

# JOINING FORCES



## Joining Families

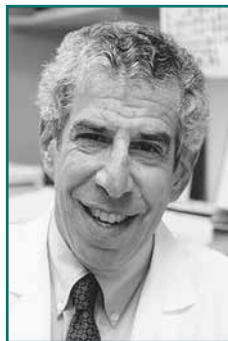
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REAL WORLD RESEARCH FOR FAMILY ADVOCACY PROGRAMS

### FEATURED INTERVIEW

## Prevention of Child Maltreatment: Home Visiting, Early Childhood Care, and Beyond

An Interview with John M. Leventhal, MD



### John M. Leventhal, MD

John M. Leventhal, MD is Professor of Pediatrics at the Yale School of Medicine and an Attending Pediatrician at Yale-New Haven Children's Hospital, where he is Medical Director of the Child Abuse and Child Abuse Prevention Programs. He was graduated from Brown University in 1969 and Tufts Medical School in 1973, and has been at Yale Medical School since 1973.

From 2001 to 2006, Dr. Leventhal served as Editor-in-Chief of *Child Abuse & Neglect*, *The International Journal*, the major international

journal on child maltreatment. His research has focused on the epidemiology of child maltreatment, risk factors for abuse and neglect, distinguishing abusive from unintentional injuries, and prevention. He has published over 175 peer-review articles and chapters and has lectured nationally and internationally.

Dr. Leventhal has received several awards for his work including the 2008 George Armstrong Award from the Academic Pediatric Association for his lifetime work in child abuse and academic pediatrics and the 2010 Ray E. Helfer, MD Award for his distinguished achievements in the field of Child Abuse and Neglect; in 2012 he received the highest honor from the International Society for the Prevention of Child Abuse and Neglect by being selected to deliver the C. Henry Kempe Memorial Lectureship at the biennial congress.

In 2011, he was appointed to the Committee on Child Abuse and Neglect of the American Academy of Pediatrics and is President elect of the Helfer Society, an honorary international society for physicians who care for abused and neglected children.



**Dr. McCarroll:** Much of your work and writing on the prevention of child maltreatment has been on home visiting. There have been many approaches to implementing child home visiting programs. What is the current evidence on home visiting in preventing child maltreatment?

**Dr. Leventhal:** There is good evidence that home visiting works (Leventhal, 2005). Basically, these programs can help to prevent child

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### In This Issue

The topic of this issue of *Joining Forces (JFJF)* is the prevention of child maltreatment. Our interview is with John M. Leventhal, MD, Professor of Pediatrics, Yale University School of Medicine. He has long been a researcher, writer, and advocate for prevention of child maltreatment. Our interview provides his current views on home visiting, the most widely accepted child maltreatment prevention program, as well as his views on the current practice of Child Abuse Pediatrics. An additional article describes his work in child maltreatment prevention as it has developed over many years. *Building Bridges to Research* describes two measures commonly used in research: meta-analysis and effect size estimation. *Websites of Interest* features prominent home visiting program that are nationally and internationally recognized as helpful in reducing child maltreatment and promoting family health. Finally, we begin a new feature, a summary of recent research that has practical implications for child abuse prevention.

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*I teach our residents always to ask parents, "Are there any concerns about domestic violence?" because if people do not ask about it, it does not come up.*

maltreatment. They are probably more effective in the randomized trials than when they are not being studied. The best evidence is from the studies by David Olds of the Nurse-Family Partnership, the NFP (Olds, Sadler, & Kitzman, 2007). Sending nurses into the home seems to be very effective and helpful, particularly for single mothers, who are often teens, have limited resources and are often on some kind of support, such as Medicaid. The NFP uses a broad approach to identify high-risk, first time mothers. It begins care prenatally and then works with parents in the home (Olds, Hill, O'Brien, Racine, & Moritz, 2003). Key issues are how to implement home visiting in a community and maintain high quality services when the program is no longer part of an ongoing study.

