An MCH Approach to Preventing Child Maltreatment

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Child maltreatment affects our society's most vulnerable members. This report provides State Maternal and Child Health (MCH) professionals with information about child maltreatment and how they can help prevent the abuse and neglect of children. It includes four sections:

Child Maltreatment—The Problem summarizes the extent, causes, and consequences of child maltreatment.

The Role of MCH in Preventing Child Maltreatment describes why and how MCH programs can contribute to preventing child maltreatment.

Child Maltreatment Prevention as a Title V State Performance Measure discusses child maltreatment as a Title V State Performance Measure.

What We Did and How We Did It includes case studies of five States that designated child maltreatment as a Title V State Performance Measure.

Child Maltreatment—The Problem

Child Maltreatment Affects Millions of Children

In 2005, State child protective service (CPS) agencies accepted an estimated 3.3 million cases of alleged child maltreatment—which includes both child abuse and neglect—for investigation. These referrals involved more than 6 million children, 899,000 of whom were found to have been abused or neglected. In that same year, approximately 1,460 children died as a result of maltreatment. Forty-two percent of the children who died were less than a year old. Seventy-seven percent of the identified perpetrators of child abuse and neglect were the child's parents. Victimization rates were highest among younger children (U.S. Department of Health and Human Services, Administration on Children, Youth and Families—HHS, ACYF, 2007).

The rate of child maltreatment has declined in recent years, decreasing from 12.5/1,000 children in 2001 to 12.1/1,000 children in 2004—although the rate of investigations into alleged maltreatment has increased (HHS, ACYF, 2007). Optimism based on this decline must be tempered with caution. It is also important to note that"many researchers and practitioners believe child fatalities due to abuse and neglect are still underreported" (Child Welfare Information Gateway, 2008).

Major Categories of Child Maltreatment

There are four major categories of child maltreatment (Thomas, Leicht, Hughes, Madigan, & Dowell, 2003):

- Physical abuse occurs when an adult inflicts physical injury on a child.
- Sexual abuse occurs when an adult involves a child in any sexual act, including pornography or prostitution.
- Emotional abuse (sometimes called psychological maltreatment), as defined by American Humane, involves treating children in ways that cause serious behavioral, cognitive, emotional, or mental disorders. For example, emotional abuse can include verbal abuse or belittling and isolating or terrorizing a child (American Humane, 2006).
- Neglect occurs when an adult caregiver fails to provide for a child's basic needs and thus threatens the child's health, safety, and well-being.

State-by-State data on substantiated child maltreatment cases can be found in Appendix 1. Despite a common understanding of the four main types of maltreatment, States have discretion in how they choose to legally define child maltreatment, which can make cross-State data comparisons difficult.

Consequences of Child Maltreatment during Childhood and Adolescence

The immediate consequences of child maltreatment can include physical injury, pregnancy, sexually transmitted infections, and death. Shaken baby syndrome (SBS), also known as abusive head trauma, can be especially damaging, given the age and vulnerability of the victims. SBS is a severe head injury that occurs when a baby is shaken hard enough to cause the child's brain to bounce against the skull. Such injuries can lead to brain damage or death (National Institute of Neurological Disorders and Stroke—NINDS, 2005).

Child maltreatment can also have a devastating impact on a child's emotional and psychological health. It can cause or contribute to depression, posttraumatic stress, anger, and anxiety (English et al., 2005), as well as suicidal ideation (Thompson et al., 2005). Child and adolescent maltreatment also increases "the risk for general delinquency, drug use, alcohol-related problems, depressive symptoms, internalizing behaviors, and externalizing behaviors" during early adolescence (Thornberry, Ireland, & Smith, 2001).

Child maltreatment does not affect every victim in the same way. Some children recover fairly rapidly. Others suffer the effects of abuse and neglect for the rest of their lives. The effects of child maltreatment depend on several factors, including the age and developmental status of the child when maltreatment occurred, the type of maltreatment, the length of time during which maltreatment took place, and other factors, including the presence of other types of domestic violence in the home (English et al., 2005).

Consequences in Adulthood

The consequences of maltreatment experienced during childhood or adolescence can have effects that last into adulthood. Child Welfare Information Gateway (2006) has identified the following long-term effects of victimization:

- Major depressive disorder and other psychiatric diagnoses
- Impaired brain development and learning disabilities
- Health problems and injuries, including heart disease, cancer, chronic lung disease, skeletal fractures, liver disease, STDs, and severe obesity. (Fellitti et al., 1998)
- Poor mental and emotional health, including depression, anxiety, and eating disorders (Thompson et al., 2005)
- Abuse of alcohol and other drugs
- Elevated risk that former victims may go on to abuse their own children
- Elevated risk of re-victimization and/or perpetration of abuse as an adult

Social Consequences

Child maltreatment also has social consequences. According to Prevent Child Abuse America (Wang & Holton, 2007), child maltreatment costs the United States approximately $104 billion each year. This figure includes direct costs—such as hospitalization, mental health care, law enforcement, and child welfare services—as well as indirect costs, such as those associated with special education, juvenile delinquency, and lost productivity. Another study reported that child abuse cost the health care system $92 million in hospitalization charges alone in 1999 (Rovi, Chen, & Johnson, 2004).

Risk Factors[1]

According to the HHS Office of Child Abuse and Neglect, factors that are associated with an increased risk of child maltreatment fall into several categories:

- Characteristics of the child, including premature birth and physical/cognitive/emotional disabilities
- Parental and family factors that increase the likelihood that a parent will perpetrate child maltreatment, such as family conflict and domestic violence; parental substance abuse, depression, poor impulse control, a low tolerance for frustration; and a lack of knowledge about parenting
- Social and environmental factors that increase the likelihood that an adult will perpetrate child maltreatment, such as poverty, lack of access to medical care and other support services, social isolation, and living in communities that are characterized by violence

Protective Factors[2]

Several factors can protect children from child maltreatment:

- Coping ability of parent or caregiver in all types of situations
- Social connections in the family and larger community that provide emotional support and assistance
- Parents' knowledge of child and youth development and appropriate expectations of a child's behavior
- Concrete supports for families when they need it, either from formal programs, which can provide health coverage, financial assistance, and housing, or from informal sources such as social networks
- A child's ability to effectively communicate emotions and interact positively with others

[1] These risk factors were drawn from Thomas, et al. (2003).

[2] These protective factors were drawn from Strengthening Families through Early Care and Education (2008).

The Role of MCH in Preventing Child Maltreatment

Child maltreatment is a multifaceted problem that requires a multidisciplinary solution. Traditionally, child maltreatment was the jurisdiction of the police, courts, and child protective service (CPS) agencies. But, by the time a child comes into contact with these agencies, the damage may already have been done. The contribution of public health to this problem is a focus on primary prevention, as well as expertise in many of the issues shown to be risk factors for child maltreatment, including substance abuse, intimate partner violence, and childhood disabilities.

