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Prevention of Child Maltreatment

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Abstract

Pediatricians and other health care providers can play a number of important roles in the prevention of child maltreatment. As part of routine patient care, pediatricians can provide anticipatory guidance for effective discipline and parent-child communication, screen for maltreatment risk factors, and refer parents and families to effective community-based programs. This article will help pediatricians incorporate child abuse prevention into their practice. Resources for systematizing anticipatory guidance and child maltreatment risk factor screening will be described. The modalities and strengths and weaknesses of community-based prevention programs will be discussed, and providers will be given tools to identify the effectiveness of available community-based programs. At a broader level, the article will describe ways that pediatricians can advocate at the local, state, and national level for policies and programs that support families and children.

Keywords

Child abuse; child neglect; prevention; health promotion; primary care

Child abuse prevention needs to be explained and understood within a broad context of child wellbeing. A child's experiences do not occur in a vacuum, but rather they occur within the context of family, community, and society. Risk factors for maltreatment such as parental depression, substance abuse, or lack of social support may lead to other adverse outcomes in addition to maltreatment. Likewise, interventions to prevent maltreatment may have other positive effects on children and families, including improved development, improved maternal health, enhanced parent child communication, decreased use of public assistance and decreased involvement in the criminal justice system.¹⁻⁵ For these reasons, many organizations and experts, including the American Academy of Pediatrics (AAP), The Centers for Disease Control and Prevention (CDC), and the Harvard Center on the Developing Child directly link child maltreatment prevention to strengthening families,

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improving developmental outcomes, and promotion of child and family safety, stability, and nurturance.⁶⁻⁸

The Role of Pediatric Health Care Providers in Child Maltreatment

Prevention

Pediatricians and other health care providers can play a number of important roles in the prevention of child maltreatment. As part of routine patient care, pediatricians can provide anticipatory guidance, screen for maltreatment risk factors, and refer parents and families to effective community-based programs. These efforts can be integrated into routine care without increasing visit length if parents complete screening questionnaires before the visit and listings of community resources are readily available. At a broader level, pediatricians can advocate at the local, state, and national level for policies and programs that support families and children. Each of these roles will be discussed in this chapter. A summary is provided in Box 1.

Screening for Maltreatment Risk Factors and Identification of Families at Risk

From an ecological perspective, interactions among and between child, parent, family, and community/society may all increase the likelihood of maltreatment.^{9,10} Any characteristic that makes a child difficult to care for, including physical, emotional, behavioral, or developmental disabilities may increase risk.¹¹⁻¹³ Parents with mental health problems, limited social support, limited knowledge of normal child development, low sense of parenting competence, or harsh, inattentive, or inconsistent parenting may be at higher risk of abusing or neglecting their children.¹⁴⁻²⁰ Families experiencing intimate partner violence or who have non-biologically related adults in the home may also be at increased risk.^{21,22} Finally, a number of community and societal factors such as violent neighborhoods, and inadequate social welfare programs like food and housing assistance may increase stress on families and increase the likelihood of maltreatment.^{23,24} Table 1 summarizes major maltreatment risk factors.

A number of protective factors should also be noted. Social support is an important protective factor; families with higher levels of social support have lower rates of physical abuse and greater use of discipline strategies other than corporal punishment.^{25,26} Self-efficacy, an individual's belief in his or her ability to succeed, is another characteristic that can limit the adverse effects of risk factors. Some parents are very adept at identifying and securing helpful resources and services such as home nursing for a sick child, or a child care center that serves children with developmental disabilities. A parent's sense of competence in child rearing may enable her to better cope with the challenges of raising children.²⁷ Children with high intelligence, self-esteem, and/or self-efficacy, are involved with extracurricular activities or religious institutions, or who have a supportive adult involved in their lives may be less likely to suffer negative sequelae from maltreatment.²⁸

A child health professional who is familiar with child maltreatment risk factors can work with families to identify and address these risks. Because many high risk parents have

limited health care access and do not seek out supportive services, they may have more contact with their child's primary care provider than any other professional. Child health professionals are therefore uniquely suited to identify and address child maltreatment risk.

