitoring, and plan to report our findings separately.

Funding Resources Are Fragmented and Unreliable

In the states we visited, program funding typically tends to (1) come in small amounts from many sources and (2) be short-term. Funding is available from federal, state, and local government agencies, as well as private foundations, trusts, and local corporations. Funding often has to be reapplied for each year, or may last for 2 to 3 years. Rarely do programs receive funding they can count on receiving year after year. Because of this erratic financial base, many programs must plan and operate without certainty about their future, expending a great deal of time seeking and administering funds rather than providing services to clients.

Many of the programs we contacted relied on money from several sources to support their activities—in some cases more than 10 sources (including, for example, government grants, foundations and trusts, and annual

solicitations). For example, one program we contacted—which had been operating for 10 years—had a 1991 budget of about $319,000 and received funding from 37 sources. Only 7 of the sources provided funding of more than $10,000, and most provided less than $5,000. Another program had as many as 26 income sources for amounts ranging from $350 to $59,786. Figures 4.1 and 4.2 illustrate the diversity of funding sources for two prevention programs we contacted.

Figure 4.1: Birth to Three Program Has Many Funding Sources

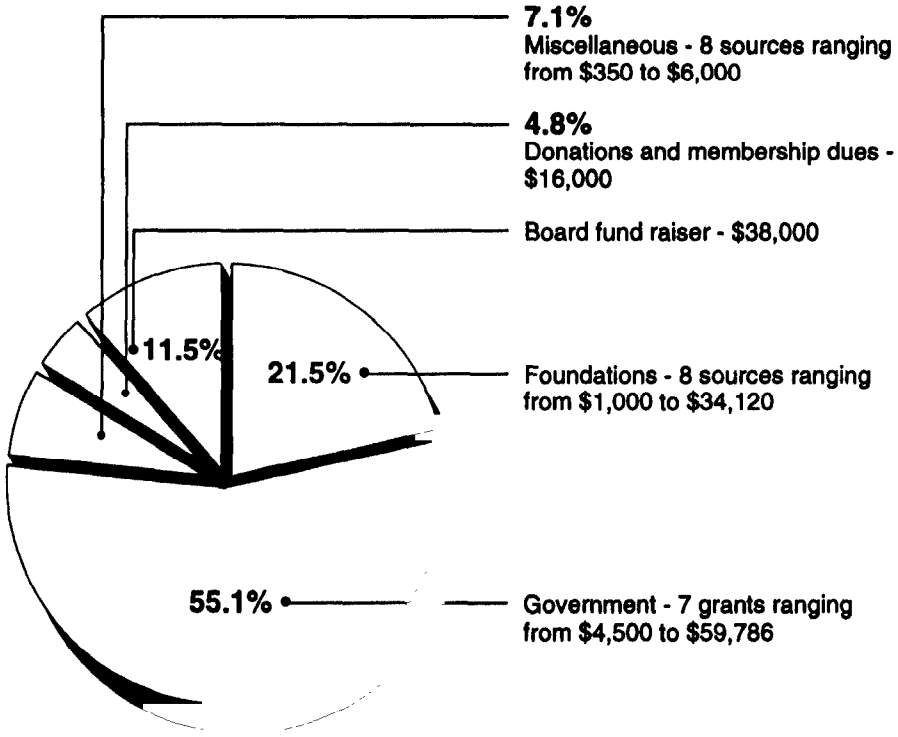
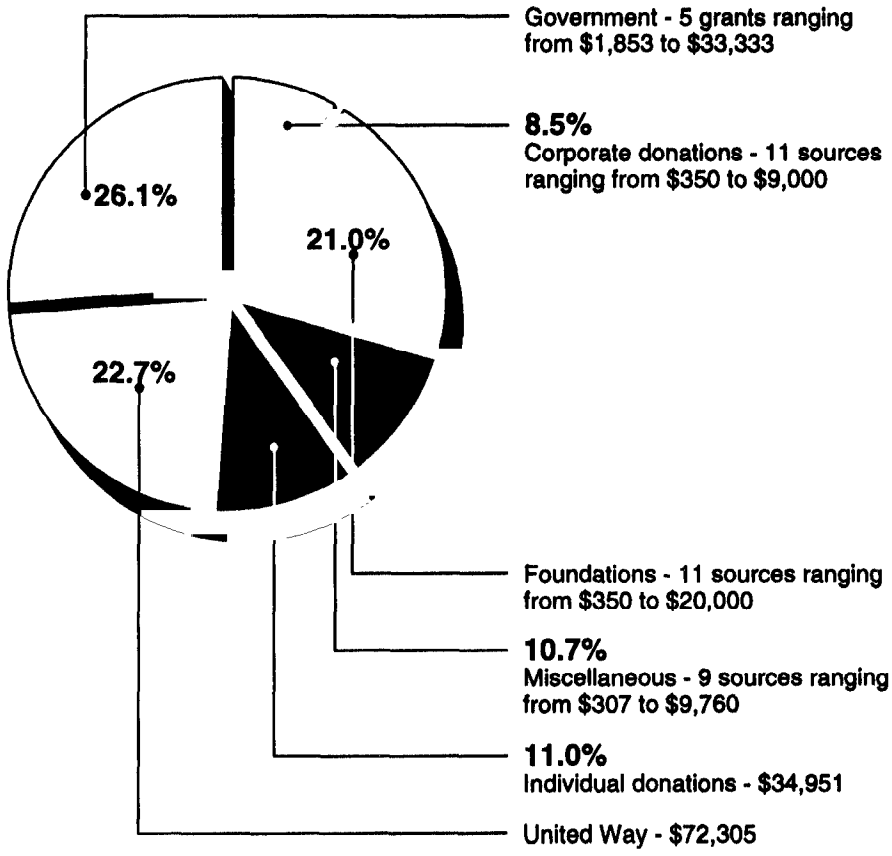


Figure 4.2: Webster Avenue Program Receives Grants of $20,000 or Less From 11 Foundations



Officials said that none of the funding for either program could be considered sustained. It is either "seed money" for 1 to 3 years or money that has to be solicited each year. Program officials said that writing grant proposals, meeting individual grant reporting requirements, and trying to find additional sources of money require an inordinate amount of their time. They mentioned that it can take several days, and often up to a week, to prepare one grant proposal. This absorbs resources that could otherwise be devoted to providing services to clients and engaging in other program activities, such as outreach. One program official mentioned that because it took a lot of time to prepare a grant proposal, she often weighed the amount of time it would take against the amount being offered and the likelihood of being awarded the grant. She said that sometimes it was not worth her time to apply for grants of $5,000 or less.

Officials also told us that grant money often goes for starting new programs rather than for maintaining established ones. Several state officials said they give programs only short-term grants or seed money because they want to promote community prevention efforts, but also want the programs to be self-sufficient. Officials said seed money also spreads funding around to as many programs as possible with the hope that—once established—they will be able to survive and provide services to the community. Government and program officials said that the concept of providing seed money to help start programs is good. However, they also said programs find it increasingly difficult to obtain new or sustained funding. Unless programs are incorporated into public agencies, they have difficulty finding permanent funding sources.

In our review of home visiting,[1] we reported that developing a strategy for ongoing funding is an important design characteristic for successful programs. We noted that funding uncertainty can contribute to operational problems and is considered to be one of the basic sources of unpredictability and unevenness in delivering home-visiting services.

State Efforts to Plan and Coordinate Prevention Efforts Have Been Limited by Lack of Resources

Although state efforts to plan and coordinate child abuse prevention activities varied, all eight states we visited had at least created a state focal point for child abuse prevention. Many state officials expressed interest in preparing and implementing a comprehensive statewide abuse prevention plan. However, they said their efforts were limited by a lack of funds. A comprehensive needs assessment and prevention plan is important because it could provide guidance to help assure that both state and federal funds will be used as efficiently and effectively as possible and in a manner that seeks to avoid gaps and overlaps in services.

The U.S. Advisory Board on Child Abuse and Neglect, together with NCPCA, has recently proposed that states develop and implement prevention plans. NCCAN has also encouraged states to create Children's Trust Funds through its Challenge Grant program. However, NCCAN grant programs have provided little funding incentive for states to develop and implement comprehensive needs assessments and prevention plans.

Three of the eight states we visited had made significant progress in developing a statewide prevention structure. However, they continued to face funding problems in sustaining their efforts. These states' activities,

[1]Home Visiting: A Promising Early Intervention Strategy for At-Risk Families (GAO/HRD-90-83, July 1990).

described below, demonstrate the variety of approaches being explored to address child abuse at the state level. Other states we visited were making efforts to move toward state planning and coordination. One of them had begun a state coordination effort through the Children's Trust Fund organization. The other four states had established a focal point at the state level for prevention efforts. Officials in these five states expressed interest in having a prevention plan, but said that lack of resources prevented them from preparing such a document.