State Maternal and Child Health (MCH) programs can bring primary prevention expertise to the field. The goal of MCH programs is to support and promote the health and safety of women, children, and families. MCH programs already provide many services designed to reduce risk and enhance resilience in families at elevated risk for child maltreatment. For example, many State MCH programs support prenatal care services for low-income women. During prenatal visits, women receive screening for child maltreatment risk factors, as well as referrals to community-based services or programs before the child is born.

MCH programs can use the following five strategies to help prevent child maltreatment:

- Collect, analyze, and disseminate data
- Develop, implement, and evaluate interventions
- Provide training and technical assistance to MCH and other professionals
- Facilitate collaborations between relevant organizations and professionals
- Work to increase funding and ensure program sustainability at the State and local levels

Collect, Analyze, and Disseminate Data

MCH programs can obtain a great deal of valuable information from State CPS agencies, which are responsible for monitoring the extent of child maltreatment and intervening in individual maltreatment cases, and Child Death Review (CDR) teams, which are charged with investigating child fatalities resulting from injuries, violence, or unexplained causes. MCH programs can also use health data systems—including hospital discharge and emergency department data—to contribute to the understanding of child maltreatment.

MCH programs can help promote the understanding and prevention of child maltreatment by taking the following actions:

- Work with CPS and other agencies to improve data collection and analysis
- Promote E-coding of hospital records
- Support legislation that allows State CDR teams to review all child deaths and requires the representation of public health staff on CDR teams
- Share data with CPS agencies by providing them with information on the extent of the injuries (physical trauma) that result from child maltreatment
- Educate policymakers and others about child maltreatment
- Work with epidemiologists to develop strategies for the surveillance of child maltreatment risk factors
- Encourage and work with research institutions to study child maltreatment—research is especially needed on the effectiveness of prevention strategies and on the relationship of risk factors and protective factors to maltreatment
- Help coordinate multiple data sources—such as CDR reports and CPS data—to develop a comprehensive understanding of children at highest risk for maltreatment and to plan appropriate strategies to reduce risks

Develop, Implement, and Evaluate Interventions

MCH programs can help address the problem of child maltreatment by integrating primary prevention strategies into MCH-supported programs and activities, and leading or supporting efforts to implement new primary prevention interventions in other programs. MCH programs can also take the following actions to support those developing and implementing policies that can reduce child maltreatment:

- Provide funding to local agencies to implement and evaluate evidence-based child maltreatment prevention programs (additional information on evidence-based prevention practices can be found in Appendix 2)
- Integrate child maltreatment prevention into MCH-supported activities, such as home visiting programs, teen parenting groups, and school- and community-based adolescent health clinics (additional information on program integration can be found in Integrating Injury Prevention into Other Maternal and Child Health Services: A Practical Guide, which is available on the CSN website)
- Work with CDR teams to identify primary prevention strategies
- Incorporate child maltreatment prevention messages into anticipatory guidance offered in MCH services, such as pediatric primary care sites and WIC programs
- Conduct public education campaigns that teach parents and the community about the protective factors that promote healthy families and reduce the risk of child abuse and neglect
- Work to reframe child maltreatment prevention as positive parenting, community support for families, and healthy child development

Provide Training and Technical Assistance to MCH and Other Professionals

State MCH programs have a lot to offer local MCH programs and professionals, as well as staff of other State agencies. For example, State MCH programs can take the following actions to build the capacity of professionals to prevent child maltreatment:

- Train public health nurses, MCH practitioners, child care staff, WIC program staff, school nurses, and other service providers to identify and respond to child maltreatment and the risk factors for child maltreatment, as well as to promote parenting practices that prevent maltreatment
- Provide technical assistance and training to community organizations and agencies that implement child maltreatment prevention programs
- Collaborate with and train CDR teams to assess the preventability of deaths resulting from child maltreatment
- Encourage medical, dental, and nursing schools to include child maltreatment identification and prevention in their curricula

Facilitate Collaborations between Relevant Organizations and Professionals

It is important for State MCH programs to bring a primary prevention focus to statewide responses to child maltreatment. MCH programs can take the following actions to contribute to statewide activities:

- Participate in local CDR teams
- Participate in, convene, or facilitate State child maltreatment prevention coalitions or work groups
- Co-sponsor child maltreatment prevention trainings or conferences with other State agencies or private organizations
- Work with State chapters of Prevent Child Abuse America and other non-governmental and community-based organizations to create or implement prevention programs
- Network with other State MCH programs that are involved in child maltreatment prevention and can provide practical advice on addressing this issue
- Work with coalitions that promote legislation supporting child maltreatment prevention
- Develop a relationship with the State's Children's Trust Fund, an important source of funding for child maltreatment prevention
- Work with partners to develop and promote a differential response system for families who come in contact with CPS, and work with CPS on ways that MCH can provide child maltreatment prevention services to families at risk

Work to Increase Funding and Ensure Program Sustainability at State and Local Levels

MCH programs can take the following actions to help ensure that programs that prevent child maltreatment receive the resources necessary to be effective:

- Designate child maltreatment prevention as a Title V State Performance Measure or priority area
- Assign a staff position to coordinate child maltreatment prevention activities
- Seek out new funding opportunities or incorporate a focus on child maltreatment into existing funding streams
- Work with local grantees to help them sustain their programs if State MCH funding for child maltreatment prevention ends

Child Maltreatment Prevention as a Title V State Performance Measure

The Maternal and Child Health Bureau (MCHB) provides funding to State and Territorial MCH programs and requires these programs to address 18 federally mandated National Performance Measures. Each National Performance Measure "describes a specific maternal and child health need that, when successfully addressed, can lead to a better health outcome within a specific time frame" (MCHB, n.d.a). In addition, States can select their own State Performance Measures "to gauge their progress toward achieving goals that are specific to the State" (MCHB, n.d.b).

As of this writing, eight states and Guam have designated child maltreatment as a State Performance Measure. Designating child maltreatment as a State Performance Measure can help States do the following:

- Maintain a focus on the issue of child maltreatment
- Justify and support expenditures by State and local government and the private sector on preventing this problem
- Promote interagency collaboration on prevention
- Provide a method of measuring progress

The box on this page identifies the States and Territories that have designated child maltreatment as a State Performance Measure and how the measure is described in the FY 2007 Title V Block Grant application.

State	Child Maltreatment Performance Measure
Alaska	Rate of substantiated reports of harm per thousand children ages 0 through 18.
Guam	Percent of children younger than 18 years maltreated/neglected.
Illinois	The incidence of maltreatment of children younger than age 18.
Kentucky	Reduce the rate of substantiated incidence of child abuse, neglect, or dependency.
Louisiana	Rate of children (per 1,000) under 18 who have been abused or neglected.
Minnesota	Incidence of determined cases of child maltreatment by persons responsible for a child's care.
North Carolina	Number of children affected in substantiated reports of abuse and/or neglect as compared with previous years.
Tennessee	Reduce the incidence of maltreatment of children younger than age 18 including physical, sexual, emotional abuse and neglect to a rate no more than 8 per 1,000.
Wisconsin	Rate per 1,000 of substantiated reports of child maltreatment to Wisconsin children, ages 0–17, during the year.

