Early home visitation in families at risk for child maltreatment

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1

General introduction

1 Introduction

During the four years it took to conduct this study at least 160 children died as a consequence of child maltreatment ([23]). Thousands more children survive the consequences of maltreatment every year; estimates say at least 80.000 in the Netherlands alone ([31]) but precise data are still unknown. It seems inconceivable that parents would maltreat their own child. For a long time the general conviction was that there must be something seriously wrong with such parents.

When we look at the first well-documented period where child maltreatment was an issue, around the beginning of the twentieth century, maltreating parents were considered "ignorant, depraved ([16, p20]), incompetent, insensitive and possibly untrained" ([16, p35]). Child maltreatment took place in poor, uneducated, deviant families. The maintenance of disbelief that a sane person could commit such an act becomes particularly clear in the early medical publications preceding the famous article on the battered child syndrome ([20]). Astley (1953) for example, studied a number of cases where children were presented with bone-fractures and subdural hematoma and concluded that in all cases parents were "normal, sensible individuals" ([1, p583]). He refused to believe that the trauma he saw could be inflicted by these parents and thus invented a new 'syndrome'. Essentially the publication of Kempe, Silverman, Steele, Droegemueller and Silver (1962) generated only a partial shift in the perception of maltreating parents: from their social status to their personality, as Kempe et all concluded, "some defect in character structure is probably present" ([20, p112]). From this point on a large number of theories has been developed ([2; 3; 7; 8; 10; 13; 19; 27–29]), trying to explain why certain parents maltreat their children while others, living under similar conditions, do not. As a result we can now predict to some extent, but never with infallible certainty, which parents might maltreat their children.

Over the past decades an understanding of the nature of child maltreatment has grown, at least amongst certain groups of scientists and (mental) health workers. To society at large, including policy-makers and politicians, child maltreatment remains an issue to be feared. After all, it is a frightening idea that, when walking any odd street with around a hundred houses, behind at least three of those front doors some form of violence or neglect takes place. Yet it is imperative that we get

past this fear and acknowledge the problem. Because "denying the problem serves to punish the victims of family violence doubly by forcing them to hide their problems and to blame themselves" ([16, p2]). When acknowledging the problem of child maltreatment the pivotal question remains: what can be done to put a stop to it? Our increased understanding of the nature of this problem should help us answer this question.

Over the years we have learned that child maltreatment has many severe consequences. Children's physical, neurological, emotional, cognitive and social development can be altered through maltreatment, causing serious impact in their physical and mental health throughout their lifetime ([12]). Although this impact can be lessened through several forms of treatment, part of the consequences will affect maltreated children for life. Early intervention in maltreating families may seem a plausible way to stop the process of maltreatment. However, research has demonstrated that such interventions are not very successful. In their review of ten years of evaluative research Cohn and Daro (1987) concluded: "treatment programs have been relatively ineffective in initially halting abusive and neglectful behavior or in reducing the future likelihood of maltreatment" ([11, p440]). It seems that only one option remains: primary prevention of maltreatment, by intervening in families before child maltreatment has taken place. To this day the possibility of primary prevention is surrounded by many reservations. These reservations are mostly related to the effectiveness of programs in actually preventing maltreatment and to the target population for such programs. Regarding effectiveness findings are not unanimous. Some types of programs, mainly home visitation, appear to hold promise ([17; 25]) and are found to produce significant reduction of (the risk for) maltreatment and neglect, although these effects are modest ([14]). Regarding the target population the debate is focused on universal or indicated preventive measures which both hold their advantages and disadvantages ([18]). Universal prevention is extremely expensive whereas indicated prevention requires sufficient knowledge on risk factors preceding maltreatment. Although some say we do have this knowledge ([24]), others, such as the Dutch government, are not convinced, given a report issued in 1990 stating "there is insufficient support, the recommendations show, for the assumption of the existence of demonstrable categories at risk" ([see 4, p63]).

In 1989 the United Nations unanimously accepted the Convention for the Rights of the Child. This convention emphasizes amongst other things that the State has a

responsibility to protect all children from any form of maltreatment and to provide parents with the appropriate assistance in the performance of their child rearing responsibilities for the upbringing and development of their child. Over the years almost all countries in the world signed this convention. The Netherlands did so in 1995 [31]. Nevertheless it appears that to this day Dutch common policy is not to interfere until danger to the child's development is eminent [30]. It needs no argument that this policy does not honor the intentions of the Convention, worse still; this could be considered a serious case of neglect of both children ánd parents. The fact that child maltreatment constitutes a threat to the moral, social and economical order of society has always been an important argument in politics. The fact that a maltreated child is a child whose rights are violated and whose childhood is denied should be an equally important argument [5]. In other countries acceptance of the Convention has lead to changes in legislation and policy [30] and governments are recommended to enforce the implementation of preventive programs such as home visiting [22]. There is no reason this should be any different for the Netherlands.

From the above we conclude that the seriousness of the consequences of child maltreatment implies the moral obligation to make every effort to end this problem, while the Convention for the Rights of the Child implies the legal obligation to do the same. Our efforts should include primary preventive interventions as they are found to have the most potential for success. Although primary prevention programs are "one of the most scrutinized human-service strategies" [15, p24], which suggests that the optimal benefits have not yet been accomplished [15], we should not cease our attempts to reach such optimal benefits. This study therefore aims to gather evidence for the effectiveness of preventive efforts in the Netherlands in order to further our country's ability to obey its legal and moral obligations.

