The Child Maltreatment Prevention Landscape: Where Are We Now, and Where Should We Go?

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Child maltreatment calls for a broad range of preventative policies and practices, but limited governmental funding and leadership has been devoted to the problem. Effective strategies to prevent maltreatment exist, but they have had limited uptake in the child welfare system. In this article, we trace how government responsibility for the prevention of child maltreatment became centered within the nation's child protection response. Further, we discuss developments in prevention science, review the existing literature on the effectiveness of a range of prevention strategies, and present a public health approach to prevention. The article concludes with a set of recommendations to inform future efforts to prevent child maltreatment through approaches that seek to expand capacity for the implementation of evidence-based prevention programs, while addressing the adverse community experiences that exacerbate risk for child maltreatment.

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Child maltreatment arises from highly varied influences on children and families, such as parental mental health, intimate partner relationships, intergenerational caregiving experiences, community characteristics, and socioeconomic status. The prevention of child maltreatment requires an equally broad view and response. From the inception of the child protection system in the United States, child welfare policies have laid the blueprint for a largely reactive child protection response. Meanwhile, interdisciplinary research and development occurring outside of

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the child welfare policy framework in fields such as behavioral science, early care and education, pediatric primary care, child development, child psychology, and others have produced an array of programs with demonstrated effectiveness in preventing child maltreatment, such as early childhood education and parenting interventions. However, widespread implementation of effective child maltreatment prevention strategies has been slow and uneven.

In this article, we trace how governmental responsibility for child maltreatment prevention became centered within the nation's child welfare system, initially created to ensure the protection of children who were at risk for or had experienced abuse or neglect. We also discuss developments in prevention science, present a public health approach to prevention, and review the existing literature on the effectiveness of a range of prevention strategies. The article concludes with a set of recommendations to inform future efforts to prevent child maltreatment through approaches that seek to expand capacity for the adoption and implementation of evidence-based prevention programs, while addressing the adverse community experiences that exacerbate risk for a host of adverse childhood experiences, of which child maltreatment is one of the most deleterious.

Child Protection and Child Maltreatment Prevention: A Brief History

In 1912, Congress established a broad role for the federal government in the welfare of children with the creation of the U.S. Children's Bureau. In the wake of the Great Depression, the Social Security Act of 1935 furthered the government's role in ensuring children's welfare by creating the Aid to Dependent Children (ADC) cash assistance program and expanding the role of the Children's Bureau in its implementation through cooperation with state public welfare agencies. Public assistance in the form of ADC, and later Aid to Families with Dependent Children (AFDC) in 1962, continued as a single federal response to child and family need

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and might be thought of as one of the earliest strategies in the primary prevention of child maltreatment (Berrick and Heimpel 2019). However, in time, the behavior of parents came to be viewed as separate from their financial needs through a series of key developments in the 1960s that would emphasize legal, cultural, medical, and technological perspectives for responding to maltreatment. The passage of the 1974 Child Abuse Prevention and Treatment Act (CAPTA) formalized a narrow role of the federal government in family life and squarely placed prevention within the federal response to child maltreatment but emphasized reporting of victims and perpetrators rather than family-focused services. Despite the breadth of new activity under CAPTA and the inception of modest financial opportunities for states to develop child abuse and neglect identification and prevention programs, CAPTA's narrow approach failed to address the depth and complexity of concerns facing families with limited resources. In its early years, CAPTA authorized research into child abuse prevention and treatment and created the National Center on Child Abuse and Neglect (2014). Primary prevention would not, however, become a major focus of the field for at least two more decades.

The 1990s ushered in a series of developments that culminated in the federal prevention policies and programs in place today. Community-Based Child Abuse Prevention (CBCAP) funds were provided through a small formula grant (still only at $39 million as of fiscal year [FY] 2019) to state-designated lead agencies for the primary prevention of child maltreatment through family strengthening and support services, interagency collaboration, and the development of prevention networks. The Family Preservation and Support Services Act (FPSSA) of 1993 revised Title IV-B of the Social Security Act to support states in creating a continuum of services to promote family strengths, enhance parental functioning, and preserve families in crisis. The act required states, for the first time, to engage in a comprehensive planning process with broad community input across programs and funding streams to develop more responsive prevention strategies. However, these funds, later reauthorized as the Promoting Safe and Stable Families program, are largely designated to address the prevention of placement into foster care.

The next 20 years of federal child welfare policy observed a number of significant changes focused on reducing foster care impermanence, improving outcomes for youth emancipating from foster care, and reducing the use of residential treatment (Child Welfare Information Gateway 2019). Most recently, the Family First Prevention Services Act of 2018 authorized a shift in child welfare financing to support states' use of evidence-based programs to prevent foster care entry (see Haskins, this volume; Testa and Kelly, this volume). However, beyond CBCAP, few policies have focused explicitly on preventing child maltreatment before it occurs.