Florida Prevention Plan

Florida was the only state we visited that had a statewide plan for child abuse prevention programs. The plan establishes a framework for developing and setting service priorities. The plan also contains information about programs receiving state funds, including program goals and objectives, service delivery methods, target population, community served, budget, funding, and staffing.

In addition, the plan enumerates goals for the state and individual districts. Goals address service delivery and program planning, improved collaboration with state offices, and coordination and integration of services. Officials said, however, that the plan does not contain information about community prevention programs that are not funded through the state. The state would like to include these programs in future versions of the plan.

The child abuse prevention plan has been required by state law since 1982. The law specifies that a comprehensive approach for preventing child abuse and neglect be developed and used as a basis for program funding. Representatives from 11 state offices with responsibility for children's issues developed the plan, with the assistance of task forces from Florida's 11 Health and Rehabilitative Services Districts.

Florida funds its prevention efforts through annual appropriations. The original appropriation of $1.1 million for 6 months of fiscal year 1982-83 had grown to $4.9 million for fiscal year 1988-89. However, funding decreased in 1989-90 to $3.8 million and again in 1990-91 to $3.2 million. Since 1987, about 25 percent has been for primary prevention services and 75 percent for secondary prevention services and services after abuse has occurred.

Michigan's Prevention Network

Michigan has also taken steps to plan and coordinate abuse prevention activities. It has established a statewide prevention network through its

Children's Trust Fund organization. The organization uses a county-based network of local volunteer child abuse prevention councils. The councils give the state information on local needs and suggestions on which programs should be funded. The councils help monitor local community Trust Fund grant programs and promote local projects. According to the Fund director, the councils are independent and can do as they wish, as long as their activities are related to abuse prevention. The network grew from the existing state NCPCA organization and now has groups in nearly all counties in the state. State officials say that although the Children's Trust Fund is separate from the state Department of Social Services, they keep close contact with the Fund and local prevention activities. The director of the state Bureau of Children's Services serves on the Children's Trust Fund board of directors.

The organization is funded by Michigan's NCCAN Challenge Grant, direct donations, monies generated by a state income tax checkoff, and some support from other state departments. It does not rely on annual appropriations. Each year a portion of the checkoff income is placed in a permanent interest-bearing trust fund, and the interest is spent on prevention efforts. However, the Children's Trust Fund has faced reduced income in the past few years. The tax checkoff funding declined from about $610,000 in 1986-87 to $374,000 in 1988-89. Total funding also declined from about $1.3 million in 1987-88 to $924,000 in 1988-89.

Michigan also established some statewide prevention activities; however, state officials said that recent budget cuts may all but eliminate them. The Children's Protective Policy Division of the Department of Social Services provided prevention services to families at risk of abuse or suspected as abusers, as part of the county-based child welfare system. According to state officials, case workers at each county child welfare office were assigned to devote their time to prevention—110 were designated statewide. Services focused on strengthening the family and facilitating access to needed services. However, because of recent budget cuts and increases in reports of abuse, officials are concerned that prevention case workers will have to be diverted to providing only intervention services.

Hawaii's Home-Visiting Program

Although Hawaii does not have a comprehensive state child abuse prevention plan, it has the only statewide prevention program of its kind in the nation. Healthy Start is a home visitation program that began in 1985. The program screens new mothers in the hospital to identify parents who are at increased risk of becoming abusers and offers them home-visiting

services. The home visitors provide emotional support, teach appropriate parenting skills, and link families with appropriate community services.

The program served about 2,200 families in 1991. Costs per family for 1993 are estimated to average about $1,500 annually. The program has reported an abuse and neglect rate of less than 1 percent among its clients, compared with estimates from 18 to 20 percent among at-risk families studied in other projects.

Healthy Start is funded with a state appropriation that totaled about $6 million in 1992. The program now screens about 55 percent of the state civilian newborn population, with the goal of 90-percent coverage by 1995. Despite its success, Healthy Start continues to be hampered by budget constraints, and new client intake is sometimes closed because the home visitors' caseloads are full. (See appendix I for a detailed description of this program.)

Healthy Start has received national recognition, including being cited as a model program in 1991 by the National Advisory Board on Child Abuse and Neglect. In addition, NCPCA and the Ronald McDonald Children's Charities have launched a new initiative called Healthy Families America to assist states in developing child abuse prevention programs modeled after Healthy Start. According to NCPCA, 36 states have formed teams to begin the development process.

Conclusions, Recommendations, and Agency Comments

HHS's National Center on Child Abuse and Neglect, in concert with such private, nonprofit organizations as the National Committee for Prevention of Child Abuse, has worked to focus public attention on the problem of child abuse and to implement programs and studies that address its prevention and treatment. These efforts, and those of many other individuals and organizations, have created a substantial base of experience and knowledge about the extent of the problem, the likely causes, and promising prevention strategies. Studies of the effects of prevention programs report success in reducing the incidence of abuse. Preliminary cost studies indicate that prevention can pay for itself.

Federal funding for activities to deal with child abuse and neglect has increased substantially in the last decade, but most of the money goes for foster care and other programs for children who have already been abused or neglected. Funding for programs that prevent abuse from occurring take a back seat to those that try to deal with abuse after it has occurred. In our view, more emphasis needs to be directed at preventing child abuse and neglect.

Enhancing Program Evaluation

The current body of research and evaluation of child abuse prevention programs, though limited, demonstrates that child abuse prevention can be effective. The evidence accumulated to date indicates that prevention programs can have a variety of positive measurable effects. Such programs help parents develop the skills they need to raise their children. They provide support systems to turn to when difficult situations occur, and they link families with needed health and social support agencies, such as those that provide counseling, day care, and employment services. Research suggests that these efforts can also reduce the dollar costs often associated with abuse and family dysfunction.

The more significant question for future evaluations is not so much whether prevention works, but rather which approach is most effective for a certain population, under a given set of circumstances. Experts agree that there is no single cause of child abuse. Therefore, there can be no single program model or strategy that will work for all individuals in every part of the country. Factors that increase an individual's vulnerability to abuse can differ considerably among different populations. As a result, evaluations need to address program effectiveness under constantly changing social and economic conditions, as well as the effectiveness of successful models that are implemented in different locations. To the extent possible, this research should be longitudinal—so that the

long-term program effects can be measured—and should use control or comparison groups—so that program benefits can be measured.

Little has been done to measure the cost benefits of preventing child abuse. This is another area of evaluation that needs emphasis. Prevention can be costly, though the limited analysis and research conducted to date suggest that such programs can pay for themselves in reducing the need for a wide range of services, including special education, law enforcement, and health care. Rigorous evaluations could provide evidence that prevention programs reduce child abuse and save money by eliminating some of the social costs associated with troubled families. More such research is needed, and NCCAN could play an important and increased role in providing both leadership and funding to encourage such efforts. It is important to keep in mind, however, that cost savings should not be the only criterion for measuring program worth. Policy makers also need to consider the human benefits of preventing child abuse and neglect. Programs that provide such benefits can be worthwhile public investments.

Modifying the Federal Funding Approach for Prevention Programs

The approach to funding prevention programs continues to be one of providing small grants as "seed money" for demonstration projects. This approach has been effective in encouraging the start of new programs, and providing seed money to encourage innovation is an important part of the total federal prevention effort. However, programs have no guarantee of survival because of the difficulty in obtaining ongoing funding. Federal efforts need to be directed toward promoting long-term funding of effective prevention programs, rather than emphasizing short-term demonstration projects.

Although HHS has played a role in funding prevention programs, its efforts have focused on assisting children who have already suffered from abuse. It has provided relatively little funding for preventing abuse from happening in the first place. Intervention and treatment efforts are vital, but they will not solve the problem of child abuse. Given the longer term promise of child abuse prevention efforts, federal programs for addressing abuse fail to give appropriate emphasis to prevention.

One way for HHS to expand its efforts in prevention programs would be to provide funding incentives for states to implement and provide continued support for such programs. The states we visited were interested in providing more prevention services, in part to reduce increasing foster

care costs. However, in times of reduced budgets and increasing foster care and other service needs related to abuse and neglect, states are unlikely to invest resources in prevention programs for which they receive no federal matching funds as they do for foster care expenses. Federal funding incentives are needed to encourage states to develop and implement prevention programs—or incorporate them into their existing family support services—without increasing federal expenditures over current levels.