As with any screening program, screening for child maltreatment risk factors should be focused on problems for which effective treatment is available, such as parental depression and substance abuse. Universal screening (i.e. screening all families in a primary care practice) is recommended because it eliminates the stigma of screening selected families, and reduces the likelihood of missing at-risk families. A number of questionnaires that screen for child maltreatment risk factors have been developed and validated.²⁹⁻³⁷ Although brief, most identify only a single risk factor.³⁶

Several screening tools identify multiple maltreatment risk factors. The SPARK (Structured Problem Analysis of Raising Kids) questionnaire identifies factors that may increase child maltreatment risk such as child health, development and behavior, parenting approach, social contacts and informal support, and family and community environment.^{38,39} The 3 step model starts with detection of problems and concerns. This is followed by an assessment of the extent and impact of problems and the parents' perception of need for support. The final step involves making decisions about next steps. The questions are intended to be administered as part of a structured interview, which takes, on average, 29 minutes to complete. Providers are taught how to administer the SPARK in a half-day training session. A recent study has shown that the included risk factors were strongly predictive of child protective service reports.³⁹ However, no data has been published on the effects of SPARK in reducing child maltreatment.

Another model that incorporates a multi-risk factor screening questionnaire is SEEK – A Safe Environment for Every Kid. The Parent Screening Questionnaire (PSQ), a component of SEEK, is a single-page document that asks about multiple maltreatment risk factors, including parental depression, substance abuse, social support, intimate partner violence (IPV), major parental stress and food insecurity.³⁶ In order to reduce the stigma associated with asking sensitive questions, an introductory paragraph adopts an empathetic tone and notes that parenting can be challenging for anyone. It also notes that the survey is given to all parents bringing their children for a check-up.

The SEEK model includes several other components in addition to the PSQ. Because many pediatricians may not have had training in addressing complicated issues such as IPV and parental substance abuse, training and skill building are incorporated. Motivational interviewing techniques are introduced as a means of enhancing parents' readiness to change. These techniques have proven effective for many types of behavior change, and pediatricians can become skilled with training and practice. With support from the Doris Duke Foundation, these training modules are now available on-line at: <https://theinstitute.umaryland.edu/SEEK/>. The SEEK website also includes algorithms for further assessment and parent handouts that address each risk factor. The SEEK model ideally includes a clinical social worker or mental health professional to assist with family assessments and referrals, either in person or by phone. Alternatively, pediatricians who

have been trained to briefly assess and initially address identified problems may implement the SEEK model with the help of office staff to facilitate referrals.

The effectiveness of SEEK has been studied extensively. Two studies have demonstrated the SEEK model's effectiveness in reducing child maltreatment.^{40,41} One study was conducted in a pediatric resident continuity clinic based in an urban, inner city community. The other was conducted at 18 mostly suburban, private primary care practices. SEEK has been endorsed as a promising practice by the federal Agency for Healthcare Research and Quality (AHRQ) Health Care Innovations Exchange, and some materials are included in *Bright Futures* guidelines for anticipatory guidance. An economic analysis of SEEK demonstrated that the program would save money by reducing the need for medical and mental health expenses.⁴² Of particular importance to the busy pediatrician, practices that implemented the SEEK model did not increase the average time spent with patients.