Prevention Science

At the turn of the twenty-first century, scientific breakthroughs in early brain development drove renewed interest in primary prevention and efforts to increase

coordination across child serving systems, particularly in the early childhood arena. Additionally, advances in the field of prevention science precipitated the implementation and evaluation of prevention strategies across multiple service sectors. The prevention science approach integrates many strands of research, including life course development, community epidemiology, etiology of disorders, intervention efficacy and effectiveness trials, and dissemination research (Hawkins 2006). Consistent with its overarching goal to prevent the manifestation of disorders or dysfunctions, research in prevention science is designed to inform policy-makers and practitioners about the best strategies to mitigate the causes of dysfunction. As such, prevention science is grounded in the conceptualization that adverse health, developmental, mental health, and life course outcomes are attributable to a variety of empirically based risk and protective factors. Thus, to be effective, prevention strategies should be designed to reduce risk factors and enhance protective factors among individuals, families, and their social ecologies.

Risk for child abuse and neglect perpetration and victimization is influenced by a number of factors that interact to increase or decrease risk over time and within specific contexts. Factors that protect or buffer children from being abused or neglected are known as protective factors. Although risk factors provide information about who is most at risk for being a victim or a perpetrator of child maltreatment, it is important to note that they are not direct causes and cannot predict who will be a victim or a perpetrator (for additional discussion, see Font and Maguire-Jack, this volume). The Centers for Disease Control and Prevention (CDC; 2016) has adopted a four-level social-ecological model that considers the interplay between risk and protective factors at the (1) individual, (2) relationship, (3) community, and (4) societal levels to inform violence prevention strategies (Fortson et al. 2016). Although the forces that contribute to the most commonly studied forms of child maltreatment (i.e., neglect, physical abuse, sexual abuse, and emotional maltreatment) differ, we argue that the factors are layered and, in the main, commonly shared.

The determinants of child maltreatment are typically understood as involving the interaction of social-ecological and transactional factors (Cicchetti and Toth 2005). At the first level of the CDC (2016) framework, key individual factors associated with neglect perpetration or victimization include parent anger/hyperreactivity, depression, substance use, low levels of social support, young parental age, unemployment, single parenting, large family size, and low family socioeconomic status (Stith et al. 2009; Slack et al. 2011). At the CDC's second level of relationships, parent-child dynamics are inextricably part of physical abuse, sexual abuse, emotional maltreatment, and, even, child neglect (Stith et al. 2009).

A growing number of studies have identified risks for child maltreatment at the *third level* of community including neighborhood characteristics, conditions, and social processes (e.g., Marco et al. 2020). Neighborhood collective efficacy (i.e., the degree to which communities exhibit social cohesion, informal social control, and mutual trust) and social organization have been found to enhance or weaken the ability of parents to care for their children (e.g., Freisthler and Maguire-Jack 2015). Neighborhoods and other social institutions almost certainly interact with child and family characteristics. For example, supportive neighborhoods appear

protective for African American girls insofar as they are associated with less exposure to adverse childhood experiences (Melton-Fant 2019).
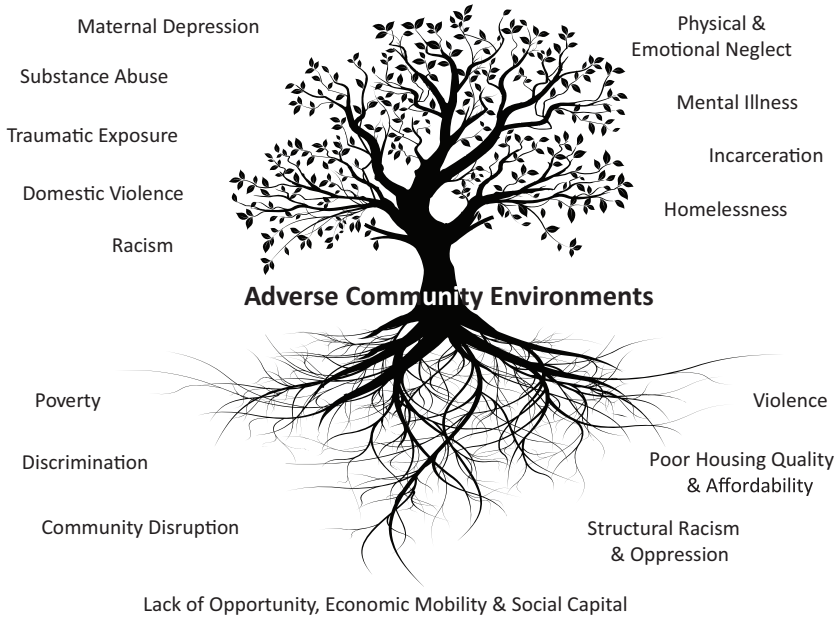
At the *fourth level* are societal factors, including social norms about the acceptability of child maltreatment and social benefit programs that strengthen household financial security. Analyses of American social norms find a general rejection of the acceptability of child maltreatment, that prevention frameworks need to be strengthened, and that prevention is possible (Klika, Haboush-Deloye, and Linkenbach 2019). Also operating at this level are local, state, and federal programs that support basic human needs and that monitor and respond to shortcomings in the provision of inadequate care at the family or community levels. For example, a recent series of experimental and quasi-experimental studies that evaluated the effects of providing economic assistance to families with limited resources attests to the role of income in child maltreatment dynamics. Specifically, rigorous evaluations demonstrate that increases in income via state-level Earned Income Tax Credit programs reduce abusive head trauma hospitalizations (Klevens et al. 2017) and family involvement with child protective services (Berger et al. 2017). State restrictions on access to Temporary Aid to Needy Families (TANF) are significantly associated with increases in the number of child protection reports, victims of child maltreatment, as well as foster care placements, even after controlling for changes in incarceration and the nation's opioid epidemic (Ginther and Johnson-Motoyama 2017). Participation in nutrition assistance programs (e.g., Lee and Mackey-Bilaver 2007), the expansion of Medicaid (e.g., Brown et al. 2019), and supportive housing experiments (e.g., Farrell et al. 2018) have also been associated with child maltreatment prevention as well as a range of other positive child and family outcomes. Yet the U.S. child maltreatment prevention landscape, which emphasizes specific prevention programs, does not significantly build upon the more universal social and health programming available in other Western countries.