Currently, states are reimbursed for part of their foster care costs but not for preventing the need for foster care by reducing the incidence of abuse. Lowering foster care costs with effective prevention programs would save money at both the federal and state levels. Effective prevention programs could also produce savings to both states and the federal government by lowering other short- and long-term social and health service costs that are often associated with child abuse and family disfunction. One approach would be to amend Title IV of the Social Security Act to provide federal matching payments to states at Title IV-E foster care rates to help offset the cost of child abuse prevention programs. States would be responsible for the cost of implementing the program and demonstrating its effectiveness, but thereafter would be assured of receiving continuing funding when they were able to demonstrate—through sound program evaluations—that prevention costs were more than offset by reduced need for foster care.

Bills introduced before the Congress—S.4, H.R.3603, S.2809 and the House companion bill, H.R.5316—have proposed amending Title IV to provide funding incentives for programs that address child abuse after it occurs. The bills would give the states more funding discretion and flexibility to implement programs that prevent foster care placement and by providing intensive services to families with existing child abuse problems. Although such services are important, funding incentives should also be extended to efforts to prevent abuse before it happens. Flexible funding strategies could promote programs designed to assist families before abuse or neglect occurs.

Enhancing State Planning and Coordination

Prevention programs face impediments that make their survival difficult. The most significant problems for all programs we visited were related to uncertain funding. Almost all the programs faced difficulties in securing sufficient funding. Program officials we spoke with expressed concern about the time they must spend trying to obtain and administer multiple

small grants from various government and private funding sources. This was often exacerbated by the fact that initial demonstration grant money is often limited to 2 or 3 years—after which a program must obtain other sources of funding.

Another impediment faced by programs was the difficulty they had in obtaining program information, such as services offered and lessons learned by others in the field. Although a variety of prevention programs operated in each of the eight states we visited, they had typically developed independently of each other and were not always aware of each other's existence. As a result, they sometimes felt isolated and had to reinvent program designs and materials that were available elsewhere.

Although one state had begun implementing a statewide program and another had developed a plan for state-run activities, efforts in other states we visited to develop a plan to address child abuse prevention based on a comprehensive needs assessment have been limited. Needs assessments and planning are important to help avoid gaps and overlaps in services and ensure the best use of scarce resources. One way to encourage states to devote more effort to developing and implementing prevention plans would be to direct future increases in NCCAN Challenge Grants to states that have put such plans in place. In commenting on a draft of this report, HHS said that it lacked legislative authority to do so.

Recommendations to the Congress

To provide incentives to states to implement and sustain child abuse prevention programs, we recommend that the Congress amend Title IV of the Social Security Act to give the Secretary of HHS authority to reimburse states, at foster care matching rates, for the costs of implementing prevention programs. The reimbursements would be provided to states where prevention programs have been demonstrated, through sound evaluations, to pay for themselves through reductions in the incidence of child abuse and the related foster care placements.

To encourage states to develop and implement state prevention plans based on comprehensive needs assessments, we recommend that the Congress give the Secretary of HHS the authority to direct any future increases in NCCAN Challenge Grants to states that are putting such plans in place.

Recommendation to the Secretary of HHS

We recommend that the Secretary provide funding incentives, such as through NCCAN, to encourage states to establish and rigorously evaluate programs with the potential for statewide implementation, and promote statewide adoption of strategies that have demonstrated effectiveness and cost benefits.

Agency Comments

In commenting on a draft of this report, HHS stated that our review of federal funding for child abuse prevention gave almost no attention to the billions of dollars that HHS and other federal agencies spend each year to reduce or eliminate the underlying stresses that contribute to child abuse. It commented that programs such as Head Start, Aid to Families With Dependent Children, the Job Opportunities and Basic Skills Training program, Medicaid, and various block grant programs play a major role in the prevention of child abuse. We agree that these programs, which are intended to improve the general health and well-being of families, may reduce the factors that cause abuse. However, child abuse prevention is not a principal objective of these programs, and the programs do not target services specifically to families at risk of abusing their children. Further, we are aware of no studies showing the resources that each of these programs devotes specifically to preventing child abuse or the effect these programs have had on abuse and neglect.

HHS commented further that our study focused heavily on home visitation programs and did not address prevention strategies that target diverse ethnic groups, families whose children have developmental disabilities, homeless families, or families where one or both parents abuse alcohol or use illegal drugs. As we state in our report, because there is no single cause of child abuse, there can be no single program or approach that will work for everyone. The Hawaii Healthy Start program, among others we discuss, uses a number of targeting factors, including social isolation, unstable housing, and substance abuse, to identify families needing services.

HHS also noted that while it supports home visitation as one important prevention strategy, it believes more development, testing, and evaluation of the programs is needed. Although we agree that better evaluations of all prevention strategies are needed, evaluations to date do indicate that home visiting can be effective in preventing child abuse and neglect in at-risk families. Furthermore, the U.S. Advisory Board on Child Abuse and Neglect has recommended that the federal government begin planning to implement a universal home visitation system, noting that the efficacy of

home visiting as a preventive measure is already well established. Finally, as we point out in our report, NCPCA has launched a new initiative to help states develop home visiting child abuse prevention programs.

HHS did not concur with our recommendation that the Congress give the Secretary authority to reimburse states for the costs of implementing prevention programs. Instead, HHS suggested that the administration's Comprehensive Child Welfare Services proposal would give states increased flexibility to use billions of dollars projected for foster care for prevention and family preservation activities ($1.3 billion in 1993 rising to $2.2 billion in 1997). We agree that this proposal (introduced on July 1, 1992) will provide states with increased flexibility to fund prevention programs, and may encourage some states to make such investments. However, under the proposal, prevention programs will compete with programs, such as family preservation, that address abuse after it has occurred. We continue to believe that funding incentives earmarked for prevention programs are needed to encourage states to develop programs to assist at-risk families before abuse occurs.

HHS advised us that our recommendation that it encourage states to develop and implement prevention plans is not within the Secretary's authority. We have, therefore, redirected the recommendation to the Congress, suggesting that it provide the Secretary with such authority. HHS also stated that such a provision would limit state flexibility in the use of prevention grants. It is not our intent to limit flexibility, but rather to direct any increases in funding levels to states that develop and implement prevention plans.

HHS also made a number of technical comments, which we have incorporated where appropriate.

Hawaii's Healthy Start Program

Healthy Start is the only child abuse prevention program we identified that is being implemented on a statewide basis. Healthy Start reports that the incidence of abuse among program participants is less than 1 percent compared with the approximately 18 to 20 percent estimated among high-risk populations. In a September 1991 report, the U.S. Advisory Board on Child Abuse and Neglect described Healthy Start as "clearly the star" of U.S. home visitation programs. We include this detailed description of Healthy Start to illustrate how one state is addressing child abuse prevention with a comprehensive statewide effort.

Healthy Start uses lay home visitors to provide supportive services to families at risk of becoming abusive. The program identifies participants by screening hospital births and interviewing new mothers. Services are voluntary and continue until children are 5 years old.

Healthy Start began in 1985 as a 3-year demonstration project in one area of the island of Oahu—in response to growing numbers of reports of child abuse—with a state grant of about $200,000. In 1988, Healthy Start received approval as a state program and has expanded services to other locations. Currently Healthy Start screens about 55 percent of the state's civilian newborn population. That figure is expected to rise to 90 percent by 1995.

The program is administered by the Maternal and Child Health Branch (MCHB), Hawaii State Department of Health. Services are provided by nonprofit organizations under contract with the Department of Health. The 1992 appropriation for Healthy Start was about $6 million.

Selection of Participants

Healthy Start accepts pregnant women and mothers with children up to the age of 3 months. Clients are identified primarily through an early identification (EID) process conducted in the hospital at the time of birth. Clients may also be identified prenatally through referrals from physicians and public health agencies. In general, EID involves screening mothers' hospital records and conducting assessment interviews. Both steps are performed by specially trained EID workers.

Screening Hospital Records

The first step requires EID workers to briefly interview mothers or review new mothers' admissions records and medical charts for the following 15 factors that indicate whether the mothers and families may be at risk for child abuse.

1.Marital status: Single, separated, or divorced mother.

2. Partner unemployed.

3. Inadequate income or no information regarding source of income.

4. Unstable housing.

5. No phone.

6. Education under 12 years.

7. Inadequate emergency contacts.

8.History of substance abuse.

9. Late or no prenatal care.

10. History of abortions

11. History of psychiatric care.

12. Abortion unsuccessfully sought or attempted.

13. Relinquishment for adoption sought or attempted.

14. Marital or family problems.

15. History of, or current, depression.

EID workers conduct assessment interviews with the mothers if any of three criteria are met: (1) 7 of the 15 risk factors cannot be answered from the information in the medical charts, (2) at least 2 of the factors are present, or (3) if any 1 of the following factors exists—single mother, no prenatal care (or late care), or abortion sought or attempted. If none of these three criteria are met, mothers are not considered at risk and are not interviewed or offered services.