Prevention Programs Rooted in Models of Anticipatory Guidance

A number of programs use anticipatory guidance to help parents effectively manage situations that might increase the risk of maltreatment. Two programs have specifically focused on the stress associated with infant crying and preventing abusive head trauma (shaken baby syndrome). Dias et al developed a hospital-based postpartum intervention that taught parents the dangers of shaking babies.⁴³ Equally important, it taught parents how to manage the stress that they might feel when their infant cries inconsolably. After receiving the educational materials, parents were asked to sign a commitment statement stating that they would not shake their baby and they would teach other caregivers not to shake. An ecologic study comparing change in rates of abusive head trauma in the Buffalo, NY area where the intervention was implemented with rate changes in neighboring Pennsylvania during the same time period showed a 47% decrease in the rate of abusive head trauma in the intervention community, but no change in rates in the control communities. Unfortunately, a case-control study of a similar intervention implemented in Utah did not show significant reductions in abusive head trauma.⁴⁴

The Period of Purple Crying program is also focused on the parenting response to infant crying. A video and brochure provide information about infant crying behavior with advice on how to reduce infant crying and address the associated parenting stress. Two randomized trials demonstrated significant improvement in knowledge about and response to crying. Because the incidence of abusive head trauma is relatively low (approximately 30 cases per 100,000 infants), enrollment of enough families to detect significant differences in rates of abusive head trauma between the intervention and control groups was not feasible.^{45,46} Therefore, the studies were not designed to examine this outcome. The program has expanded from their original sites in Vancouver, BC and Seattle, WA to many other communities in the U.S. and Canada. A statewide campaign in North Carolina has incorporated in-hospital postpartum education, community-based education in primary care offices and health departments, and a media campaign.⁴⁷ To date, there have been no publications specifically examining whether the intervention leads to a reduction in the rate of abusive head trauma.

The American Academy of Pediatrics has developed two programs for primary prevention of child maltreatment in the clinical setting. *Connected Kids: Safe, Strong, Secure* is a resiliency-based educational program for parents and providers focused on managing challenging developmental stages, providing effective discipline, and other topics.⁴⁸ While the developers have demonstrated that implementation is feasible, there has not been any evaluation of program effectiveness in reducing maltreatment rates or other benefits. *Practicing Safety* is another AAP-developed program that helps providers screen for and address maternal depression, and uses anticipatory guidance to help parents cope with challenging developmental stages such as infant crying and colic and toilet training.⁴⁹ It was initially implemented as a Quality Improvement Innovation Network (QuIIN) project to increase attention to and address specific risk factors for child maltreatment. Participants demonstrated changes in practice behavior, but effects on child maltreatment were not examined.

Community-Based Prevention Programs

In addition to providing anticipatory guidance and screening for maltreatment risk factors, pediatricians can also refer families to community-based programs, and encourage them to participate. In order to do so, however, pediatricians must be aware of what programs are available in their communities. Gathering this information may initially require several hours of pediatrician or office staff time, followed by periodic updates. Community resource information may be available from one's local or state health department, United Way agency, and/or through an internet search, supplemented by phone calls and requests for brochures and program information. Identifying and communicating periodically with key contact persons at community-based agencies may also be worthwhile. Brief conversations can be helpful in learning more about the program, and in collaboratively addressing the needs of referred families. In addition, families in need of services may be more willing to engage when their pediatrician is familiar with program staff and services.

Pediatricians also must be knowledgeable about the quality and effectiveness of the available programs, keeping in mind that many programs have had little or no formal evaluation. A number of websites focused on evidence-based interventions can help pediatricians acquire this knowledge by summarizing key information. Most provide program descriptions as well as information on program location(s), targeted populations, research outcomes, and effectiveness ratings. Table 2 lists several useful sites.

There is a great deal of variability among programs. While some explicitly focus on child abuse prevention, the goals of others are framed in a broader context, such as enhancing parenting skills. The background and training of program staff varies considerably. Professionals such as nurses or social workers work directly with participants in some programs. These professionals may be equipped with a large fund of knowledge and years of experience. However, some programs prefer using lay persons from the intervention community because of the potential for better connections with participants. Some programs have been studied extensively with rigorous methods including randomized controlled trials, and both process and outcome evaluations; others have not been as carefully or extensively evaluated, and many have not been evaluated at all.

When successful programs are replicated, fidelity to the original model becomes an important consideration. Consistency in training, implementation, and oversight may help ensure that all program components are implemented properly. However, sometimes program changes are needed with replication, particularly when they are implemented in communities that are culturally or geographically different than the original intervention community.