Case Studies: What We Did and How We Did It

These case studies examine five States that have, either presently or in the recent past, designated child maltreatment as a Title V State Performance Measure. The case studies share some elements:

- **Data collection and analysis.** Most of the five State Maternal and Child Health (MCH) programs use child protective service (CPS) agencies as their primary source of data on child maltreatment. Several recognize the problematic nature of using data on confirmed cases when their focus is prevention. At least one State MCH program is collecting its own data to better understand how child maltreatment can be prevented.

- **Interventions.** The most commonly used interventions are (1) nurse or paraprofessional home visiting for at-risk families, (2) public education or media campaigns, and (3) parent support groups and information lines.

- **Training and technical assistance.** Several of the five State MCH programs train public health nurses, dental health providers, and child care providers to identify and assess child maltreatment or the risk factors for child maltreatment. Involving professionals who already work with children is an effective approach.

- **Partnering.** The five State MCH programs participate in several different types of multidisciplinary coalitions, including those focusing on child maltreatment prevention, violence prevention, and general childhood injury prevention. Some agencies also have a representative on their State child death review team.

- **Funding and sustainability.** The five State MCH programs use a variety of funding sources to support their child maltreatment prevention activities, including Title V Block Grants, tobacco settlement funds, Preventive Health Services Block Grants, and State general revenues.

The five States featured as case studies showcase the benefits of creating a State Performance Measure on child maltreatment and model a range of strategies that MCH programs can use to prevent child maltreatment. MCH programs in the other States with child maltreatment performance measures—as well as in some States that have not designated child maltreatment as a State Performance Measure—are also taking action on this issue. Additional information on these activities can be found in the Title V Block Grant annual reports, available online at **https://perfdata.hrsa.gov/mchb/mchreports/Search/search.asp** under "Narrative".

Hawaii

Family Health Services Division
Hawaii Department of Health

Why did Hawaii make child maltreatment prevention a State Performance Measure?

In conjunction with the Title V Needs Assessment process, which is done once every five years, data was presented to work teams and community groups, who were asked to rank the issues and select priorities. Child abuse prevention emerged as one of the top 10 issues. Under State law, the Hawaii Department of Health is responsible for preventing child abuse. Loretta Fuddy, chief of the Family Health Services Division, Hawaii's Maternal and Child Health (MCH) program, reports:

> *Adopting child abuse as one of the Title V State Performance Measures is one way of maintaining a focus on the issue. We must report on the State Performance Measure annually and thus need to be in continuous dialogue with the Department of Human Services about the progress being made. Having child abuse prevention as a State Performance Measure also helps justify the need for the Child Death Review System, as well as the Hawaii Children's Trust Fund, which focuses on the prevention of child abuse.*

What data does Hawaii use to understand child abuse?

Sources of data used to understand child abuse in Hawaii, include the Department of Human Services (DHS), the Department of Health Injury and Hospital Data, the Child Death Review (CDR) System, and Child Welfare Services. The Hawaii Healthy Start program's assessment and screening process itself is a valuable source of information about families whose children are at risk of abuse.

What intervention and prevention strategies does Hawaii use?

Hawaii's MCH program uses a number of strategies to prevent child abuse. One of these, home visiting, has become a nationally recognized model.

Home Visiting: Hawaii pioneered the use of home visiting as a child abuse prevention strategy. The predecessor of today's statewide Hawaii Healthy Start program began in 1975 with one site on the island of Oahu. This program, funded by the U.S. Department of Health and Human Services (HHS), National Center on Child Abuse and Neglect (NCCAN), proved successful enough that it was expanded to several other communities on Oahu. In 1977, this program was replicated on the other Hawaiian Islands under the sponsorship of the Statewide Council on Child Abuse (a private advocacy group), with funding from a combination of sources including State money administered by Hawaii's MCH program. In 1984, with the support of the State legislature, an expanded version of this program, now called Hawaii Healthy Start, was piloted. Hawaii's program became the basis for home visiting programs across the nation, including several sponsored or supported by State Title V programs. Many of these programs receive technical support from Healthy Families America, which is a project of Prevent Child Abuse America, a private organization with chapters in 40 States.

Hawaii Healthy Start uses a universal hospital-based screening and assessment process to identify families whose children (or expected children) are at risk of child abuse. These families are offered a support program that uses trained, paraprofessional home visitors to help parents improve their problem-solving and parenting skills and links parents with needed services, including income and nutritional assistance and clinical health services.

Hawaii Healthy Start was originally housed in the Child and Adolescent Mental Health Division of the Department of Health and later transferred to the Family Health Services Division. Loretta Fuddy reports that this change made sense, as the Child and Adolescent Mental Health Division focused on treatment, while Family Health Services focuses on prevention. She says that Family Health Services "saw home visitation as an excellent strategy for the delivery of multiple health messages that would ensure the health and safety of children, since physical and mental health are closely linked. Both are based on parental support, education, and appropriate linkage to health and other community resources."

Hawaii Healthy Start relies on hospitals for screening and assessment and delivers services to families through contracts with local agencies. The program is funded with general revenues, tobacco settlement funds, and Medicaid reimbursement.

Other Activities: The Family Health Services Division is involved in a number of other efforts to prevent child abuse:

Baby SAFE (Substance Abuse Free Environment) Hawaii is designed to decrease the number of pregnant women and new mothers who abuse substances, improve birth outcomes for women who do abuse substances, and decrease the number of infants affected by maternal substance use.

Play + Learn, a support group program, provides a place for parents to play with their young children and share concerns with and offer support to other parents. Play + Learn group leaders offer information on the health and developmental needs of young children, as well as referrals to other services. Play + Learn programs are based in community organizations.

Parent Line is a toll-free telephone service for parents with child development or behavioral questions. Parent Line also provides referrals.

The Hawaii CDR System focuses on preventing the deaths of all children under the age of 18. The CDR System operates under the guidance of a multidisciplinary State CDR Council, which was established under the leadership of the Family Health Services Division. The Council comprises a number of Federal, State, and private agencies and organizations.

The Family Health Services Division is also involved in two statewide coalitions that seek to prevent child abuse. The first, the Hawaii Children's Trust Fund, is a public-private partnership committed to establishing a permanent endowment to fund projects that strengthen families, prevent child abuse and neglect, and promote healthy child development. The second, the Keiki Injury Prevention Coalition, is a partnership with broad public and private participation that seeks to prevent intentional and unintentional injuries to children. The coalition also functions as Hawaii's SAFE KIDS chapter.