Beyond the CDC's model, Ellis and Dietz (2017) have conceptualized, in their discussion of health disparities, two broad clusters of problematic influences that are co-occurring with child maltreatment. They frame the general influences as the "two ACEs": adverse childhood experiences (commonly referred to as ACEs) and adverse community environments (see Figure 1). Child maltreatment is a specific adverse childhood experience that often occurs in the context of, and in combination with, multiple adverse childhood experiences and is more likely to be activated for children living in adverse community environments (Friesthler and McGuire-Jack 2015). *More broadly, adverse childhood experiences have a significant antagonistic relationship to individuals' short- and long-term health* (Jones, Merrick, and Houry 2020).

Adverse Childhood Experiences

The likelihood and impact of child maltreatment is also aligned with a critical body of research on poly-victimization (the increased likelihood of victims to

FIGURE 1
Lack of Opportunity, Economic Mobility, and Social Capital

Maternal Depression

Substance Abuse

Traumatic Exposure

Domestic Violence

Racism

Physical &
Emotional Neglect

Mental Illness

Incarceration

Homelessness

Adverse Community Environments

Poverty

Discrimination

Community Disruption

Violence

Poor Housing Quality
& Affordability

Structural Racism
& Oppression

Lack of Opportunity, Economic Mobility & Social Capital

experience multiple forms of violence) (Turner, Finkelhor, and Ormrod 2010), poly-perpetration (the increased likelihood of those who commit violence in one context to commit violence in other contexts), common consequences of different forms of violence, and the common risk and protective factors for different forms of violence over the life course (Wilkins et al. 2014). Further, the number of types of maltreatment experienced (e.g., physical, sexual, emotional) is associated with the likelihood of perpetrating violent delinquency in adolescence (Wolfe 2018).

This body of research is moving the field away from looking for single causes or antidotes to child maltreatment and toward common causes that suggest interventions that reduce exposure to adverse acts and environments that are cumulative, ubiquitous, and toxic risks for children (Wolfe 2018). Notably, economic conditions feature heavily across the multilevel axis of risk for multiple forms of violence (Wilkins et al. 2014). A consistent body of research demonstrates the relationship between economic hardship and child maltreatment (e.g., Berger and Waldfogel 2011) and its disproportionate impact on children of color (see Dettlaff and Boyd, this volume).

Reinforcing our understanding of the array of adverse family and community factors associated with the likelihood, and outcome, of child maltreatment is the recognition that child maltreatment is not necessarily a singularly influential risk factor for later behavioral problems. Maltreated children are likely to have many other vulnerabilities and untoward influences. Thus, maltreatment can be

conceptualized as a signal of more general problems in the environments of our most vulnerable children, rather than the problem itself (MacKenzie et al. 2011).

To address the breadth and magnitude of human dysfunction, prevention science has evolved as an interdisciplinary field that incorporates many scientific frameworks. More recently, prevention science has integrated knowledge from developmental science. In this vein, scholars advocate for a developmental approach to prevention design (Wulczyn et al. 2005). They postulate that the effects of risks vary depending on the developmental phase of the individual. For example, very young children may be more susceptible to the effects of risks, as well as more amenable to the benefits of preventive intervention, as a result of the rapid brain and behavioral maturation that occurs during this developmental period (Shonkoff 2010).

A developmental approach to the design of prevention strategies also emanates from two conceptualizations of the impact of adversity on children's functioning. First, Toth and Cicchetti (2013) argue for the use of a developmental psychopathology framework to address child maltreatment, which employs a developmental perspective to understand children's adaptation and maladaptation in the face of maltreatment and the varying outcomes of maltreatment. A second perspective emanates from Shonkoff's (2010) biodevelopmental framework, in which maltreatment can be understood as an experience of toxic stress that potentially disrupts brain architecture, compromises physiological and psychological responses to future stressors, limits development, and increases lifelong vulnerability to stress-related illnesses. Taken together, these conceptualizations underscore the import of positive caregiving to attenuate risks for maltreatment and promote resilience in maltreated children.