Keeping families engaged in community-based services can be challenging. Many families referred to community-based programs struggle with stressors such as poverty, single-parenthood, intimate partner violence, and depression, in addition to pregnancy and parenthood. High quality interventions may better engage and retain participants than lower quality programs.⁵⁰ Engagement and retention is often more difficult in families coping with intimate partner psychological aggression, substance abuse, and depression.⁵⁰ If pediatricians screen, identify, and help families access services for these problems, they may reduce child maltreatment by both ameliorating risk factors and improving community-based program participation.

Most community-based programs fall into one of two categories: home visiting and parent training. However, some parent training programs include a home visiting component, and many home visiting programs include parenting skills training. A review of twelve carefully evaluated community-based programs (including both home visiting and parent training) with control groups and measurement of child abuse outcomes demonstrated an overall positive effect of the interventions. The weighted average rate of child maltreatment was 2.9% lower in intervention families compared to controls.⁵¹ However, only four of the twelve programs showed a statistically significant reduction in substantiated maltreatment rates. The most effective programs had a high dosage of intervention and comprehensive services addressing multiple family needs. Highly trained service providers also increased program effectiveness.

Home visiting programs assign a professional or layperson to serve families in their own environment. Services may include an assessment of needs, case management, education, emotional support, and role modeling. Home visitors assist families in accessing needed services such as health insurance, WIC, mental health and substance abuse treatment, housing assistance. Most begin during pregnancy or shortly after birth.

The 2010 federal Patient Protection and Affordable Care Act included funding for evidence-based home visiting through the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV). At least 75% of MIECHV community funding must be spent on evidence-based home visiting programs. In order to determine which programs would be designated as “evidence-based”, the U.S. Department of Health and Human Services (DHHS) conducted a systematic review, the Home Visiting Evidence of Effectiveness (HomVEE). Data from HomVEE led DHHS to designate 12 programs as meeting evidence-based criteria (Box 2).⁵² It is important to note that while all DHHS designated programs have shown positive outcomes for children, not all have demonstrated effectiveness in preventing child abuse and neglect. Descriptions of several widespread HomVEE designated programs with evidence of child abuse prevention are provided in Table 3.⁵³

With the recent increases in home visiting funding, pediatricians may find that more resources are available for their patients, particularly those living in high-risk communities. However, pediatricians should also be aware of some of the challenges of program expansion and replication. Some interventions that worked well in relatively small randomized controlled trials may be less effective when implemented on a larger scale, with different community and service provider characteristics, and with fewer resources available for oversight and evaluation. Some programs that have demonstrated effectiveness in clinical trials have not performed as well when replicated.^{54,55} Pediatricians can assist families by advocating for adoption of high quality programs, with funding for ongoing evaluation. In addition, pediatricians should develop relationships with local home visitation programs to facilitate coordination of care in addressing family needs.

Parent training programs are intended to improve parents' comfort and competence with parenting. Program components may include child development, responsiveness, sensitivity and nurturing, positive interactions, emotional communication, and disciplinary approaches. The specific services and mode of implementation vary by program and may include individual, group, office-based, and/or home-based programs. Unfortunately, few program evaluations have directly measured child maltreatment outcomes, instead focusing on potential mediators such as child-rearing skills and emotional adjustment. A 2009 review of program reviews identified two meta-analyses (integration of data from multiple studies that examine similar outcomes) showing small to medium effects of parent training programs; others showed effects on child maltreatment risk factors, but not on actual maltreatment.⁵⁶ Several meta-analyses of parent training programs have identified characteristics that may improve program effectiveness.⁵⁷⁻⁶⁰ Programs that include multiple modalities and higher dosage of intervention are more likely to be successful.