2 THIS STUDY

This study is about the development, implementation and evaluation of a primary preventive program that is to be embedded within the settings of local Well Baby Clinics, known in the Netherlands as the OKZ (*Ouder- en KindZorg*). As such the program has been given the name *project OKé*, an abbreviation of *Ouder- en Kindzorg extra*, which is translated as Parent- and Childcare extra.

The purpose of this study is to determine the effectiveness of prevention of child maltreatment by means of home visitation in families at risk. These families were selected based on a number of risk factors, which have been established through theory and research. The process of recruiting families for this program was carefully monitored and characteristics of non-respondents were investigated. The program of home visitation was provided by specially trained nurses from local Well Baby Clinics and started within six weeks after the birth of a child. The program consisted of a total of six home visits, provided in a tapered fashion, with the final visit at eighteen months after birth.

Aside from the primary objective in this intervention study, the prevention of child maltreatment in participating families, several intermediate objectives have been established. These are: (a) the improvement of parental understanding and handling of feelings of ambivalence, (b) the enlargement of parental knowledge of child development and behavior, (c) the improvement of parental skills and knowledge on child rearing, nurture and care, (d) the confirmation of parental competence and self-confidence in child rearing and (e) the improvement of parental skills and attitudes regarding the interaction with the child. Further intermediate objectives are (f) the improvement of stress-coping abilities in parents, (g) the establishment of functional connections to professional support and (h) the improvement and enlargement of social support systems.

The program was evaluated twofold. First of all a process evaluation was conducted to ensure correct implementation. For this evaluation questionnaires were developed for participating parents and nurses. These questionnaires provided information on the implementation of program protocol, on the attainment of objectives according to the visiting nurses and on the satisfaction of participating

parents. Secondly the effects of the intervention program were evaluated in a randomized controlled setting. For this purpose three measurements were taken both in the intervention group and in a control group that was selected based on the same criteria. These measurements were taken at baseline (within six weeks after the birth of a child and before the intervention started), and at the child's ages of one and two years. In this way effects during and after the intervention were established. The measurements consisted of four instruments: a short version of the Child Abuse Potential Inventory ([26]), the Adult Adolescent Parenting Inventory ([6]), the Short Psychological and Pedagogical Problems Inventory ([21]) and the Social Support Scale ([9]). Aside from measurements administered to the participating parents information was obtained from the family's general practitioner and the local Well Baby Clinic physician as well as from the *Advies en Meldpunt Kindermishandeling*, the Dutch maltreatment reporting center.

3 Outline of this thesis

As the object of this study is the prevention of child maltreatment, it is important to first establish what is to be understood of these two terms. It is with the definitions of these terms and the consideration of several limitations for our study that we start in *chapter 2*. This chapter is continued with a historical overview, as it is important to understand how the problem of child maltreatment was perceived over time and how this perception evolved into an impetus on prevention. Chapter 2 closes with a summary of different theories on child maltreatment that were developed throughout the previous century and an explanation of the preferred paradigm for this study.

In *chapter 3* we continue upon our paradigm for a further exploration. This exploration is meant to provide insight in the factors influencing and surrounding families at risk of maltreatment, with two purposes. The first purpose is the preparation of a solid foundation for the instrument that is to be used for the selection of families at risk. The second purpose is to gain insight in the processes that should be changed through the preventive program implemented by this study. The second part of this chapter presents a review of empirical research on risk factors for child maltreatment, thereby providing information on the precise relationship between individual risk factors and maltreatment. The chapter is closed with a conclusion on the risk factors to be used in the selection of families at risk.

Considerations on the design of the intervention program constitute the contents of *chapter 4*. The first subject of this chapter is the design of the program itself. As such a rationale is provided for the choices in population and recruitment of this population, for the onset, duration, frequency, implementation and staffing of the program and finally for the objectives and content of the program. The second subject of this chapter is concerned with the ways in which the program should be evaluated. Conclusions on the evaluation of our program are based on an exploration of the choices in evaluation, the instruments for evaluation as they are available and the possibilities and limitations these instruments create when combined with the objectives of this study.

The following chapters present the results of this study. In *chapter 5* the process of selecting families at risk is described. This process was continued over a period of thirteen months during which almost 9,000 families were approached. Furthermore the results of the selection are presented in this chapter. A total of 17% of all families were found to be at risk for maltreatment. As a substantial proportion of families failed to respond to the selection questionnaire, in *chapter 6* the characteristics of these non-respondents are investigated. Several methods were deployed for this purpose: aside from the construction of a name algorithm and the investigation of neighborhood characteristics of all families a random sample of Well Baby Clinic files on non-respondent families was evaluated.

Based on the understanding that the effects of an intervention can be influenced by both the individualization of services provided as well as the heterogeneity of participating families, in *chapter 7* an extensive process-evaluation is presented. Three aspects of the program are evaluated: the implementation of the program protocol, the realization of the program objectives as perceived by the visiting nurses and the parental satisfaction about the program. For each of these aspects differences in nurses and participating parents are explored. Several parental characteristics as well as the amount of time spent per family turn out to be influential and therefore warrant further investigation in the effect-evaluation. This evaluation is presented in *chapter 8*. Of the 1263 families, which were found to be at risk of maltreatment, 500 participated in this study. The results of all measurements administered to the participating parents as well as information provided by external sources are discussed. The study is concluded with a general discussion in *chapter 9*. In this discussion, based on the findings of this study, implementation into daily practice is recommended.

4 References

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