From an epidemiologic standpoint, Wulczyn et al. (2005) have asserted that interventions for maltreated children should be designed using a developmental perspective because children are more vulnerable to child welfare involvement at distinct periods (i.e., the beginning of life, during the transition to formal schooling, and in adolescence). They have argued for a developmental approach to linking families with appropriate programs in the child welfare system. Thus, preventive interventions should employ strategies that are aligned with the age of the target child and account for the distinct outcomes for children of different ages when they experience child welfare involvement.

A Public Health Approach to Prevention

Addressing the complexity of maltreatment through a prevention science lens, scholars have also advocated for using a public health approach in the design of strategies to prevent maltreatment (Prinz 2016; Whitaker, Lutzker, and Shelley 2005). Specifically, a public health approach would entail research that examines rates of maltreatment in the general population, studies on the risk and protective factors pertinent to maltreatment, the design and evaluation of interventions to address maltreatment, and the dissemination of evidence-based interventions

to prevent maltreatment (Whitaker, Lutzker, and Shelley 2005). With respect to maltreatment prevention, a public health framework would entail a three-tiered approach that addresses (1) the point in the trajectory of maltreatment that an intervention occurs (i.e., primary, secondary, and tertiary) and (2) the maltreatment intervention's target population (i.e., universal, selected, and indicated) (Institute of Medicine and National Research Council 2009, 2014; see also Roygardner, Hughes, and Palusci, this volume).

The first tier of prevention strategies includes primary and universal approaches to prevent maltreatment. Primary strategies are designed to prevent the onset of maltreatment; universal strategies are geared to entire populations or vulnerable subgroups of a population (e.g., low-income families with no evidence of maltreatment). Thus, primary/universal prevention approaches aim to reduce the incidence of maltreatment and related outcomes through the implementation of population-based programs. These strategies may ameliorate risk factors for child maltreatment, such as poverty and violence in communities, and promote positive outcomes in vulnerable subgroups of families and children (e.g., families living in poverty).

In the second tier are secondary and selective intervention strategies to prevent maltreatment. The purpose of secondary preventive interventions is to reduce harm from the experience of risk factors associated with maltreatment. Selective interventions are targeted to individuals who have demonstrated elevated risk for maltreatment. Thus, secondary/selective interventions are designed to ameliorate the effects of maltreatment risks, such as parental physical and mental illness, parental lack of knowledge and skill about parenting and how to promote child development, family social isolation, child physical and psychological disabilities, and inadequate concrete resources (Institute of Medicine and National Research Council 2014), as well as the double ACEs that we mentioned earlier in this article.

Finally, the third tier of maltreatment prevention programs includes tertiary and indicated preventive interventions. Tertiary prevention approaches aim to prevent the recurrence of maltreatment and its adverse outcomes or mitigate the outcomes of maltreatment. Indicated preventive interventions are targeted to individuals who display symptoms emanating from exposure to maltreatment. As such, tertiary/indicated preventive interventions are designed to counteract the effects of abuse and/or neglect on maltreated children and their families and may have family preservation or placement prevention as a goal. Although programs at this level may entail involuntary services (i.e., court-mandated) or therapeutic treatment, they are beyond the scope of this article.

Services and Programs to Prevent Maltreatment

Despite the relatively low level of child welfare financing targeted to prevention services, policy-makers, practitioners, and researchers have brought attention to these services and their relation to child welfare outcomes. Studies that have

examined the effectiveness of prevention services financed through federal child welfare financing mechanisms such as CBCAP have typically lacked rigorous evaluation, leaving considerable gaps in our knowledge about the programs' effectiveness in the primary prevention of child maltreatment (Institute of Medicine and National Research Council 2014). Services funded through Title IV-B of the Social Security Act have historically focused on secondary or tertiary prevention by preventing the recurrence of child maltreatment and foster care entry through "usual care" services: the screening of hotline calls, assessment or investigation of a number of accepted reports (which varies by jurisdiction), and the provision of services ranging from brief family visits and resource referrals to longer-term case management and intensive family preservation services (Jonson-Reid et al. 2017). Well-designed studies that have examined the extent to which usual care services have been successful in achieving child protection's tertiary prevention goals have yielded inconsistent and often disappointing findings that have raised questions about the capacity of such services to ameliorate the often complex and chronic needs of the families served (Jonson-Reid et al. 2017).

Further, there have been many evaluations (with comparison groups) of differential response (DR) programs, which provide a modicum of services in lieu of formal court-ordered services. Results have demonstrated that child safety, typically measured by report recurrence, substantiated rereport, or removal of a child from the home, is not significantly different than it is for those involved with more formal child welfare services (e.g., Fluke et al. 2019; Fuller and Zhang 2017). Although many questions about DR remain, including the threshold of risk and level of utilization at which child safety can be maintained without court supervised services (Fluke et al. 2019), a recent quasi-experiment in economics found states using DR experienced fewer victims and foster care entries over time when compared to states without the program (Johnson-Motoyama et al. 2020). The reductions in victims and foster care entries were causally related to the implementation of DR, suggesting DR may have an important role in secondary and tertiary prevention.