Multimodal community-based interventions have also been developed, which may include home visiting, parent training, public service announcements, and/or primary care anticipatory guidance. One of the most effective programs is Triple P-Positive Parenting Program. Triple P focuses on addressing children's behavioral, emotional, and developmental problems, enhancing family protective factors, and reducing family risk factors for maltreatment.⁶¹

Five tiers of Triple P services are available to families; the services received depend on family needs. Tier 1 services are universal, and include print and electronic media messages. Goals are to increase awareness of parenting challenges and reduce or eliminate the stigma associated with participation in parenting programs. Tier 2 services are intended to address discreet behavioral or developmental concerns (e.g. toilet training, sleep). Trained program staff offer assistance by phone or in-person in a few brief sessions (e.g. two 20-minute sessions) or 60-90 minute seminars. More serious problems may require level 3 services; about 4 80-minute sessions that include active skills training. When parents have multiple concerns about their child or the child has more severe behavior problems, tier 4 services may be warranted. Assistance may be provided as individual, group, or self-directed services for up to 12 weeks. Tier 5 services are provided when, in addition to significant child behavior problems, parents have their own issues to address. Additional services may involve home visits and mental health services for parents.

An evaluation of Triple P implementation in 18 South Carolina counties showed promising effects in reducing child maltreatment. Counties that implemented Triple P had significantly lower rates of substantiated child maltreatment, fewer out of home placements, and fewer child maltreatment injuries that required inpatient or emergency department care.⁶²

Sexual Abuse Prevention

Prevention of child sexual abuse is addressed separately in this article because it poses unique challenges in developing effective interventions. While many caregiver risk factors have been identified for physical abuse and neglect, caregiver characteristics are much less predictive of sexual abuse. There is no typical profile of a sexual abuse perpetrator. This makes it challenging to develop prevention programs predicated on keeping children away from risky caregivers. In addition, some adults are uncomfortable with any discussion about sexuality as it pertains to their children. They may therefore be reluctant to participate in prevention programs directed at parents, and even more reluctant to allow their children to participate in prevention programs.

Pediatricians may be uniquely suited to educating parents about preventing sexual abuse. Parents typically listen to and trust their provider's recommendations and they have frequent contact with their pediatrician during the first few years of a child's life. While there are no studies examining the effectiveness of anticipatory guidance in reducing victimization, some general concepts can be extrapolated from other interventions. Several key concepts are summarized in Table 4.

Education-based prevention programs became prevalent in the 1980s and have been extensively studied and critiqued. Most are school-based and focused on understanding and protecting personal boundaries, identifying and avoiding dangerous situations, refusing sexual approaches and invitations, and telling an adult if inappropriate behavior occurs. Evaluations of these programs show that children do learn the concepts being taught, and that they respond appropriately when challenged during simulations.⁶³⁻⁶⁶ They also may lead to increases in sexual abuse disclosure, and decreased likelihood of self-blaming.^{67,68}

Few studies examining whether these programs lead to reductions in sexual abuse have been published. One retrospective case-control study with college-student participants did demonstrate a lower rate of sexual abuse among those students who recalled participation in a school-based program.⁶⁹ However, a prospective cohort study of 10-16 year old students did not show any difference in victimization rates between those who did and did not participate in a prevention program.⁶⁷ Critics of child-focused prevention programs have argued that it is unfair to expect children to bear the responsibility for preventing sexual abuse, and that it may be harmful to tell children that someone close to them could abuse them. However, program evaluations have identified few negative consequences.^{66,70}

Several public health media campaigns have been developed and disseminated in recent years. STOP IT NOW is a program first introduced in Vermont that incorporated public service announcements on television and radio, newspaper articles, bus advertising and an interactive website. Evaluation demonstrated greater awareness about sexual abuse, and an increased number of helpline calls.⁷¹ Darkness to Light educates parents and child serving

organizations about methods to keep children safe, including the avoidance of one adult-one child situations. A media campaign evaluation found that the program led to increased knowledge of sexual abuse, and improvements in protective behavior on hypothetical vignettes. Unfortunately these effects did not persist 9 months post-intervention.⁷² The Enough Abuse campaign takes a multi-pronged approach, incorporating education of adults and children, and advocacy efforts to ensure child-safety focused policies and regulations.