Did Hawaii encounter any significant obstacles in addressing child abuse? If so, how did the State address these obstacles?

Loretta Fuddy says, "Prevention has always been difficult to sell, especially using a paraprofessional model. Treatment has often been given a higher priority, especially when resources are limited." The Family Health Services Division worked with a coalition to create the political will to support prevention. The coalition included pediatricians, legislators, and organizations, including Prevent Child Abuse Hawaii, Blueprint for Change, Keiki Injury Prevention Coalition, Hawaii Children's Trust Fund, Keiki Caucus, Child Welfare Advisory Committee, and Healthy Start Network of Providers. Coalition members used data to show that the incidence of child abuse was increasing and educated policymakers about early childhood development and how appropriate parenting can prevent child abuse. Ms. Fuddy also points out that it was helpful that "Hawaii is one of a handful of States that elected to include the environmentally at-risk as a classification for services through Part C of the Individuals with Disabilities Education Act (IDEA)."*

Have any of these child abuse prevention activities been evaluated?

Healthy Start had three years of formal case-control evaluation, conducted in the late 1980s by Johns Hopkins University. The original evaluation found that the outcomes were weak but promising. The evaluation also identified some program fidelity issues. In response, the Hawaii Department of Health launched a quality improvement program, strengthened the training curriculum, and made adjustments to the model. Evaluation data has shown that the program adjustment improved the fidelity to the program design, enrollment, and retention. The evaluation is now working to determine if outcomes have also improved.

The Department of Health contracts with community-based agencies to provide some of these child abuse prevention services (such as Play + Learn). Each contract specifies the goals and objectives the contractor is expected to meet, as well as how progress will be measured. The Department of Health uses its own data system to monitor these contracts.

* Some States limit services that can be provided under IDEA to children with diagnosed physical or mental disabilities. Other States, such as Hawaii, offer these services to children living in families with characteristics that research has shown to be correlated with developmental delays (such as high levels of parental stress).

Illinois

Bureau of Child and Adolescent Health
Division of Community Health and Prevention
Illinois Department of Human Services

Why did Illinois make child abuse prevention a State Performance Measure?

Healthy Families Illinois (HFI), a home visiting program targeting child abuse and other issues, began in 1994 when Voices for Illinois Children, a private advocacy group, approached the Illinois Department of Public Health (IDPH) with the suggestion that the two groups work together. What began as a public-private initiative eventually found a home in the Bureau of Child and Adolescent Health, which is part of the Division of Community Health and Prevention—Illinois's Title V program, which itself is part of the Illinois Department of Human Services (DHS). Denise Simon, Chief of the Bureau of Child and Adolescent Health, says that once this program was underway, it made sense to include child abuse as a State Performance Measure. Simon reports that including child abuse as a performance measure also helps maintain a focus on that issue.

What data does Illinois use to understand child abuse?

The Bureau of Child and Adolescent Health used data collected by the Illinois Department of Children and Family Services (DCFS), Illinois's child protective agency, to identify the counties and communities in which the child abuse prevention programs (described below) should be implemented.

What intervention and prevention strategies does Illinois use?

The Bureau of Child and Adolescent Health oversees a number of initiatives designed to prevent child abuse.

Healthy Families Illinois (HFI): HFI is an intensive home visiting program designed to prevent child abuse and neglect. HFI is described by a Bureau of Child and Adolescent Health fact sheet as follows:

> *The Healthy Family Illinois (HFI) program strengthens family functioning and improves parent-child interaction through intensive home visiting. The home visitor supports parents as children's first teachers and caretakers by modeling good parenting skills and providing information about parenting and child development. Home visitors also provide emotional support for new parents and link families with community resources.*

HFI uses the Healthy Families model, the history of which is described in the case study on Hawaii. HFI currently serves nearly 4,000 families, with well over 56,000 home visits each year. These families are identified by the local HFI programs, often with the assistance of local social service agencies, mental health centers, and health care providers.

The Bureau of Child and Adolescent Health currently supports 52 HFI programs. The Bureau contracts with the Ounce of Prevention Fund, a private organization that works with State agencies and communities on issues affecting children and families, to operate 12 HFI programs—all of which serve adolescent parents—and to provide training for all HFI providers, including hospitals, community organizations, mental health providers, and local health departments. Voices for Illinois Children supports the program through its advocacy and public education activities. Funding for Bureau of Child and Adolescent Health staff responsible for these programs, as well as for the HFI programs and Ounce of Prevention training, comes from a combination of Title V and State general funds, as well as some Centers for Disease Control and Prevention (CDC) Preventive Health Services Block Grant monies.

Parents Too Soon (PTS): PTS is a home visiting program for adolescent parents and their young children. In addition to the services provided by HFI, some PTS programs also provide specialized infant mental health intervention and *doula* services. "Doula" is a Greek word referring to a woman who assists another woman during labor and provides support after the birth. The Doula Initiative offers home-visiting services to pregnant teens. Doula home visitors also attend labor and delivery, make weekly home visits until the baby is three months old, and then make monthly visits until about the sixth month, when the family is transitioned into a PTS/HFI program. PTS programs are operated by a network of community-based organizations in partnership with the Ounce of Prevention Fund, and funded by the Bureau of Family and Adolescent Health with a combination of Title V and State general funds.

Other Activities: Denise Simon says that it is important to realize that many MCH programs prevent child abuse and neglect, even if this is not one of their major goals. One such program in Illinois is Teen Parent Services (TPS), which helps teen parents complete their education, avoid additional pregnancies, and improve their parenting skills. TPS also conducts well-baby visits and developmental delay screenings. Other Illinois MCH initiatives contributing to the prevention of child abuse include Family Case Management/High-Risk Infant Follow-up and Intensive Prenatal, Performance, and First Year support programs, all of which support families and can refer families to HFI if appropriate, as well as the Developmental Child Education and Life Skills Literacy programs. The Bureau of Child and Adolescent Health works with local organizations and agencies to ensure that these activities respond to community needs and take full advantage of community resources.

Did Illinois encounter any significant obstacles in addressing child abuse? If so, how did the State address these obstacles?

Denise Simon reports that a careful planning process before each program was the key to avoiding significant obstacles in their implementation. She also says that it is important for programs to respond to the needs of the communities they serve—and to change as these needs change.

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Denise Simon

Have any of these child abuse prevention activities been evaluated?

HFI has been evaluated by Northern Illinois University (NIU). The Bureau of Child and Adolescent Health also uses internal data generated by the HFI program itself—caseloads, composition of caseloads, and number of first visits—and accumulates this information monthly. Many of the local HFI programs evaluate the effect of their efforts on child abuse rates and on the participating children, parents, and families.

PTS program activity and participant outcome data are reported through the Ouncenet Management Information System, which is provided by the Ounce of Prevention Fund for every PTS site. Ouncenet data reports are used to assess progress, plan services, supervise staff, and develop new training for every site.