Despite the small number of policy-level studies on prevention services, a proliferation of programs to prevent child maltreatment has emerged from prevention science research. Further, the wide-ranging research on risk and protective factors for maltreatment has facilitated the design and evaluation of prevention programs that address influences on and features of maltreatment. In this section, employing a public health approach, we describe the strategies found to be effective in preventing maltreatment at the primary, secondary, and tertiary levels. Although maltreatment can occur in the context of other perpetrators (e.g., peers, school personnel, other adults), we focus herein on the prevention of maltreatment by birth parents.

Because we cannot discuss every program documented to prevent maltreatment, we also include two tables that delineate a broader range of programs found to be effective in reducing maltreatment (see Table A1 in the online appendix) and enhancing parenting outcomes related to maltreatment (see Table A2 in online appendix). Only programs that have been evaluated using rigorous designs (i.e., experimental or quasi-experimental), or are delineated in evidence-based

clearinghouses are included. These tables offer a brief description of the programs, the developmental phase of the target population of children, the designs used to evaluate the programs, and information pertinent to program effectiveness (i.e., formal designation as effective, magnitude of effects). Our delineation of programs is presented with an understanding that other prevention programs that are more community-driven and socio-culturally grounded may not appear in designations of evidence-based programs but may nevertheless be effective for specific populations (Tawa 2020).

Primary prevention of maltreatment

Primary prevention strategies aim to prevent maltreatment by promoting protective factors for optimal family functioning. They are often universal programs (i.e., geared to an entire population of families) but may also be targeted to families at risk (e.g., low-income families) who do not necessarily display risk for maltreatment. Strategies for the primary prevention of maltreatment include early care and education, home visitation, clinic-based programs, school-based programs, and community education and mobilization initiatives.

Early childhood education programs. Robust evidence exists for the positive effects for young children and their families of participation in early care and education programs. These programs tend to serve low-income families with children under the age of five and have enhanced child development as a major goal. Many of these programs are comprehensive and two-generational (i.e., targeting the development of the parent and child), with an explicit focus on promoting positive parenting and parent-child interaction. The programs may include center-based services (i.e., provide full-time childcare for young children) as well as home-based services. Typically, these programs provide supportive services to parents on a global or an as-needed basis (e.g., general parenting education, self-sufficiency services, case management and referral to public income supports and other concrete services), but do not necessarily provide family-specific, intensive interventions to improve parenting. However, the family support provided by these programs may be the mechanism by which they reduce maltreatment. Early care and education programs have been documented to prevent maltreatment, including reduced child protection reports (Early Head Start: Green et al. 2014; Chicago Child-Parent Centers: Reynolds and Robertson 2003).

Home visitation. High-quality home visiting programs represent another primary preventive strategy found to enhance child and family functioning, as well as to reduce the incidence of child maltreatment (Donelan-McCall, Eckenrode, and Olds 2009). These programs tend to recruit parents during the prenatal or early postnatal period and provide preventive services to families during infancy and early childhood. Depending on the program, home visits may be offered weekly or the dosage may be determined based on specific family characteristics. Many of these programs use nurses as the service providers; others employ developmental

specialists or social workers to deliver the home-based services. Fueled to a great extent by the recent Maternal, Infant, and Early Childhood Home Visiting legislation (MIECHV; Administration for Children and Families 2020), research has documented the positive impact of several high-quality home visiting programs on global parenting and maltreatment-specific outcomes (see Sama-Miller et al. [2017] for a review; Nurse Family Partnership: Olds et al. 2014; Family Connects: Dodge et al. 2014; Family Check-up; Dishion et al. 2015).

Clinic-based programs. There has been recent growth in the delivery of primary prevention programs during early childhood (i.e., zero to five years), which are situated in pediatric care clinics. These models supplement conventional preventive medical services with a child development specialist or social worker, who provides developmental and parenting guidance to parents, as well as case management services, during children's pediatric visits. Additionally, health care personnel may be trained to understand early childhood development and mental health. Clinic-based models of primary prevention show promise with respect to preventing maltreatment and promoting positive parenting practices in the context of pediatric care (SEEK: Dubowitz et al. 2009; Healthy Steps: Minkovitz et al. 2003).

School-based programs. Many programs aimed at preventing sexual abuse are based in schools. Schools are an excellent context in which to share information about abuse prevention because teachers can reach a wide audience of children before they are affected by maltreatment. Almost all school-based programs involve discussions, and many involve modeling and interactive learning with role-play or behavioral skills rehearsal (Topping and Barron 2009; Walsh et al. 2018). Meta-analyses have concluded that school-based programs can have positive effects on self-protection, personal safety knowledge, awareness of others' behavioral intentions, and knowledge about abuse behaviors (Topping and Barron 2009; Walsh et al. 2018). However, findings regarding disclosure of abuse, a key outcome, have been inconclusive in most studies (Walsh et al. 2018). Longer programs (i.e., four or more sessions) and programs that had an experiential component for children seemed to be more effective (Davis and Gidycz 2000).