Assessment Interviews

During hospital assessment interviews, EID workers ask mothers questions, assign scores based on their answers, and then place the families in particular child abuse risk categories based on a tally of various

stress factors, which include substance abuse and criminal history, potential for violence, parents' unrealistic behavioral expectations for the baby, and abusive disciplinary practices.

Families with scores of less than 25 are considered to be at low risk for child abuse and are not offered Healthy Start services. However, EID workers refer families to other services as appropriate. Families with scores of 25 or above are considered to be at risk for child abuse and are offered Healthy Start services. Mothers who accept services are assigned to a program in their area. According to data obtained from the provider responsible for EID screening on Oahu, less than 10 percent of mothers refuse Healthy Start services.

EID Screening

On Oahu, six hospitals participate in the screening process. At five of the hospitals, EID workers are responsible for screening clients. At the other hospital, social workers do the screening. EID procedures on the neighbor islands vary. Healthy Start providers on Hawaii have access to medical records and review medical charts to screen mothers. An official noted that in Hilo area hospitals, the screener must be a nurse or a social worker.

Hospitals in some areas do not allow the EIDs access to medical records for reasons of confidentiality. The EIDs must find other sources of information. The Healthy Start director on Maui said that EID workers there do not have access to records and use the hospital's nursery log to identify births. The EID workers then screen mothers through face-to-face interviews. Provider officials believe that interviewing all new mothers results in greater accuracy in identifying high-risk families because of the extensive personal information gained from the interviews.

On Kauai, most of the clients are identified prenatally by public health nurses, physicians, midwives, and a support group for pregnant teens. The Healthy Start director on Kauai said that Healthy Start does not have access to hospital records, but has arranged for hospital nurses to ask mothers to sign consent forms allowing the Healthy Start provider to contact them. EID workers contact consenting mothers and screen and assess them by telephone.

The MCHB coordinator said that the Healthy Start provider on Molokai does not have access to hospital records and receives referrals primarily from obstetricians and the public health nurse.

Service Delivery Format

Healthy Start assigns home visitors to families who are assessed as high risk and are willing to accept Healthy Start services. The home visitors are paid staff who receive a training course developed for Healthy Start. Ideally, home visitors first meet the mothers in the hospital before they are discharged. Otherwise, the visitors contact mothers by telephone to arrange the first home visit, usually within the first week after they are discharged from the hospital. Visits initially take place every week.

Home visits are the core activity of Healthy Start services. Home visitors provide support to the families and help reduce family stress, which lowers the potential for child abuse and neglect. Services include counseling and assistance in obtaining needed resources—such as housing, financial assistance, medical aid, nutrition, respite care, employment, and transportation. In addition, home visitors promote positive child development by focusing on parent-child bonding to assure social and emotional growth in the infant and early childhood stages.

Home visitors initially concentrate on building trust with the families. Home visitors told us that often on the first visit they take families gifts, such as diapers or toys, to "break the ice." For some clients, the home visitors are their only contact with the outside world. By visiting families regularly, home visitors give families someone on whom they can rely for support and assistance.

Home Visitors' Case Plans

Home visitors help establish goals for their clients and monitor the progress at achieving these goals. These goals are listed in family case plans, which home visitors prepare in consultation with their supervisors after about 2 months of home visits. Family case plans are updated about every 6 months to help keep track of progress in meeting the goals.

Goals listed in the case plans may include obtaining a driver's license or high school diploma for the parent, having their children immunized, or referring the families to another agency for particular services. Goals could also include developing basic child care skills, such as learning how to change diapers, or teaching mothers how to use toys appropriately and play with their babies. Still other goals could involve intangibles, such as establishing trust with the families and improving the mothers' self-esteem.

Additional Activities of Home Visitors

Healthy Start attempts to prevent child abuse and promote child development by addressing the range of problems that at-risk families

face. The program model includes referral to other social service agencies as well as physicians. Home visitors encourage families to select a pediatrician and to schedule regular well-baby visits.

To detect child developmental delays and measure progress in parent-child interaction, providers administer questionnaires and other instruments to the families. Based on the scores of these instruments, home visitors refer families to health and educational organizations to address the children's developmental needs.

To identify problems in parent-child bonding, providers administer the Nursing Child Assessment Satellite Training (NCAST) scales. The NCAST records observations regarding the safety and learning environment of the home and parent-child bonding in terms of the parent's teaching and feeding techniques. Families are assessed using the NCAST Home Observation for Measurement of the Environment when the child is 4 months old. Some are also assessed using the feeding and teaching NCAST.

Children are assessed using the NCAST at different ages; for example, those for teaching are given when they are 6 months and 18 months old. Information obtained from the NCAST provides feedback, enabling home visitors to intervene to improve parent-child interaction.

In addition to home visits, some providers offer parent education and social activities, respite day care, toy lending libraries, and male home visitors to work with fathers. Providers also sponsor excursions and host arts and crafts projects for their clients.

Frequency of Visits

The frequency of home visits ranges from weekly to quarterly, depending upon the clients' assessed level of need. Families begin the program at level 1 with weekly visits. After the families accomplish certain objectives (for example, improved parent-child bonding), they progress to level 2, which consists of visits twice a month. Families at level 3 and level 4 receive visits monthly and quarterly, respectively.

Number of Participants

Healthy Start served about 2,000 families in fiscal year 1991—a 12-percent increase over the preceding year. MCHB expects to serve more than 3,300 participants in fiscal year 1992 (a 67-percent increase). The chief of MCHB said the anticipated increase is a result of improved screening and

interviewing techniques, increased funding, and increased visibility in the community.

Determining Caseloads

Because the frequency of home visits varies depending on the level of service the family needs, MCHB has established guidelines for maximum caseloads for home visitors based on the service levels. MCHB recommends the following maximum caseloads for home visitors:

- 15 families at level 1,
- 20 families at level 2, and
- 25 families at levels 3 and 4.

MCHB advises providers to set the maximum caseload at 25 for home visitors who serve families at various levels. This maximum caseload allows providers to weight their caseloads based on service levels. For example, the more level 1 families home visitors have, the lower their caseloads. Some providers work with specified maximum numbers of cases regardless of the mix of levels.

Participant Profile

Healthy Start data on the families who were offered services show that 78 percent were unmarried, 60 percent were under 24 years of age, and 27 percent did not complete high school. Thirty percent of Healthy Start cases involve substance abuse, and 34 percent involve domestic violence. Seventy percent of the families are on welfare, and 21 percent have a prior history of Child Protective Service involvement.

On Maui, where 30 percent of Healthy Start clients are teenagers, part of the home visitor staff deals exclusively with teenage clients. The provider has also sponsored teen peer support groups at neighborhood high schools. One of the Healthy Start providers on Oahu has a social worker on staff to provide therapy and administer psychosocial assessments to its high-risk population. The provider's administrator of prevention services said that the area served has the highest rate for various social indexes on Oahu, including drug abuse rate, teenage pregnancy, and illiteracy.

Attrition Rate of Participants

The chief of MCHB said that the attrition rate for Healthy Start participants ranges from 7 to 20 percent for families in the first 2 years of the program and usually increases to 40 percent as families progress to level 4. The attrition rate within the first 2 years is caused primarily by families

moving—either to an area where Healthy Start is not available or without letting providers know where they have moved. Families that have progressed to higher levels usually drop out because they believe they can function without Healthy Start. The MCHB chief does not believe the attrition rate reflects poorly on the program because 60 percent of the families stay with the program, and families that discontinue home visiting are usually at level 4—where the risk of abuse is lowest.

Number and Coverage of Program Sites

At the beginning of fiscal year 1992, Healthy Start sites were located in 13 areas—7 on Oahu, 3 on Hawaii, and 1 each on Maui, Kauai, and Molokai. On Oahu, program sites screen about half of the total births on the island. Because of fewer births, providers on the other islands are able to screen almost all of the births in their areas. According to the chief of MCHB, total coverage for the state is about 55 percent of all births. About 20 percent of those screened are identified as at risk and offered services.

Ability to Serve All Referrals

Healthy Start providers periodically close their intake of new clients when their staff has reached or exceeded the maximum caseloads recommended by MCHB or set by the provider. Officials told us that when intake was closed, the EIDs attempted to link high-risk mothers with other appropriate social and health services. We were unable to obtain an estimate of the number of potential clients that were not served by Healthy Start as a result of closed intake because MCHB had not completed the analysis at the time of our review.