Several of the doula programs are undergoing their own evaluations. HFI programs that also participate in the Illinois Violence Prevention Authority's (IVPA) "Safe Start" demonstration projects are involved in the "Safe from the Start" efforts to evaluate the doula programs. "Safe from the Start" programs address violence in the community, including child abuse.

Kentucky

Division of Adult and Child Health Improvement
Cabinet for Health and Family Services
Kentucky Department for Public Health

Why did Kentucky make child abuse prevention a State Performance Measure?

The Division of Adult and Child Health Improvement, Kentucky's Title V program, determined that the following factors put significant numbers of the State's children at risk of child abuse:

- Families with incomes at or below the poverty level
- Residents who are illiterate or have not completed high school
- Relatively high rates of drug and alcohol abuse
- The presence of two large military bases
- Younger first time parents
- Adults who were abused as children
- Families in which men, most often boyfriends or stepfathers, tend children to whom they may have no emotional attachment

The presence of groups with these risk factors in Kentucky indicated that it would be prudent for the Division of Adult and Child Health Improvement to include child abuse prevention as a State Performance Measure.

What data does Kentucky use to understand child abuse?

The Division of Adult and Child Health Improvement relies on data provided by the Child Protection and Permanency Division of the Department for Community-Based Services, which is located within the Cabinet for Health and Family Services (CHFS). This data includes both the number of substantiated child abuse and neglect cases and an estimated number of cases that go unreported. The Division of Child and Adult Health Improvement also relies on data from special reports published by the Department for Public Health (DPH) and the annual report of the Child Fatality Review (CFR) Program (described below), which uses data from Kentucky's Vital Statistics Death Certificate files and Kentucky's Child Fatality Coroner Report Form database.

What intervention and prevention strategies does Kentucky use?

Home Visiting: In 1999, the Governor's Early Childhood Task Force recommended voluntary home visiting programs to promote the overall wellness of Kentucky's young children. One way in which the State responded to this recommendation was by creating the Health Access and Nurturing Development Services (HANDS) program. HANDS is modeled after the nationally used Healthy Families and Healthy Start programs, which are based on a social model and a medical model respectively. Kentucky combined these approaches to create a program model that addresses such issues as low birth weight, preterm infants, child abuse and neglect, domestic violence, underdeveloped parenting skills, teen pregnancy, financial difficulties, and substance abuse. HANDS was piloted in 1999, expanded to 15 counties in 2000, and established in all of Kentucky's 120 counties by the end of 2003. During that year, HANDS served more than 2,000 families.

HANDS is a voluntary home-visiting program implemented through county health departments that work with first-time families—people who have, or are about to have, their first child. HANDS prefers to start working with a family during pregnancy, but also takes referrals for first-time families with infants up to three months of age. Anyone can make a referral to HANDS, including physicians and churches. HANDS also includes a public outreach component that encourages families to volunteer within the program.

HANDS begins with a screening program that reviews 15 risk factors, including substance abuse, a history of psychiatric care, depression, marital status, poor prenatal care, and a history of abortion. If any one of these risk factors is present, the family is eligible for HANDS home visiting services. The family will be offered a meeting with a professional who will complete a more in-depth assessment that considers such factors as mental health, parenting experience, coping skills, support system, anger management skills, expectations of the infant's milestones and behavior, plans for discipline, perceptions of the new infant, bonding, and parental strengths. If the results indicate that the child may be at risk, HANDS offers its home visiting services to the family. Parents who are not appropriate for HANDS but could benefit from some services are provided with information on and referrals to community agencies.

All teen parents are referred for monthly home visitation until the infant is one year of age. Home visits are usually conducted weekly for six months to a year. After that period, the frequency of the visits depends on the family's needs. HANDS usually works with a family until the child is two years of age.

HANDS assessments and home visits are conducted by local health department staff. The Division of Adult and Child Health Improvement provides technical assistance, training, assistance with data collection and analysis, and other support services to the individual programs.

HANDS has two major sources of funding. Twenty-five percent of Kentucky's tobacco settlement money goes to the Kids Now Initiative, which helps fund HANDS and several other programs. HANDS is also funded through Federal Medicaid case management services.

Well-Child Visits: Another activity used by the Division of Adult and Child Health Improvement to prevent child abuse is the Well-Child Program. Division of Adult and Child Health Improvement staff train nurses from local health departments to include child abuse screening in their well-child visit examinations. The nurses learn how to recognize behavioral clues that indicate children may have been abused, how to evaluate a child for possible sexual abuse, how to take a history of a child who may have been abused physically or sexually, and how to determine whether a follow-up clinical evaluation is warranted. The nurses also learn about demographics related to child abuse, its incidence and prevalence, the different types of abuse, and abuser profiles. Nurses who suspect that child abuse may be taking place contact Child Protection Services (CPS), and CPS initiates a review to evaluate the child for sexual abuse. Title V funds support many well-child activities at both the State and local levels.

Child Fatality Review (CFR): A third strategy used by the Division of Adult and Child Health Improvement to prevent child abuse is its participation in the Kentucky CFR State Team. This multidisciplinary team examines data to assess the extent of the child abuse problem, establishes priorities for preventing abuse, partners with local agencies in activities that prevent child abuse, and supports county CFR teams that are responsible for the actual death investigations. The Division of Adult and Child Health Improvement provides leadership and coordination for the team, manages the development of the annual report, coordinates data collection, and notifies local health department grief counselors in the event of a child death. The Division's participation on the team is supported by general funds. Other participants on the CFR State Team include representatives from CHFS, law enforcement, the Justice Cabinet's Office of Medical Examiners, the coroner's association, Prevent Child Abuse Kentucky, legal counsel, a local health department, the State Fire Marshal's Office, the Emergency Medical Services for Children Program of the Kentucky Board of Emergency Medical Services, and the Kentucky Injury Prevention and Research Center at the University of Kentucky.

Did Kentucky encounter any significant obstacles in addressing child abuse? If so, how did the State address these obstacles?

Each program faces its own obstacles. Some families are uncomfortable having HANDS program staff come into their homes. Explaining to families how the program benefits children and families helps increase their comfort level with having program staff in their homes.

Staff from the Division of Adult and Child Health Improvement report that some local coroners did not fully understand the importance of CFR teams in preventing child abuse. Coroners without some medical background often need greater assistance to lead a team that assesses high-risk threats to child health and prioritizes prevention strategies. The health department CFR representative's perspective is invaluable in helping coroners understand these issues.

Have any of these child abuse prevention activities been evaluated?

Kentucky studied 3,500 families, comparing HANDS families with first-time families in the same counties that were not participating in the program. The study found that there was 58 percent less physical abuse and 62 percent less neglect among the families participating in HANDS. The study is currently being repeated.