Community education and mobilization. Representing a distal primary prevention approach, community education and mobilization have been employed to prevent maltreatment at a population or community level. These strategies include media campaigns, global parenting education provided in community settings, and community mobilization efforts. For example, public education campaigns have been mounted in many states to address a specific form of infant maltreatment—abusive head trauma (also known as Shaken Baby Syndrome)—but they have yielded varying and inconclusive results (Zolotor et al. 2015). Leventhal, Asnes, and Bechtel (2017) have advocated for integrating these strategies into other primary prevention programs (e.g., home visiting), addressing

parental affect, and targeting male caregivers who are often perpetrators of this form of maltreatment as a means to strengthen program effectiveness.

Media campaigns for the primary prevention of other forms of maltreatment have also been launched by scholars and practitioners in the field of child abuse and neglect. In a systematic review of universal campaigns to reduce physical abuse, Poole, Seal, and Taylor (2014) documented enhanced parental self-efficacy and knowledge of concepts and actions relevant to preventing child abuse, but more variability in outcomes regarding reductions in physical abuse. Similarly, findings from evaluations of media campaigns to prevent child sexual abuse are somewhat mixed (e.g., Rheingold et al. 2007).

Community mobilization efforts to prevent child maltreatment often enlist volunteers and community members to support families at risk for maltreatment. Although there are many examples of these community mobilization strategies, many of these initiatives have not been subject to rigorous evaluation. A rare example is Strong Communities for Children (SCC), designed to prevent the maltreatment of children from birth through adolescence, which yielded many benefits for families including decreased parental stress, substantiated child maltreatment, and childhood injuries related to maltreatment, as well as enhanced social support, collective efficacy, child safety, and parenting practices (McDonnell, Ben-Arieh, and Melton 2015).

Secondary prevention of maltreatment

Secondary prevention strategies focus on families that have been identified as at risk for maltreatment. Programs in the secondary prevention arena are designed to promote the parenting skills of individuals at risk of maltreating their children, may concentrate on risk factors for maltreatment, or may be adapted from theoretically and evidence-based parenting interventions.

Home visitation. Home visiting programs in the secondary tier address the functioning of families who have displayed risk for maltreatment. Similar to programs in the primary tier, these programs may be comprehensive in nature, geared toward improving family, parenting, and child outcomes, and longer in duration (e.g., two to five years). An exemplar of this approach is Healthy Families America (HFA), which uses an eligibility screener for families to determine risks of maltreatment. HFA evaluations have documented reductions in child maltreatment (e.g., DuMont et al. 2011; Lee et al. 2018), more positive parenting practices (e.g., LeCroy and Krysik 2011), improved home environments, and decreased violence in the home (LeCroy and Lopez 2020).

Other home visiting programs in the secondary tier are intensive in terms of content (e.g., specific set of parenting skills) and format (e.g., parent-child interaction), and tend to be brief in duration (e.g., 10–20 weeks). Many have a foundation in attachment theory, underscoring attachment as a critical developmental milestone, and a focus on promoting positive parent-child interaction. Others are grounded in social-cognitive theory, with a focus on parent management. Regardless of theoretical orientation, these programs tend to be

very experiential, employing active coaching to promote improved parenting behaviors. More recently, some have been integrating video feedback as a method of facilitating participants' observation, awareness, and change relative to their parenting practices. Burgeoning research demonstrates the benefits of several high-quality home visiting models with respect to maltreatment risk, specifically increased sensitive and responsive parenting (e.g., Attachment and Bio-behavioral Catchup: Dozier and Bernard 2019; Promoting First Relationships: Oxford et al. 2016), less physical punishment (Cognitively-Enhanced Home Visiting: Bugental and Schwartz 2009), improved child safety (Family Connections: Collins et al. 2011), and reduced child abuse recidivism (Safe Care: Chaffin et al. 2012).

Interventions to address parental risks. Because secondary prevention programs address risk factors for maltreatment, it is important to identify specific caregiver risks for maltreatment when designing preventive interventions. Interventions designed to explicitly address these risks in the context of parenting have been found to affect maltreatment risk. For example, substance using mothers participating in parenting interventions displayed more sensitive and responsive caregiving (Mothers and Toddlers Program: Suchman et al. 2010) and reported reductions in their child abuse potential (Parents under Pressure Program: Dawe 2009). Mothers affected by intimate partner violence who participated in a risk-specific parenting intervention were more likely to show a decrease in their use of corporal punishment over the course of the intervention than those who did not participate in the intervention (Moms' Empowerment Program; Grogan-Kaylor et al. 2019).

Parent management interventions. Parent management interventions are grounded in social-cognitive theory and aim to reduce maltreatment by increasing parental skill at managing child behavior. Such interventions may be delivered in multiple settings, including the home, early childhood center, school, or mental health clinic. Because children and adolescents who exhibit behavior problems are more likely to have experienced maltreatment (Mills et al. 2013), parent management interventions assist parents to alter their cognitions and behaviors in response to children's and adolescents' negative behaviors.

Parent management programs appear to be an effective method of treating externalizing behaviors and disorders and reducing harsh parenting behaviors (Dretzke et al. 2005; Weber et al. 2018). These programs typically follow two approaches: behavior change (e.g., teach specific parenting skills to reduce problem behaviors) or relationship building (e.g., facilitate responsive parent-child interaction). Programs are typically short (several weeks), conducted in individual or group format, and administered by therapists or other qualified individuals (e.g., social workers, psychologists). Many of these programs are geared toward children from 2 to 12 years of age. Research has found such interventions to be effective in preventing new reports of physical abuse and reducing child welfare recidivism (Parent Child Interaction Therapy: Chaffin et al. 2011; Batzer et al.