During fiscal year 1991, some Healthy Start programs closed intake while others did not. For example:

- The provider in West Hawaii told us intake closed for 2 months at its sites.
- On Oahu, the provider for the Central and Waianae areas closed intake for 3 months and 9 months, respectively. One of the providers serving the Ewa area closed intake intermittently.
- The providers for the Kauai and Molokai programs accepted new clients throughout 1991.

Evaluations Performed

Healthy Start has been evaluated several times to measure its effectiveness in reducing the incidence of child abuse and neglect. These evaluations have varied in scope and results. A more detailed, rigorous evaluation is

planned. In addition, Healthy Start receives ongoing performance monitoring from MCHB.

1990 MCHB Effectiveness Evaluation

To evaluate Healthy Start's effectiveness, MCHB matched names and dates of birth of clients of Healthy Start and other home-visiting programs to Child Protective Service data. For 1,204 families served from July 1987 to June 1989, 3 cases of abuse and 6 cases of neglect were confirmed for these clients. This means that less than 1 percent of program participants—who were screened as a high-risk population—were confirmed as abusive and/or neglectful.

MCHB plans to match the same type of data each year for the next 5 years to follow children from the time they enter Healthy Start to the time they complete the program. MCHB began with 1987 data and will continue until 1991-92.

Additionally, when families reach level 4, EID workers administer the Family Stress Checklist again to determine if families have reduced the changeable stresses they had when they began using Healthy Start services. EID workers ask only questions that deal with factors families can change, such as parent-child bonding and potential for violence, rather than historical questions, such as whether parents have been abused as children. Finally, some providers use client surveys and questionnaires to help them gauge client satisfaction.

Proposed Effectiveness Evaluations

With assistance from MCHB, the Hawaii Family Stress Center is applying for a grant from the Robert Wood Johnson Foundation to conduct a 5-year evaluation of the Healthy Start program on Oahu. The evaluation would (1) assess whether the Healthy Start program meets its goal of no abuse or neglect among 95 percent of target children served and (2) compare Healthy Start and control groups for such factors as cases of abuse and neglect, levels of family stress, child development, and parent-child bonding. (Target children are those whose birth resulted in screening, assessment, and service by the Healthy Start program.)

The proposed evaluation would use a control group to assess Healthy Start's benefits. Two groups, each comprising 120 high-risk families, would be established through routine screening procedures. One group would consist of clients served by the Ewa and Central program sites. The other group would be a control group. The control group would consist of

high-risk families residing in areas in central Oahu not yet served by Healthy Start. These areas would be ethnically and economically similar to the Ewa and Central areas. The control group would be selected using the same procedures used to select families for Healthy Start. Control group families would be referred to Child Protective Services or other social service agencies if the screening process reveals they need services, but they would not receive any home visits.

According to a Hawaii Family Stress Center official, partial Healthy Start coverage on Oahu presents a unique opportunity to establish a control group without confronting the ethical issue of intentionally denying child abuse prevention services to particular families. Due to funding constraints, this official does not anticipate any increased Healthy Start coverage on Oahu before the fall of 1992. The evaluation could, therefore, identify a control group in areas where Healthy Start is not yet available. The control group would be developed as births occur, and is expected to be established before the Healthy Start program expands. The families in the control group would be ineligible for Healthy Start services once the services became available because their children would be over 3 months old, the maximum age for admission to the program.

In addition, MCHB has contracted with a consultant to develop studies to evaluate Healthy Start's effectiveness. These studies would compare outcomes across program sites, analyze the frequency of responses obtained in assessment instruments, document changes in families during Healthy Start services, and obtain the views of a focus group of community professionals on Healthy Start services. The chief of MCHB told us that collecting and analyzing the data for these studies depends on funding.

To gauge clients' progress in parent-child interaction, MCHB is considering using NCAST for pre- and post-measurements to evaluate program effectiveness.

Ongoing Operational Monitoring

MCHB continually monitors Healthy Start operations by collecting quarterly and year-end expenditure reports as well as monthly progress reports from providers. MCHB visits program sites quarterly and conducts annual audits to verify that the services outlined in the contract are being provided. The reviews cover a variety of operational matters, such as minutes of board of directors and staff meetings, agency policies for staff training and evaluation, and progress on establishing data management

systems. If respite care is provided, MCHB reviews facility maintenance policies. As part of the annual audit, MCHB also conducts a fiscal audit of Healthy Start sites.

During the monitoring visits, MCHB asks provider administrators and staff about the program's problems and accomplishments. When participant intake is closed, MCHB monitors EID procedures to ensure that the screens and assessments are still conducted and potential clients are still referred to other agencies.

Program Administration

Day-to-day services are provided by seven private nonprofit agencies under contract with MCHB. MCHB and providers communicate with each other through quarterly meetings.

The contracting process requires that providers respond to biennial requests for proposals. MCHB contracts outline the minimum levels of services providers must deliver. These contracts specify

- the number of new postnatal and prenatal clients providers must register and service;
- the type of home-visiting services providers must deliver, such as crisis intervention, parenting groups and parent-child interaction activities, and referrals to health, social, and educational programs as needed;
- the types of measurements providers must use to gauge progress in parent-child bonding and to detect developmental delays (for example, NCAST and the Revised Denver Prescreening Developmental Questionnaire); and
- the levels of effectiveness the providers must demonstrate—95 percent of the families served shall not have a confirmed report of child abuse or neglect, at least 80 percent of level 4 families shall have reduced the risk factors on the Family Stress Checklist by 40 percent, and at least 90 percent of all families served for at least 12 months shall visit a physician regularly.

Budget and Funding

Based on providers' contract budgets, state funds for Healthy Start increased from fiscal years 1990 to 1992 by 85 percent, from about $3.4 million to $6.3 million, partly due to increased screening and participation. From fiscal year 1990 to 1991 the number of new mothers screened increased by about 1,500, and the number served grew by about 300.

To cover the costs of monitoring Healthy Start operations, 3 percent of the providers' budgets is allocated to MCHB. This allocation totaled about $154,000 for fiscal year 1991. MCHB used the funds to pay salaries, maintain its data collection system, establish its client tracking system, and purchase educational materials for providers.

Healthy Start does not receive any federal funds. Most of its funding comes from state appropriations, supplemented in some cases by county funds and fund-raising projects. Healthy Start providers plan to rely on Medicaid funding for their services and to fund their child development positions through the Governor's Office of Children and Youth.

Staff Profile

Each provider determines its own staff qualifications. Directors and managers of Healthy Start have nursing degrees and/or master's level educational training (for example, masters of social work or public health). Directors of program sites require EID and home visitor supervisors to have college degrees and preferably clinical experience. Most of the home visitors and EID workers have high school diplomas or the equivalent. Some home visitors have 1 or 2 years of college, and others have bachelor's degrees.

None of the providers interviewed used volunteers for service delivery. Some providers use volunteers for fund-raising projects, to assist in child care for respite centers, or for special parent activities. The executive director of one provider said that few volunteers are available in the community, but that even if they were, using volunteers is not economical because of the extensive training and time needed to develop Healthy Start employees.

Staff organization and size varies among providers. Most providers employ an executive director, a program manager, supervisors, home visitors, and data entry clerks. On the neighbor islands, provider staffs include EID workers as well.

Staff Recruitment and Retention

Healthy Start providers said that they recruit employees through newspaper advertisements, word-of-mouth, or transfers within their agency. Applicants complete job applications or submit resumes and, for some providers, give written answers to questions dealing with child abuse issues. Providers also interview applicants to determine their suitability.

Providers said they employ people who have a capacity to develop trusting relationships, have successfully reared children, and can cope with flexible work schedules. Home visitors must have reliable cars.

Providers said recruiting staff is not always easy. An executive director on one island said recruiting is difficult because the unemployment rate is low and the provider competes with the hotel and service industries, which can pay higher wages. The executive director of the provider on another island said that improving salaries and the benefit package had increased the provider's ability to attract workers.

The level of staff retention varies by provider. One provider has retained most of its original home-visiting team for more than 5 years. Other providers, which have been operating Healthy Start sites for shorter periods, told us staff retention averages about 2 years or less. Employees leave for various reasons, such as relocating to the mainland, continuing their education, or obtaining a higher paying position.

Training

The Healthy Start standard training curriculum was developed by the Hawaii Family Stress Center, which began the demonstration project in 1985. The center is under contract to provide this training to Healthy Start staff. Individual providers may supplement training to meet the needs of their staff and clients.

The Hawaii Family Stress Center provides 5 weeks of training to newly hired home visitors and EID workers. Training activities include instruction in child abuse and neglect dynamics, EID screening, problem-solving skills, crisis intervention, parent-child interaction, cultural sensitivity, and communication skills. Provider staff are also trained in Child Protective Services reporting, administering NCAST, and developmental screening.