Advocacy

Pediatricians can be advocates for child maltreatment prevention in multiple ways, at the level of the individual child, parent, community, and society. Helping parents meet their children's needs is advocacy on behalf of individual children who may be unable to communicate these needs. Acknowledging parental stress, identifying other maltreatment risk factors and motivating and facilitating help-seeking efforts is another form of advocacy. Pediatricians can play leadership roles in implementing hospital-based abusive head trauma prevention programs and practice-based policies for risk-factor screening and anticipatory guidance. While pediatricians may not have direct involvement in community-based prevention programs, they can advocate for implementation and dissemination of quality home visitation and parent training programs in their community or state. Finally, pediatricians can advocate for increased resources to help families meet the needs of their children.

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Box 1**Opportunities for Child Maltreatment Prevention in Pediatric Primary Care**

1. Screen for child maltreatment risk factors, including parental depression, substance abuse, intimate partner violence, parental stress, harsh punishment, and food insecurity
2. Identify family protective factors (e.g. social support, self-efficacy, parenting competence)
3. Provide anticipatory guidance about challenging behaviors and developmental issues that may increase the risk for maltreatment (e.g. infant crying, toilet training)
4. Ask parents about discipline and help them replace corporal punishment with more effective and less harmful strategies
5. Discuss sexual development and behavior with parents. Help parents and children become more skilled in communication about sexuality and sexual abuse (see Table 4)
6. Become knowledgeable about the availability and effectiveness of local community-based resources. Encourage families to use your expertise to identify services that meet their needs.
7. Advocate for implementation and sustaining of community-based services to help families prevent maltreatment.
8. Advocate for implementation and sustaining of federal, state, and local programs that ameliorate underlying maltreatment risk factors (e.g. poverty, substance abuse, depression and other mental health disorders)

Box 2**Home Visiting Programs Meeting DHHS Criteria for an Evidence-Based Early Childhood Home Visiting Model**

ChildFIRST	Healthy Steps
Early Head Start-Home Visiting (EHS)	Home Instruction for Parents of Preschool Youngsters (HIPPY)
Early Intervention Program for Adolescent Mothers (EIP)	Nurse Family Partnership (NFP)
Early Start (New Zealand)	Oklahoma's Community-Based Family Resource and Support (CBFRS) Program
Family Check-Up	Parents as Teachers (PAT)
Healthy Families America (HFA)	Play and Learn Strategies (PALS) for Infants

Key Points

1. Prevention of child maltreatment can be incorporated into pediatric practice through anticipatory guidance, risk factor screening, and referral to community-based resources
2. There is wide variation in the methods and effectiveness of community-based prevention programs. Pediatricians should therefore be knowledgeable about what programs are available in their community and the evidence-based support for those programs
3. Pediatricians can be effective prevention advocates at the level of the individual patient and family, as well as at the local, regional, and national level.

Table 1

Examples of Child Maltreatment Risk Factors by Ecological Level

Child	Parent	Family	Community/Society
Prematurity	Teenage parent	Intimate partner violence	Violent/unsafe neighborhood
Colic/fussy baby	Depression/Anxiety/other mental health conditions	Single parent	Lack of availability of affordable, high quality child care
Chronic illness	Substance abuse	Poverty	Absence of community activities, programs for children
Emotional/behavioral difficulties	Poor impulse control	Unemployment	Lack of government support for social welfare programs
Developmental disability	History of abuse or harsh punishment as a child	Non-biologically related adult living in the home	
Physical disability	Lack of social support		
Unwanted child	Single parent		
Multiple gestation	Poor knowledge of normal child development & behavior		
	Major stress		