2018), as well as increasing the use of appropriate discipline and praise/incentives among families at risk of neglect and improving parents' nurturance and positive affect in families with a history of maltreatment (The Incredible Years; Webster-Stratton and Reid 2010).

Tertiary prevention of maltreatment

Tertiary-level prevention programs have a goal of preventing the recurrence of maltreatment or maladaptive outcomes associated with maltreatment. Due to their focus on preventing maltreatment among families with the most intensive needs, these programs often have an intensive, therapeutic component that seeks to reduce maltreating parents' negative parenting behaviors. They may have a relationship-based approach in which providers intervene with nurturance and reflection, or may have a parent management orientation, in which providers actively coach parents to alter negative interaction patterns with their children.

Evaluations of relationship-based programs have shown benefits for partici-pant families with regard to maltreatment risk, including increases in secure attachment and decreases in disorganized attachment among maltreated chil-dren (Child Parent Psychotherapy [CPP]: Stronach et al. 2013); reductions in behavior problems and trauma-related symptoms (CPP: Lieberman, Ippen, and Van Horn 2006); and decreases in parenting stress, maternal psychopathology, and family involvement with the child protection system (Child First: Lowell et al. 2011). Parents who participated in a parent management intervention showed reductions in disruptive child behavior, dysfunctional parenting, parental distress and relationship conflict, negative parental attribution for children's mis-behavior, potential for child abuse, unrealistic parental expectations, rates of child protection systems reports, foster care placement, and abuse/neglect related medical injuries (Triple P; Prinz et al. 2009; Sanders et al. 2014).

Summary and Recommendations

Contemporary approaches to the prevention of child maltreatment in public health typically entail a four-step process of establishing the prevalence of mal-treatment in general and specialized populations, building knowledge of the risk and protective factors for maltreatment, designing and testing strategies to pre-vent and address maltreatment, and widely disseminating evidence-based strate-gies to prevent maltreatment (Hanson et al. 2012). As other articles in this volume note, progress has been made toward the first two steps of this model through periodic national child maltreatment incidence surveys in the general population, ongoing surveillance data for the population of children reported to child protection agencies, etiological research regarding risk and protective fac-tors, and research on the consequences of child maltreatment.

Further, as outlined in this article, a growing number of studies have contrib-uted to the third step of developing and testing effective interventions. Several

meta-analyses and reviews have documented the impacts of maltreatment prevention programs (e.g., Chen and Chan 2016; Euser et al. 2015; Gubbels, van der Put, and Assink 2019). In general, these reviews have suggested that parent training programs, no matter at which level of prevention or theoretical orientation, tend to be effective in preventing child maltreatment. Programs with moderate dose and duration have more consistently favorable outcomes than very short or very long programs. Maltreatment prevention programs such as high-quality home visiting and parent training programs have small to moderate effects on maltreatment and related risk factors (Chen and Chan 2016; Euser et al. 2015; Gubbels, van der Put, and Assink 2019). However, when the outcomes are narrowed to direct measures of child maltreatment, effects are generally small (Euser et al. 2015).

Despite evidence of positive impacts, critical questions remain about prevention programs' capacity to reduce maltreatment, which should be prioritized for research investment. First, many of the evidence-based programs have not been taken to scale and implemented and evaluated in "real-world" community contexts and have not been tested with a broad range of sociocultural groups. In addition, many of these programs have not been tested with child welfare–involved families, or families that display extreme risk for maltreatment. Many evaluations of prevention programs have not included outcome measures of child maltreatment, such as substantiated CPS reports, child injuries, or out-of-home placements. Instead, evaluations have tended to focus on outcomes related to risk and protective factors for maltreatment, which are difficult to compare across studies. Additionally, the magnitude of the effects of the programs are variable; thus, there may be limited "clinical and practical significance" with respect to the differences between program participants and those who did not experience the program. Effect size information is not available for many evaluations at the population level because exact sample sizes are unknown. Further, many interventions are only effective for certain subgroups and cannot be compared to programs created for the entire population. Finally, many studies of the effectiveness of programs for the reduction of maltreatment are not methodologically rigorous and do not use "gold standard" designs such as randomized control trials or high-quality quasi-experimental designs.

These caveats notwithstanding, extant evidence underscores that child and family service entities should integrate evidence-based, developmentally appropriate preventive interventions into their ongoing work with vulnerable families. However, scholars have suggested that these interventions are not broadly utilized by clinicians or child welfare systems, a necessary fourth step in the public health process that requires dedicated investments (Toth and Manly 2011; Saul et al. 2008). The lack of widespread adoption and implementation can be partly attributed to a range of key system-level factors, including leadership, organizational capacities and resources, and relationships between stakeholders across multiple sectors that must be addressed to advance prevention (Smith, Wilkins, and McClure 2020).