After about 3 to 6 months, staff attend advanced training courses, which include such topics as language development, advanced home visitor techniques, medical risk indicators, and the effects of prenatal substance abuse. The center provides ongoing training on a variety of issues, such as domestic violence, stress management, cultural aspects of prenatal care, child discipline, child dental care, and interviewing techniques. Individual providers also conduct in-service training and attend courses offered by other community services.

Start-Up Guidance

To assist organizations that are interested in replicating Healthy Start services, the Hawaii Family Stress Center also provides a packet of general program information and addresses questions regarding the Healthy Start model, EID process, and home visiting. The director of the center said that 41 states have inquired about Healthy Start services.

Program Strengths

MCHB and Healthy Start provider officials mentioned the following factors as strengths of the program:

- Healthy Start is community based, which allows providers to tailor services to meet client needs.
- Funding has been continuous since 1988, allowing the program to maintain services once they are established. This is important because clients, staff, hospitals, and other community agencies are more likely to support the program if they can rely on services being available.
- The length of time the program serves families (5 years) is enough to build relationships and affect families' lives.
- Using home visitors without college degrees helps them relate to the families and the environment and gain the clients' trust.
- The cooperation received from MCHB has helped increase funding by encouraging providers to lobby as a network and has helped broaden the scope of services.

Program Barriers

Healthy Start provider officials mentioned the following as barriers:

- Insufficient funding to cover the entire state.
- Limited cooperation with hospitals to improve screening of prospective clients.
- Difficulty finding doctors willing to deal with Healthy Start participants, which makes it hard to get families into well-baby care.
- Overall poor state of the economy (for example, lack of affordable housing and other resources), which makes it difficult to deliver the complete package of Healthy Start services.
- Difficulty in finding trained staff to administer NCAST.
- Lack of public transportation on neighbor islands, which prevents clients from accessing other social and health services in the community.
- Inability to recruit and retain good workers due to low pay.
- A state system that requires contract renewal every 2 years.

MCHB is still developing its data management system. The chief of MCHB added that the lack of a fully implemented data management system and sufficient staff impedes MCHB's ability to evaluate the effectiveness of program services.

The Elmira Prenatal/Early Infancy Project

The Elmira project has been cited as one of the most rigorous and persuasive studies of the effects of a prevention strategy. It shows the positive effects achievable from prevention programs—specifically, nurse home-visiting programs—not only in reducing child abuse, but also in improving conditions through maternal education and the reduction of subsequent unintended pregnancies. We have included this detailed description of the project to illustrate the kind of rigorous evaluation and cost-benefit research that we believe should be encouraged. Such efforts would contribute important information on what kinds of activities work best and offset costs in a variety of locations, populations, and circumstances.

The Elmira study tested the effects of a comprehensive, intensive program of prenatal and postnatal nurse home visitation. The program had a variety of objectives, including a reduction of child abuse among women who were either teenaged, unmarried, or poor and bearing first children. The project reported achieving a 50-percent reduction in the child abuse rate—from 10 percent among the control group to 5 percent among the nurse-visited mothers. Among mothers who were at high risk because they were poor, teenaged, and single, the reduction was even greater. The abuse rate among those in the high-risk group who did not receive home visits was 19 percent, compared to a rate of 4 percent among those who did.

The premise of the program was that nurse home visitors can identify and help change factors in the family environment that interfere with maternal health habits, infant caregiving, employment, education, and family planning.

The study design consisted of a clinical trial in which participants were assigned at random to one of four treatment groups. The most intensive service group received nurse home visits until children were 2 years old. One group received home visits only before the child's birth, and the other two groups, no home visits.

The study was carried out in a small semi-rural county of about 100,000 residents in the Appalachian region of New York State. According to project reports, despite an abundance of health and human services, the community had consistently exhibited the highest rates of child abuse and neglect in the state.

Selection of Participants

The project actively recruited women who had no previous live births and met any one of the following criteria: (1) were less than 19 years old, (2) were a single parent, and (3) were of low socioeconomic status. However, anyone bearing a first child was welcome to register. The women were recruited through the health department clinic, offices of private obstetricians, Planned Parenthood, public schools, and various other health and human service agencies. Between April 1978 and September 1980, the project interviewed 500 women and enrolled 400.

Participant Profile

All participants were bearing their first child and were enrolled before their 30th week of pregnancy. At registration, 47 percent were under 19 years of age, 62 percent were unmarried, and 61 percent came from households of semiskilled and unskilled laborers. Fifteen percent of the women were not at risk according to age and marital or socioeconomic status, while 23 percent had all three risk characteristics.

Project Design

Participants were randomly assigned to one of four treatment groups. One group of 116 women received nurse home visits for the first 2 years of the child's life as well as the three other services listed below.

- Sensory and developmental screening at the 12th and 24th month of the child's life.
- Free transportation to regular prenatal and well-child visits.
- Nurse home visits during pregnancy.

Each of the other three groups had from 90 to 100 participants and received one to three of the listed services—but did not receive home visits after the birth of their child.

Service Delivery Format

Nurse home visitors carried out three major activities that formed the basis of the program:

- Educating parents on fetal and infant development and issues involving the mother's decision on whether to return to school, find work, or bear additional children.
- Involving family members and friends in the pregnancy, birth, early care of the child, and support of the mother.
- Linking family members with other health and human services.

During pregnancy, the nurses concentrated on achieving a various specific objectives; for example, helping the women improve their diets and monitor their weight gain; helping them to quit smoking or using alcohol or drugs; and preparing the parents for labor, delivery, and early care of the infant.

The curriculum used during the child's infancy focused on (1) infant temperament, (2) the infant's socioemotional and cognitive needs, (3) the infant's requirements for physical care, and (4) family planning, education, and vocational training programs for the mother.

Frequency of Visits

The initial nurse visit was made within 7 days of enrollment. Throughout pregnancy, visits took place every other week and lasted about 75 minutes.

The visits during the first 2 years of the infant's life began on a weekly basis and gradually decreased to every 2 weeks when the child was 6 weeks old, 3 weeks when the child was 4 months old, and so forth. When the child reached 20 months old, visits took place every 6 weeks.

Staffing and Training

Home visitors were registered nurses with backgrounds in maternal and child health. They all had children of their own. The project reported that there was no nurse visitor attrition during its 5-year duration. Nurses had a 3-month training program during which they worked with a few "pilot" families before they started to work with the families in the study. Nurses had day-to-day supervision and weekly case reviews to present and discuss. Nurses followed a detailed curriculum and worked in teams of two, with each nurse serving as a backup for the other's cases.

Ecological Model

The program used an ecological model, which attempts to explain how behavioral, biological, psychological, social, and economic factors interact to influence maternal and child functioning. The model leads the home visitors to consider maternal personal resources, social support, and stresses in the home, family, and community that can facilitate or interfere with pregnancy and subsequent care of the child.

In keeping with this model, the nurses attempted to create a therapeutic alliance with the mother and her family by focusing on maternal and family strengths. They also educated women about health-related

behaviors, such as smoking, consuming alcohol, using nonprescription drugs, and managing the complications of pregnancy. They attempted to enhance social support for the mother by involving other family members and friends in the program. Finally, they helped families find needed health and human services.

Generalizing the Findings

The project reported that a number of features limit generalizing its results to other programs and communities. For example:

- The program was carried out under favorable circumstances, in that the nurses were hired and trained exclusively for the program, and each carried a manageable caseload.
- The community in which the study was carried out is not representative of hard-core inner cities or extremely isolated rural areas.
- There are many women and children to whom the results cannot be applied; for example, the study did not include women who had been pregnant for more than 30 weeks.

Results

Child Abuse and Neglect

The project reported that the program significantly reduced the rate of child abuse among poor, unmarried teens. During the first 2 years of the children's lives, 4 percent of the families who received home-visiting services had abused their children, compared with 19 percent of the control group.

The incidence of verified cases of child abuse and neglect during the first 2 years of the child's life was 5 percent among the entire nurse-visited group compared with 10 percent for the entire control group—a reduction of 50 percent.

Other Outcomes

Nurse-visited poor, unmarried women showed an 82-percent increase in the number of months they were employed, and had 43 percent fewer subsequent pregnancies during the 4 years after the delivery of the first child. High-risk mothers restricted and punished their children less frequently. Their children also required less emergency medical care during the first 2 years of life. Nurse-visited women also showed

improvement in diet and smoking reduction, as well as increased levels of social support and use of community services such as WIC.

Cost-Benefit Study

One of the Elmira studies focused on the costs and benefits accruing to the government from the nurse home-visiting project.[1] It examined whether the demonstrated improvements in maternal and child health were translated into government savings. The benefits to the government are based on estimated averted expenditures for other government services and on increased tax revenues from the mothers' increased participation in the work force. The study then compares the benefits with the program's original cost to establish its net cost.