Louisiana

Maternal and Child Health Program
Center for Preventive Health Services
Office of Public Health
Department of Health and Hospitals

Why did Louisiana make child abuse prevention a State Performance Measure?

Dr. Jean Takenaka of Louisiana's Office of Public Health reported that the results of the 1995 Maternal and Child Health (MCH) Needs Assessment sparked an investment of resources in child abuse prevention. Adding a State Performance Measure on child abuse was a way of measuring the results of Louisiana's efforts in this area.

What data does Louisiana use to understand child abuse?

The Office of Public Health uses the rate of validated child abuse cases. This data is obtained from the Office of Community Services (Louisiana's child protection agency).

What intervention and prevention strategies does Louisiana use?

Louisiana uses a number of prevention and intervention strategies, including several screening and assessment programs, as well as a number of programs to which parents and at-risk children can be referred.

Screening and Assessment: The MCH program created two psycho-social risk assessment questionnaires—one for use in the prenatal period and one for use in early infancy. These questionnaires are used by public health nurses in the Office of Public Health Prenatal and WIC clinics to assess factors associated with child abuse and neglect, including substance abuse, domestic violence, financial/social service needs, and mental health and developmental risk factors. Women whose children are thought to be at risk are referred to appropriate preventive and intervention services, including substance abuse treatment facilities, battered women shelters, the Early Childhood Supports and Services Program (operated by the Louisiana Office of Mental Health), the Nurse-Family Partnership (NFP) and Best Start programs, and other community-based resources (the NFP and Best Start programs are described below). The screening and assessment activities are funded by a combination of Title V and General Funds.

Child Protective Services (CPS): Through an interagency agreement with the Office of Community Services (OCS), MCH utilizes public health nurses to assist child protection workers in investigating suspected cases of medical neglect, malnutrition, and failure to thrive. Nurses assess the child in the clinic or at home within 24 hours of a request from OCS.

Home Visiting: MCH funds several home-visiting programs. One of these, the Nurse Family Partnership (NFP), is for first-time mothers who are identified as needing services before the 28th week of pregnancy. NFP nurse visitors begin regular visits to families during a woman's pregnancy and continue until the child is two years of age. Nurses provide health education, referrals, case management, and other support. NFP was originally developed in Colorado. Louisiana's NFP is funded by Title V funds and Medicaid reimbursements and is available in all regions of the State.

Louisiana's MCH program funded other home visiting programs based on the Hawaii Healthy Start and Healthy Families America models (more information on these models can be found in the case study on Hawaii). However, Louisiana's evaluation of its implementation of Healthy Families America indicated that the State required a more focused health/mental wellness intervention to serve those children and mothers at greatest risk. Louisiana responded by replacing the Healthy Families program with Best Start, a new initiative that uses professionals (rather than paraprofessionals) to provide a focused small-group mental health/health intervention, psycho-educational support, screening, case management, and individual counseling. Best Start serves pregnant women and women with young children who are at high risk, and prevents abuse and neglect by strengthening the parent-infant relationship. Louisiana uses Title V funds to finance Best Start.

Public Information Campaign: A child abuse prevention public information campaign is funded through a contract with Prevent Child Abuse (PCA) Louisiana. The campaign includes a media campaign that promotes the PCA Louisiana toll-free counseling hotline for parents. About 30 percent of the calls to the hotline are from parents undergoing stress and in danger of harming their children. The hotline, as well as healthy parenting and positive discipline, are promoted through radio public service announcements, billboards, and a speakers bureau.

Prevent Abuse & Neglect through Dental Awareness (PANDA): MCH initiated and oversaw Louisiana's PANDA program, which distributes materials on recognizing and reporting signs of child abuse to dentists and dental hygienists. Studies indicate that dentists are five times more likely to report suspected cases if they receive appropriate education in this area. The PANDA program was originally developed in Arkansas and is now being implemented in 44 states. Louisiana's PANDA program was carried out with the assistance of the PANDA Coalition, which includes the Louisiana Children's Trust Fund, the Louisiana Dental Association and its Alliance, the Louisiana Academy of Pediatric Dentistry, the Louisiana Dental Hygienists Association, OCS, the American Society for Dentistry for Children, and PCA Louisiana. Responsibility for this program has been transferred to the Louisiana Dental Society.

Staff Training: The Louisiana MCH program developed a 30-hour training in infant mental health that is provided to all MCH nurses and staff to increase awareness of the importance of early childhood experiences and early development of a secure parent-infant relationship on later child health and development. This training includes such issues as normal social-emotional development, positive parent-infant relationships, factors associated with parenting difficulties and risk for abuse and neglect, and assessment and brief intervention skills. In addition, all staff are trained in *Bright Futures*, an intervention focusing on psychosocial approaches to well-child care.

Child Death Review (CDR): The CDR panel, established by the State legislature in 1993, reviews all unexpected deaths in children under the age of 15. This panel includes representatives from MCH, OCS, the Coroners Association, the Attorney General's Office, the American Academy of Pediatrics (AAP), the Louisiana Medical Society, the Vital Registrar, the State Police, the Fire Marshal, the legislature, and the public. The MCH program staffs a full-time position on the CDR Panel.

Did Louisiana encounter any significant obstacles in addressing child abuse? If so, how did the State address these obstacles?

Dr. Jean Takenaka reports that the MCH program has had to face two major obstacles in addressing child abuse. The first is that it is difficult to get good data, especially when seeking data on psychosocial issues. The MCH program has decided to use child protective data, while realizing that this data has limitations and that it underreports some types of child abuse—especially emotional abuse. Dr. Takenaka says that only the most severe cases of emotional abuse find their way into the child protective system. She also reports that OCS was extremely cooperative in providing child abuse data, since it is also interested in preventing abuse.

The second obstacle that Dr. Takenaka reports is that by the time a CPS report on child abuse is filed and validated, it is too late for primary prevention. She says that they are working with the Office of Mental Health's Early Childhood Support and Services Program to address this issue. Parents are referred to this program based on risk factors rather than child abuse reports. This program is truly preventive in that it seeks to intervene before a child is abused.

Have any of these child abuse prevention activities been evaluated?

Louisiana evaluated its implementation of the Healthy Families America model. An evaluation of Best Start is underway.

The Nurse Family Partnership (NFP) approach has been evaluated and shown to be effective in other parts of the country. NFP in Louisiana has not been evaluated for its effect on child abuse and neglect, however, a small randomized controlled trial found that participants in Louisiana's NFP had significant decreases in prenatal depression, premature and low-birth-weight babies, and postpartum partner violence—all of which are risk factors for abuse and neglect. The children of parents who participated in NFP had fewer emergency room visits for injuries and medical illnesses than comparable children whose parents did not participate.

Nevada

Bureau of Family Health Services
Nevada State Health Division

Why did Nevada make child abuse prevention a State Performance Measure?