First and perhaps foremost, national leadership to coordinate and deliver effective child maltreatment prevention strategies has not been well organized or

funded. Roughly a quarter century after CAPTA was originally funded and managed under the Children's Bureau to provide a modest and decentralized source of support for case finding, the CDC has been given a greater role in reframing child maltreatment as a public health concern in the United States. The CDC's vision has been expressed through national objectives conveyed in the Healthy People's 2020 initiative (U.S. Department of Health and Human Services 2020); technical packages for policy, norm, and programmatic activities that cut across multiple health and social welfare policies; funding streams and governmental activities (Fortson et al. 2016); and a strategic vision for addressing the overlap among multiple forms of violence (CDC 2016).

The CDC's (2016) vision focuses attention on four areas: "(1) the developmental periods of childhood and adolescence, where prevention efforts are likely to achieve the greatest long-term impact; (2) the populations and communities that disproportionately bear the burden of violence in society; (3) the shared risk and protective factors that are most likely to influence multiple forms of violence; and (4) priority to the programs, practices, and policies that are most likely to impact multiple forms of violence." Connecting child maltreatment to the health sector is long overdue but is still not accomplished at the state level, where child abuse prevention continues to be excluded from the main strategic efforts of health departments (see, also, Roygardner, Hughes, and Palusci, this volume).

Our broader understanding of how child maltreatment occurs also demands an expanded response to child maltreatment prevention that incorporates a developmental perspective in its interplay with levels of family adversity. Singular efforts such as increasing parent skills training or relationship enhancement—although helpful in their singular way at certain points in a child's development—do not satisfactorily match up with the dynamic and multiply determined phenomena of child maltreatment. Therefore, population-level reductions to child maltreatment are unlikely to be achieved solely through scaling up particular evidence-based programs but rather through comprehensive national and local efforts that combine the dissemination of evidence-based strategies with approaches that address social, economic, health, education, and policy-system levers. Preventing exposure to the dual ACEs associated with child maltreatment requires a strong and sustained social and public health strategy that is integrated across child and family serving systems and sectors (for a detailed discussion, see Feely et al., this volume).

The CDC, in its technical manual, has identified seven necessities: (1) *strengthen economic supports for families*, (2) *promote social norms that protect against violence and adversity*, (3) *ensure a strong start for children*, (4) *enhance parenting skills to promote healthy child development*, (5) *intervene to lessen harms and prevent future risk*, (6) *engage and connect services across sectors, and* (7) *monitor, evaluate, and improve*. Notably, only the last requires the central role that we often assign to child welfare services and to medical and legal specialists in child abuse and neglect. All the other elements can be steered by designated leaders and implemented by an array of other organizations that need not have specialty training. Thus, efforts by child maltreatment specialists can be pursued in tandem with comprehensive community-based ACE prevention strategies and

evidence-based approaches that ensure a strong start for children, enhance the coping skills of parents and youth, connect youth to caring adults and activities, promote social norms that protect against violence and adversity, and strengthen economic supports for families (Jones, Merrick, and Houry 2020).

At the same time, when young children are at the highest levels of risk, their families are repeatedly engaged with CWS, and children are experiencing poly-victimization, there is a need for intensive, coordinated, and longitudinal care (National Academies of Sciences 2016). There is evidence that a call to a child protection hotline, regardless of the disposition, is the best predictor of a later child abuse or neglect fatality (Commission to Eliminate Child Abuse and Neglect Fatalities 2016). Further, research shows that CWS involvement as a child is related to CWS involvement when the child becomes a parent, although there is considerable variation in outcomes that requires flexibility in response (Eastman and Putnam-Hornstein 2019). Taken together, the accumulating information on the risks of subsequent child maltreatment among those who have ever been reported to CWS and ever been involved with CWS requires developing an approach with more sustained engagement and support provided to families.

We also have an ongoing need for linked data and collaboration across multiple programs for multiple purposes including surveillance, evaluation of existing and new policies, planning and implementation of community-level violence prevention and child maltreatment prevention strategies, and evaluation of services. The CDC could certainly better leverage funding to states for the accumulation of birth records—under the National Vital Records Program—by asking states to link those data to CWS data to generate intervention opportunities to assist CWS-involved families who are having newborns (Shaw et al. 2013). We could also learn much more about service needs, usual care in child welfare, and preventive services through investments in cross-systems data exchanges such as the Comprehensive Child Welfare Information System (CCWIS) and efforts to enhance and modernize existing data systems to support research, business, practice, and client data needs (Harrison et al. 2018). Additional investments are also needed to rigorously evaluate and potentially expand CBCAP's role in primary prevention.

In sum, child maltreatment is a complex phenomenon that requires a broad range of strategies to prevent its incidence and recurrence. These strategies should be evidence based, developmentally informed, specific to family need, grounded in a prevention science approach, and address the adverse community experiences that render families susceptible to child maltreatment. Hawkins (2006) states, "As a result of the progress of prevention science, we now have an opportunity to help communities reinvent themselves as protective environments for the positive development of all children" (p. 149). For children in the United States, this requires a marked shift from the reactive responses of the child welfare system to a set of prevention strategies that crosses disciplines, service sectors, policies, and funding streams to build the safe, stable, and supportive environments that all children deserve.

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