Summary of Results

When focused on low-income families, 96 percent of the program's cost, after discounting, was recovered within 2 years after the program ended. Even if the rate of return on the investment is reduced by one-half between the children's 4th and 6th birthdays, the program will more than recover its costs to government before the children of low-income families enter school.

The Evaluation

The Elmira cost analysis is based on data from maternal interviews and from medical and social service record reviews. The study uses participants who did not receive pre- or post-natal home visits as a comparison group and contrasts it with the group that received both pre- and post-natal home visitation. The study analyzed the net cost of the program to the government by:

- Calculating the total cost per family of nurse visitation program services provided, assuming that all program costs would be covered by the government.
- Estimating, through the 4th year of the child's life, the per family cost of other government services that were averted and the increase in tax revenues resulting from the women's participation in the program.

Costs of the Home Visitation Program

Program costs were separated into direct and secondary program costs. Direct costs are those that are directly attributable to the program. These included such costs as taxi rides for clients to medical appointments,

[1]David L. Olds and others, "Effect of Prenatal and Infancy Nurse Home Visitation on Government Spending" (Presented at the 1990 Annual Meeting of the America Pediatric Society and Society for Pediatric Research, May 9, 1990).

nurses' salaries and fringe benefits, supplies, and a part-time supervisor and secretary. Secondary costs are those that resulted from the nurses' encouraging families to use existing community services. These included Women, Infants, and Children nutritional supplementation program, child birth education, and family counseling. Nurse-visited participants tended to use more preventive services, and the comparison group tended to use more crisis services. The secondary cost estimates for treatment and control groups turned out to be so similar that these costs were not factored into program cost calculations.

Estimates of Benefits to the Government

During the 2-year period in which the program was carried out, there were no statistically significant differences in government benefits for the sample as a whole. However, among low-income women, there was an estimated government benefit of about $1,000 in 1980 dollars.

During the 2-year period after the program ended, the benefits to the government increased substantially. The estimated savings were $1,502 per family for the sample as a whole and $1,999 per family for low-income families. For the entire 4-year period after delivery, the estimated benefits were $1,708 for the whole sample and $3,013 for low-income families.

The program cost $3,171 for the sample as a whole and $3,017 for low-income women in 1980 dollars. For low-income families, about 96 percent of the investment in the home-visiting service was recovered within 2 years after the program ended. Even assuming that the rate of savings is reduced by one-half over the next 2-year period, the program will have more than paid for itself before the children from low-income families enter school. Thereafter, all improvements in maternal and child functioning will lead to additional savings to the government.

The authors of the study concluded that the results suggest that well-designed programs of nurse home visitation, when focused on low-income families, can pay for themselves through improved maternal and child functioning. This conclusion is based on the estimate of government savings to be realized if such services are provided in New York State. Other states will have different net cost outcomes, depending on their public assistance, food stamp, and Medicaid reimbursement rates, and the proportions of these costs that they share with the federal government.

The authors also noted that some of the assumptions built into the analyses may understate the impact of the program on government spending and income, while others may overstate it. Government tax receipts, for instance, are likely to be underestimated among the nurse-visited women. This is because a number of positions that women held were estimated at minimum wage and did not assume cost-of-living raises over the course of the study. The nurse-visited women, especially those who were poor, unmarried, and older, were employed more frequently and started to work sooner after delivery than their counterparts in the comparison group.

Similarly, the estimate of the impact of the program on expenses related to child abuse and neglect is confined to those tied directly to the delivery of services to the abused children and their families, and did not consider the substantial costs associated with the small number of cases that go to court.

Also, the incidence of admissions to neonatal intensive care among subsequent children was estimated to be affected only by the reduction in subsequent pregnancies. No allowance was made for possible reductions due to improved maternal health-related behaviors and longer birth intervals. Consequently, this assumption is likely to understate the impact of the program on Medicaid expenditures.

Less comprehensive programs that focus more directly on family planning may provide equally large cost reductions. However, according to the study, such an approach overlooks the substantial improvements in health produced for the families in other areas, including reductions in child maltreatment and injuries. The study notes that home-visiting programs with narrowly defined objectives tend to be less successful overall.

A limitation of this study is that it follows women and children through only the first 4 years of the children's lives. Study authors believe that it is possible that the cost savings from home visitation will continue to accrue over time, producing lifetime savings that are much larger than estimated in the current analyses. They also note that it is possible that program benefits will diminish with time. Only additional longitudinal work with this sample will resolve the question.

The authors emphasize that the nurse home visitation program in this study was unlike many other such programs. It employed nurses who visited mothers bearing first children and who visited them frequently

from pregnancy through the second year of the child's life. The nurses systematically addressed the behavioral and psychosocial conditions that lead to poor maternal and child outcomes. Home visitation programs that do not include all of these elements are less likely to improve maternal and child functioning.

Programs Contacted by GAO

Programs Visited

California

Family Support Program
3701 Branch Center Road
Suite 115
Sacramento, CA 95827

Family Service Agency
1757 Waller Street
San Francisco, CA 94117

Early Parenting Project
San Francisco General Hospital
Department of Pediatrics
1001 Potrero Avenue, Room 6D-40
San Francisco, CA 94110

Florida

Parents Anonymous
P.O. Box 4295
Tallahassee, FL 32315

The Ounce of Prevention Fund of Florida
123 North Monroe Street
Tallahassee, FL 32301

Brehon Institute for Human Services, Inc.
425 East Call Street
Tallahassee, FL 32301

Project Safety Net
Florida Department of Health
and Rehabilitative Services
1317 Winewood Boulevard
Tallahassee, FL 32399

Hawaii

Healthy Start
Hawaii Department of Health
Family Health Services Division
Maternal and Child Health Branch
741-A Sunset Avenue, Room 204
Honolulu, HI 96816

Illinois

Mini O'Beirne Crisis Nursery
423 North Seventh Street
Springfield, IL 62702

The Parent and Child Place
2211 Wabash Avenue
Springfield, IL 62704

Hephzibah Children's Association
946 North Boulevard
Oak Park, IL 60301

Family Enhancement Program
Illinois Department of Children
and Family Services
406 East Monroe
Springfield, IL 62701

North Lawndale Family Support Initiative
c/o National Committee for Prevention of Child Abuse
322 South Michigan Avenue
Suite 1600
Chicago, IL 60604

Michigan

Families First
Michigan Department of Social Services
Office of Child and Family Services
235 South Grand Avenue
Lansing, MI 48909

New York

Foster Grandparent Program
Woodhull Medical and Mental Health Center
760 Broadway
Brooklyn, NY 11206

Passage House
c/o New York State Department of Social Services
40 North Pearl Street, 11th Floor
Albany, NY 12243

Washington Heights—Inwood Coalition, Inc.
652 West 187th Street
New York, NY 10033

Oregon

Birth to Three
3411-1 Willamette
Eugene, OR 97405

Parent to Parent
2990 Experiment Station Drive
Hood River, OR 97031

Insights—Teen Parent Program
1811 Northeast 39th Avenue
Portland, OR 97212

Teen Parent Program
Community Youth Services of Washington County
4825 Southwest Main Street
Beaverton, OR 97075

Parent Outreach Program
4800 Northeast 74th
Portland, OR 97218

Washington

Medina Children's Services
123 16th Avenue
P.O. Box 22638
Seattle, WA 98122

Harborview Medical Center
325 Ninth Avenue, Room 635
Seattle, WA 98104

Parent Place
600 Broadway
Longview, WA 98632

Program for Early Parent Support (PEPS)
4649 Sunnyside Avenue North
Room 346
Seattle, WA 98103

Parent Aide Program
Children's Hospital and Medical Center
4800 Sand Point Way Northeast
P.O. Box C5371
Seattle, WA 98105

Additional Programs Contacted

Florida

Healthy Start
Florida Department of Health and Rehabilitative Services
1317 Winewood Boulevard
Tallahassee, FL 32399

Illinois

Parents Too Soon
Illinois Department of Children and Family Services
406 East Monroe
Springfield, IL 62701

New York

Webster Avenue Family Resource Center
283 Webster Avenue
Rochester, NY 14609

Tennessee

Memphis New Mothers Study
Shelby County Health Department
814 Jefferson Avenue
Memphis, TN 38105

Washington

Well Family Project
P.O. Box 1067
Okanogan, WA 98840

Parents Anonymous
1305 4th Avenue
Suite 310, Cobb Building
Seattle, WA 98101

First Steps Program
Washington Department of Social and Health Services
Division of Children and Family Services
Olympia, WA 98504

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUL 6 1992

Mr. Gregory J. McDonald
Director, Human Services Policy
and Management Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. McDonald:

Enclosed are the Department's comments on your draft report, "Child Abuse: Prevention Programs Need Greater Emphasis." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE U.S. GENERAL ACCOUNTING OFFICE'S DRAFT REPORT, "CHILD ABUSE: PREVENTION PROGRAMS NEED GREATER EMPHASIS," REPORT NO. HRD-92-22

Thank you for the opportunity to respond to your draft report regarding the need for greater emphasis on child abuse prevention programs. Following are our general comments on the substance of the draft report, our comments with regard to the report's recommendations and comments on the technical errors and omissions identified in the report.