Table 2

On-line Resources for Information on Community-Based Prevention Programs

Resource	Website	Information Provided
DHHS, Administration for Children and Families - Home Visiting Evidence of Effectiveness	www.homivise.acf.hhs.gov/Default.aspx	Review of research on home visiting programs Program descriptions Evidence of effectiveness Findings by outcome domain
California Evidence-Based Clearinghouse for Child Welfare	www.cebc4cw.org	Topic area: Home visiting for prevention of child abuse and neglect Descriptions of specific home visiting programs Ratings of effectiveness in preventing child maltreatment
Centers for Disease Control and Prevention – Child Maltreatment: Prevention Strategies	www.cdc.gov/violenceprevention/childmaltreatment/prevention.html	Listing of Effective and Promising Programs Guidelines and Planning Tools
Promising Practices Network on children, families and community	http://www.promisingpractices.net/programstopiclist.asp?topicid=16	Listing and description of proven and promising programs
The Guide to Community Preventive Services: The Community Guide, What Works to Promote Health	http://www.thecommunityguide.org/violence/index.html	Systematic reviews of evidence for early childhood home visitation and other violence prevention topics

Table 3
Characteristics and Outcomes of Selected Evidence-Based Home Visitation Programs

Program	Type of Home Visitor	Eligibility	Program Components	Evaluation Design	Positive Outcomes - Child Abuse & Neglect	Other Positive Outcomes
Healthy Families America ^{73,74}	Paraprofessional	Risk-based screening	Home visits from 3 rd trimester to child age 2-3 years; biweekly to 1 year of age, then monthly	Multiple sites Randomized controlled trials	Yes – by parent report in randomized controlled trials; by substantiated child maltreatment report in quasi-experimental studies	Health care Birth outcomes Child behavior & development
Nurse Family Partnership ^{74,75-77}	Nurse Also Nurse vs. paraprofessional comparison	First time, low-income pregnant women. Prior to 28 weeks gestation	Home visits prenatal through 2 years Weekly to every other week to 20 months, then monthly	Multiple sites, randomized controlled trials	Yes – decrease in substantiated child protective service reports; not all sites.	Health care Birth outcomes Child behavior & development Other
Early Head Start ⁷⁸	Educators, trained paraprofessionals	Low-income	Pregnancy to age 3 Center-based services with at least 2 home visits/year Home-based services with weekly home visits and bi-monthly groups	Randomized controlled trial	Not measured Did find improvements in parenting behavior: more emotional support, fewer negative parenting behavior, less spanking at age 3	Cognitive development Child behavior Parent employment Parent emotional support to child
Teen Parents as Teachers ⁷⁹	Nurses, teachers, social service professionals, or trained parent educators	All families pregnancy to age 5	Pregnancy to age 5 Monthly, biweekly or weekly depending on family needs	Randomized controlled trial	Yes – fewer current suspected cases by CPS and school records, (Binghamton, NY program). No difference in confirmed cases or cases remaining open with CPS	Child behavior & development

Table 4
Anticipatory Guidance Messages to Parents and Children for Reducing Risk of Child Sexual Abuse

Message	Target	Example/Context
Only the doctors and specific adult caregivers are allowed to see "private parts"	Child	Pediatrician can mention this to the child during th genital exam
	Parent	Pediatrician can ask parent to clarify which caregiver(s) are permitted to bathe/clean/dress child
It is important to maintain open channels of communication	Parent	Pediatrician can talk to parents about ways to foster good communication. For example, parents can tell children that they can and should talk to them when something is bothering them or someone's behavior is making them uncomfortable.
	Child	Pediatrician can encourage children to talk to parents when something is bothering them or someone is making them uncomfortable.
Parents can do some things to limit opportunity for perpetrators to access children	Parent	Parents can limit some one-adult/one-child situations through their choice of child care provider and child activities.
Resources are available to help parents better understand child sexual abuse, communicate with their children about this topic, and take steps to protect them.	Parent	Pediatrician can provide parents with additional resources such as those from: Enough Abuse Campaign: www.enoughabuse.org Darkness to Light: www.d2l.org Stop It Now: www.stopitnow.org