The last five-year assessment conducted by the Nevada Bureau of Family Health Services—the State's Maternal and Child Health (MCH) program—found that child abuse ranked among the top 10 issues on which stakeholders thought the Bureau should be working. These stakeholders included perinatal care providers, Family Resource Center personnel, medical care providers, and other professionals, as well as the general public.

What data does Nevada use to understand child abuse?

The Bureau of Family Health Services uses data provided by the Division of Child and Family Services (DCFS), Nevada's child protective agency. Child Death Review (CDR) data is used to develop a social marketing plan addressing child abuse and to propose changes to policies and State law.

What intervention and prevention strategies does Nevada use?

Prevent Abuse and Neglect through Dental Awareness (PANDA): Cynthia Huth, Perinatal Nurse Consultant for the Bureau of Family Health Services, reports that PANDA was "a natural" choice for the Bureau, since it already had a very active oral hygiene program. PANDA provides training and materials to dental professionals on how to recognize and report suspected child abuse and neglect. Studies indicate that dentists are five times more likely to report suspected cases if they receive appropriate education in this area. The PANDA program was originally developed in Arkansas and is now being implemented in 44 States.

Child Death Review (CDR) data is used to develop a social marketing plan addressing child abuse and to propose changes to policies and State law.

The Oral Health Program of the State Health Division has sponsored more than 60 PANDA classes, trained more than 1,100 dental professionals, and recently used a mailing to offer the training to all licensed dentists and their staff in the State. The program has been incorporated into the curriculum of the two dental hygiene schools in Nevada, as well as the University of Nevada at Las Vegas (UNLV) School of Dental Medicine and the Pediatric Dental Residency in the UNLV School of Medicine. The Bureau of Family Health Services has also offered PANDA training to Head Start programs, and plans to expand this effort by offering training to health care providers, child care providers, and any organization or agency working with children and families.

Training: The Bureau of Family Health Services provides training on preventing, identifying, and responding to child abuse for a number of constituencies in Nevada. At the request of the Bureau of Licensure for Child Care Facilities, the Bureau of Family Health Services created and implemented classes for child care providers on identifying child abuse, the child abuse laws, and the responsibilities of mandated reporters. This training was being conducted in Nevada's two most densely populated counties but not in the rural counties, which is where the Bureau's efforts are directed. The Bureau developed material on child abuse for the University of Las Vegas, Reno's (UNR) Healthy Child Care America program, which trains child care health consultants. The Bureau also developed and implemented a class called "Prevention of Illness, First Aid and Safety," in which child care providers learn how to evaluate a child's health, including identifying signs of abuse.

Perinatal Substance Abuse Prevention (PSAP) Initiative: PSAP uses television and radio public service announcements to discourage the use of alcohol and other drugs (including tobacco) by pregnant women, which produces healthier babies and reduces the risk of child abuse.

Healthy Child Care America: This program is funded with Title V and State general funds as well as a Community Integrated Services System grant from the Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA).

Safe Haven: Nevada collaborates with the Junior League of Nevada to produce and distribute a statewide multimedia campaign titled "Safe Haven." The Safe Haven campaign is designed to educate the public about a new Nevada law that allows parents to leave babies up to 30 days of age at any "safe haven," which includes hospitals, fire stations, law enforcement agencies, obstetric centers, and licensed emergency medical care centers. Nevada law ensures that a parent will not face criminal prosecution if he or she leaves a baby at a designated safe haven. Proponents hope that this campaign will prevent parents from abandoning babies in dangerous places.

Child Death Review (CDR): A Bureau of Family Health Services representative serves on Nevada's CDR Team.

Have any of these child abuse prevention activities been evaluated?

Participants in PANDA are asked to fill out evaluations to ask about satisfaction immediately after the training.

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Appendix 1:

State-by-State Breakdown of Substantiated Child Maltreatment Cases, 2005

(from U.S. Department of Health and Human Services, Administration on Children, Youth and Families, 2007)

State	Total Victims	Rate per 1,000 children	Physical Abuse	Sexual Abuse	Neglect	Psychological Maltreatment
			N / %	N / %	N / %	N / %
AL	9,029	8.3	3,659 / 40.5	2,123 / 23.5	4,021 / 44.5	67 / 0.7
AK	2,693	14.3	392 / 14.6	121 / 4.5	1,663 / 61.8	792 / 29.4
AZ	6,119	3.9	1,303 / 21.3	377 / 6.2	4,592 / 75.0	58 / 0.9
AR	8,124	12.0	1,566 / 19.3	2,373 / 29.2	4,527 / 55.7	108 / 1.3
CA	95,314	9.8	12,118 / 12.7	7,051 / 7.4	67,506 / 70.8	17,073 / 17.9
CO	9,406	8.0	1,623 / 17.3	946 / 10.1	5,949 / 63.2	484 / 5.0
CT	11,419	13.7	809 / 7.1	527 / 4.6	8,465 / 74.1	3,480 / 30.5
DE	1,960	10.0	544 / 27.8	183 / 9.3	548 / 28.0	442 / 22.6
DC	2,840	25.2	457 / 16.1	163 / 5.7	2,391 / 84.2	0 / 0.0
FL	130,633	32.1	15,661 / 12.0	5,205 / 4.0	39,484 / 30.2	2,294 / 1.8
GA	47,158	20.0	4,919 / 10.4	2,158 / 4.6	33,173 / 70.3	10,104 / 21.4
HI	2,762	9.2	307 / 11.1	156 / 5.6	415 / 15.0	26 / 0.9
ID	1,912	5.1	344 / 18.0	116 / 6.1	1,374 / 71.9	7 / 0.4
IL	29,325	9.0	7,783 / 26.5	5,538 / 18.9	19,401 / 66.2	43 / 0.1
IN	19,062	11.9	2,630 / 13.8	4,058 / 21.3	13,460 / 70.6	0 / 0.0
IA	14,016	20.9	1,881 / 13.4	814 / 5.8	11,008 / 78.5	105 / 0.7
KS	2,775	4.1	603 / 21.7	649 / 23.4	603 / 21.7	426 / 15.4
KY	19,474	19.9	2,407 / 12.4	993 / 5.1	16,560 / 85.0	121 / 0.6
LA	12,366	10.8	3,427 / 27.7	892 / 7.2	9,423 / 76.2	424 / 3.4
ME	3,349	12.1	751 / 22.4	426 / 12.7	2,207 / 65.9	1,504 / 44.9
MD	14,603	10.4	3,893 / 26.7	1,961 / 13.4	9,025 / 61.8	42 / 0.3
MA	35,887	24.6	5,055 / 14.1	975 / 2.7	32,690 / 91.1	85 / 0.2
MI	24,603	9.7	4,399 / 17.9	1,172 / 4.8	18,465 / 75.1	529 / 2.2
MN	8,499	6.9	1,438 / 16.9	907 / 10.7	6,490 / 76.4	72 / 0.8
MS	6,154	8.2	1,302 / 21.2	926 / 15.0	3.485 / 56.6	675 / 11.0
MO	8,945	6.5	2,460 / 27.5	2,347 / 26.2	4,627 / 51.7	554 / 6.2