General Comments

Our primary observation is that GAO's examination of Federal funding for child abuse prevention gives almost no attention to the billions of dollars that HHS and other Federal agencies spend each year to reduce or eliminate the underlying stresses that contribute to child abuse.

Although the report recognizes that risk factors for child abuse "include a variety of stresses, such as single and teenage parenthood, parental isolation, poor coping abilities, lack of social skills, drug and alcohol abuse, unemployment and low income," and that "abuse prevention programs often attempt to reduce family stresses caused by risk factors, such as poverty and single parenthood," it does not mention the many HHS programs that unquestionably help prevent child abuse in many families. Programs such as Head Start, AFDC, the JOBS program, Child Care and Development Block Grant, Medicaid, Healthy Start, the Maternal and Child Health Block Grant, and the Alcohol, Drug Abuse and Mental Health Block grant, are just a few of the many HHS programs that play a major role in the prevention of child abuse, even though they are not "child abuse" programs in name. Many of these programs are priorities of Secretary Sullivan and President Bush, and have been targeted for increases in the FY 1993 President's Budget. We believe GAO would be remiss to exclude discussions of these efforts in future versions of this report.

We are also concerned that the scope of prevention strategies studied is too narrow. In particular, the report is heavily focused on home visitation programs. Although child abuse occurs in all age groups of children, home visiting programs only address children from birth to age 4, at the most. The study did not address prevention strategies that target, among others, diverse ethnic groups, families whose children have developmental disabilities, homeless families, or families where one or both parents abuse alcohol or use illegal drugs.

In addition, the study does not differentiate prevention strategies that address different types of child maltreatment. Although the study discusses the definition of child abuse and neglect, it does not distinguish between efforts to prevent physical abuse from those to prevent different types of neglect or from those to prevent sexual abuse. We are unaware of any research that indicates that home visitation programs prevent or reduce the incidence of child sexual abuse.

We support home visitation of new parents as one important prevention strategy, especially as demonstrated by the program in Hawaii, and we are looking forward to further evaluation of such high quality programs. While there are different models of home visitation, not all are as effective as the two that were described most fully in the report. We believe that further model development, testing and evaluation of home visiting programs need to be conducted so that both their strengths and limitations can be assessed.

GAO Recommendation to the Congress

To provide incentives to states to implement and sustain child abuse prevention programs, we recommend that the Congress amend Title IV of the Social Security Act to give the Secretary of HHS authority to reimburse states, at foster care matching rates, for the costs of implementing prevention programs. The reimbursements would be provided to states where prevention programs have been demonstrated, through sound evaluations, to pay for themselves through reductions in the incidence of child abuse and the related foster care placements.

Department Comment

We do not concur with this recommendation. GAO does not mention the Administration's Comprehensive Child Welfare Services proposal in its discussion on various legislative proposals being considered to better focus efforts on prevention. On page 40, the report states: "In five of eight states we visited, officials said they were interested in using a portion of federal foster care funds for abuse prevention programs." The Administration's proposal would give States increased flexibility to use the billions of dollars currently projected in baseline funding for Foster Care and Adoption Assistance administrative and training costs--$1.3 billion in FY 1993 and growing to $2.2 billion by FY 1997--for prevention and family preservation activities. GAO's examination of current and proposed Federal efforts in the area of child abuse prevention is incomplete without discussion of the Comprehensive Child Welfare Services proposal in its report.

GAO Recommendations to the Secretary of HHS

We recommend that the Secretary of HHS:

-- provide funding incentives, such as through NCCAN, to encourage states to establish and rigorously evaluate programs with the potential for statewide implementation, and promote statewide adoption of strategies that have demonstrated effectiveness and cost benefits.

-- encourage states to develop and implement state prevention plans based on comprehensive needs assessments by directing any future increases in NCCAN Challenge Grants to states that are putting such in place.

Department Comment

The Department has long recognized the importance of program evaluation and continues to work to improve evaluations of child abuse programs funded at Federal, State, and local levels within the mandates of current law. Post P.L. 102-295, the 1992 reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA), evaluation is required for all Federal grants and contracts for demonstration or service programs to prevent, identify, and treat child abuse.

However, in reauthorizing CAPTA, the Congress amended two National Center on Child Abuse and Neglect (NCCAN) grant programs so that States are restricted in their ability to establish and evaluate programs with the potential for statewide implementation with the funds they receive. First, when the appropriation for the Basic State Grant program in §107(a) reaches $40 million--or as of October 1, 1993, whichever occurs first--States will not be permitted to use more than 15 percent of their allotment for the combined purposes of prevention, treatment and research programs. Second, when the appropriation for the Community-Based Child Abuse and Neglect Prevention Grants (formerly known as the Challenge Grant) in §201 reaches $10 million, States will not be permitted to use more than 50 percent for statewide efforts. Prior to these changes, some States had used both grant programs to establish and evaluate statewide programs.

The recommendation on the Challenge Grant program is not within the authority of the Secretary. P.L. 102-295 changed the funding formula for a State's allotment under the Community-Based Child Abuse and Neglect Prevention Grants program (formerly the Challenge Grant program). Half of a State's allotment is based on its population of children, with a minimum of $30,000 provided to each eligible State. The other half is based on the amount the State collected in its Children's Trust Fund the previous year. Although a State's application must demonstrate

coordination with other child abuse and neglect prevention activities at the State and local level and demonstrate the outcome of services and activities funded under the program, it would take another amendment to restrict funding increases to States that are developing and implementing State prevention plans based on comprehensive needs assessments. While we agree that State planning is desirable and should be encouraged, we would have serious reservations about further Federal planning requirements that limit State flexibility in the use of this prevention grant program.

Technical Comments

1. The correct name of the office responsible for Federal child abuse prevention efforts is the National Center on Child Abuse and Neglect not the National Center for Child Abuse and Neglect. (See references noted throughout the report.)

2. Although the NCCAN appropriation has been less than $60 million annually, NCCAN administers an additional $9.5 million which is transferred from the Justice Department for the Children's Justice Act grant program. It would be more correct to say that NCCAN provides almost $70 million annually to address both prevention and treatment. (See pages 2, 7, 18, and 35.)

Now on pp. 2, 4, 14, 28.

3. An additional error occurs in the Background section of the Executive Summary on page 3. An animal protection law was not used to protect a child in court. Rather, an animal protection society served as the child's advocate in court.

Now on p. 2.

4. The U.S. Advisory Board on Child Abuse and Neglect (the "Board") is not legislatively mandated by the CAPTA to develop abuse policy. (See page 8.) The Board's duties, which are set forth in §102(f) of CAPTA, are to make recommendations to the Congress, to the Secretary of Health and Human Services, and to the NCCAN Director. These recommendations encompass all Federal efforts to address child abuse and neglect, including those for intervention and treatment. They are not merely recommendations regarding Federal efforts to reduce child abuse and neglect, as is stated on page 18.

Now on p. 5.

Now on p. 15.

5. Although the Director of NCCAN chairs the Inter-agency Task Force on Child Abuse and Neglect and NCCAN provides staff support for the task force, it is not an NCCAN task force. (See pages 19 and 36).

Now on pp. 15, 29.

Now on pp. 32, 33.

6. On pages 41 and 42, the report lists legislation currently being considered by Congress to amend the Adoption Assistance and Child Welfare Act (P.L. 96-272) and reform the child welfare/foster care system. It erroneously lists both HR 2571 and HR 3063. First, we note that HR 3063 should be HR 3603. Only HR 3603 should be listed as it is HR 2571 as amended by the House Ways and Means Subcommittee on Human Resources when marked up on September 24, 1991.

Now on p. 45.

7. The reference to HR 2571 on page 58 of the report should be deleted and HR 3063 should be changed to 3603.

8. The Hatch/Johnson proposal is not mentioned in the report. Rep. Nancy Johnson introduced HR 5316 on June 3, 1992 and Senator Hatch introduced the identical bill, S.2809, on June 4, 1992. This legislation was not introduced at the time the draft was issued, but should be included in the final report.

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