State	Total Victims	Rate per 1,000 children	Physical Abuse	Sexual Abuse	Neglect	Psychological Maltreatment
			N / %	N / %	N / %	N / %
MT	2,095	10.2	225 / 10.5	145 / 6.9	1,557 / 74.3	428 / 20.4
NE	6,630	15.4	931 / 14.0	591 / 8.9	5,509 / 83.1	364 / 5.5
NV	4,971	8.0	887 / 17.8	213 / 4.3	4,114 / 82.8	392 / 7.9
NH	941	3.1	192 / 20.4	185 / 19.7	625 / 66.4	9 / 1.0
NJ	9,812	4.5	3,273 / 33.4	865 / 8.8	4,865 / 49.6	144 / 1.5
NM	7,285	14.9	1,055 / 14.5	385 / 5.3	5,130 / 70.4	1,613 / 22.1
NY	70,878	15.6	7,957 / 11.2	2,732 / 3.9	64,875 / 91.5	507 / 0.7
NC	33,250	15.5	1,162 / 3.5	1,254 / 3.8	21,385 / 64.3	120 / 0.4
ND	1,547	11.3	258 / 16.7	119 / 7.7	1,239 / 80.1	825 / 53.3
OH	42,483	15.4	8,889 / 20.9	7,889 / 18.6	23,381 / 55.0	4,214 / 9.9
OK	13,941	16.3	2,545 / 18.3	896 / 6.4	11,484 / 82.4	3,149 / 22.6
OR	12,414	14.6	1,064 / 8.6	1,079 / 8.7	3,827 / 30.8	350 / 2.8
PA	4,353	1.5	1,411 / 32.4	2,720 / 62.5	153 / 3.5	48 / 1.1
PR	15,807	15.3	3,802 / 24.1	672 / 4.3	8,068 / 51.0	2,576 / 16.3
RI	3,366	13.7	479 / 14.2	168 / 5.0	2,792 / 82.9	10 / 0.3
SC	10,759	10.5	3,228 / 30.0	903 / 8.4	7,515 / 69.8	137 / 1.3
SD	1,442	7.7	187 / 13.0	59 / 4.1	1,255 / 87.0	54 / 3.7
TN	18,376	13.2	6,126 / 33.3	3,749 / 20.4	9,799 / 53.3	101 / 0.5
TX	61,994	9.8	14,491 / 23.4	7,37 / 11.9	43,835 / 70.7	958 / 1.5
UT	13,152	17.7	1,937 / 14.7	2,536 / 19.3	2,719 / 20.7	5,591 / 42.5
VT	1,080	8.1	523 / 48.4	502 / 46.5	61 / 5.6	12 / 1.1
VA	6,469	3.5	1,773 / 27.4	970 / 15.0	3,868 / 59.8	69 / 1.1
WA	7,932	5.3	1,311 / 16.5	476 / 6.0	6,589 / 83.1	0 / 0.0
WV	9,511	24.9	2,588 / 27.2	448 / 4.7	5,223 / 54.9	2,169 / 22.8
WI	9,686	7.5	1,234 / 12.7	3,659 / 37.8	2,748 / 28.4	29 / 0.3
WY	853	7.5	60 / 7.0	63 / 7.4	606 / 71.0	113 / 13.2
Total	899,454	12.1	149,319 / 16.6	83,810 / 9.3	564,765 / 62.8	63.497 / 7.1

Reference

U.S. Department of Health and Human Services, Administration on Children, Youth and Families. (2007). *Child maltreatment 2005* (Tables 3-3 & 3-6, pp. 36 and 41). Washington, DC: U.S. Government Printing Office.

Appendix 2:
Resources on Evidence-Based and Promising Child Maltreatment Prevention Programs

These resources will help Maternal and Child Health (MCH) programs identify and learn about child maltreatment programs that research and experience have shown to be effective or that are grounded in a research base that indicates they stand a reasonable chance of being effective.

Handbook of Injury and Violence Prevention edited by L. Doll, S. Bonzo, J. Mercy, and D. Sleet. Atlanta: Springer, Inc., 2007. This anthology includes a chapter on child maltreatment prevention strategies which have been shown to reduce child abuse and neglect reports or to ameliorate the risk factors for maltreatment, including parental attitudes, beliefs, and behaviors.

Emerging Practices in the Prevention of Child Abuse and Neglect (http://www.childwelfare .gov/preventing/programs/whatworks/report/index.cfm) by D. Thomas, C. Leicht, C. Hughes, A. Madigan, and K. Dowell, n.d. This publication of the Office on Child Abuse and Neglect (OCAN) of the Children's Bureau, U.S. Department of Health and Human Services (HHS) describes the major types of child maltreatment prevention strategies and provides specific examples of effective and innovative programs, including information about why the programs have been successful.

Child Maltreatment Prevention (http://www.cdc.gov/ncipc/dvp/CMP/default.htm). This website, created by the National Center for Injury Prevention and Control (NCIPC) of the Centers for Disease Control and Prevention (CDC), presents child maltreatment data sources, risk and protective factors, prevention programs and activities, and suggestions for distributing prevention information and promoting widespread adoption of prevention strategies.

Preventing Child Abuse and Neglect (http://www.childwelfare.gov/preventing/). This website created by the Child Welfare Information Gateway of the Children's Bureau provides an overview of child abuse prevention, strategies for promoting healthy families, and tips for identifying, selecting, planning, implementing, and evaluating child abuse prevention activities. The site also contains a link to the *Evaluation Toolkit and Logic Model Builder*, a tool to assist child maltreatment prevention programs in evaluating the outcomes of their activities.

Prevent Child Abuse America (http://www.preventchildabuse.org). Prevent Child Abuse America (PCA America) is an organization dedicated to the prevention of child maltreatment. Its website contains information on child maltreatment research studies, prevention strategies—including home visiting—and advocacy tools.

State Secrecy and Child Deaths in the U.S.: An Evaluation of Public Disclosure Practices about Child Abuse or Neglect Fatalities or Near Fatalities, with State Rankings (http://www.caichildlaw.org/ or http://www.firststar.org/) by the Children's Advocacy Institute of the University of San Diego School of Law and First Star. 2008. Written by two leading national child advocacy groups, this report issues letter grades from "A" to "F" based on an analysis of the child death and near death disclosure laws and policies of all 50 U.S. States and the District of Columbia.

Healthy Families America (http://www.healthyfamiliesamerica.org) a program of PCA America, is a national program model designed to help expectant and new parents get their children off to a healthy start.

Children's Safety Network
Education Development Center, Inc.
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http://www.ChildrensSafetyNetwork.org