Another approach is the Triple P (Sanders, 2008). It uses everything from trying to change some of the perceptions of how children should be treated in a community to intensive one-on-one home visiting with families that are already in trouble. One large study in the U.S. concluded that it seemed to work (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009).

I do not know what home visiting is like in the Army, but I would think that families would appreciate the opportunity to work with

someone coming to their home and talking to them about child development and parenting. The home visitor can also work with young spouses in an effective way to minimize problems such as domestic violence, which can have a very powerful impact on families and children's development. I teach our residents always to ask parents, "Are there any concerns about domestic violence?" because if people do not ask about it, it does not come up.

***Dr. McCarroll: The Army programs screen mothers prenatally and at birth to identify high risk people and visit them in their home. Every Army installation can select its own program.***

*Dr. Leventhal:* There is a training program at Yale-New Haven Children's Hospital providing pediatric care during the first year of the child's life in a group setting. Instead of seeing one mother and one baby and doing that again every 20 minutes, we meet with six families at a time. Residents examine each child, talk to the mother about her concerns, and then run the group for about an hour. In the group, we discuss topics such as post-partum depression, what it is like to have frustration when caring for an infant, and how to care for babies more effectively. We invite fathers and grandmothers and often they show up as well. An important advantage of the group is that parents learn from each other; interestingly, the group creates a social network. It would be interesting to see if that would work in the Army. There is even a prenatal care program similar to the pediatric group called Centering Pregnancy — The Center of Your Life [See Websites of Interest]. Families seem to like it a lot.

***Dr. McCarroll: Do you have difficulty attracting families to your home visiting program?***

*Dr. Leventhal:* We have over 100 slots available, both in Spanish and English, and we are always running about 85% full. We have one person who focuses on fathers. He has about 20 slots. We offer our home visiting program to all our first time, socially high risk births at the hospital; the families are mostly single and about 25–30% accept the services.

***Dr. McCarroll: Do you know why they refuse?***

*Dr. Leventhal:* They say they have enough support. They are living with their mother or they feel that they and the father can do fine.

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## **JOINING FORCES**

### *Joining Families*

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**Dr. McCarroll: Do you have any trouble keeping fathers in the program?**

Dr. Leventhal: I think that once they are in the program, we are pretty good at keeping them hooked in. But, just getting them engaged is very hard.

**Dr. McCarroll: In some of your papers you used the term disease in referring to child maltreatment. I am not sure what you mean by that.**

Dr. Leventhal: You know it is listed in ICD-9 as a disease, under specific ICD codes 995 for child abuse (Slep, Heyman, & Foran, 2015).

**Dr. McCarroll: There are different ways of talking about child maltreatment.**

Dr. Leventhal: I like to think of it as an experience. Maltreatment changes your experience. One experiences neglect, one experiences abuse, one experiences parents fighting. It becomes part of you in some way. When you think about factors that affect a person's life trajectory, most people can handle one adverse experience like abuse or neglect, but handling three or four is much more difficult, there is a growing literature on the Adverse Childhood Experiences study (Felitti et al., 1998). Your cumulative experience of adverse life events is the thing that can do you in.

**Dr. McCarroll: The U.S. Preventive Services Task Force found that there is not sufficient evidence to recommend for or against primary care interventions for child maltreatment. What is your opinion?**

Dr. Leventhal: The primary care approach to child maltreatment has been limited. The person who has done the most work with this is Howard Dubowitz with his Safe Environment for Every Kid (SEEK) program (Dubowitz, Lane, Semiatin, Magder, Venepally, & Jans, 2011). It has a strong evidence base and it effectively asks parents about problems such as substance abuse or depression and connects the families to a social worker who can help. If you talk to families and connect with them and they tell you something important about their life, you then can link them to services that can be very helpful. That can diminish the level of stress in the family and then allow for that child to be cared for more in a more nurturing way because you have decreased the stress and cut back on the cumulative number of risk factors.

**Dr. McCarroll: Practitioners in child abuse prevention have common concerns about communication, feedback, and information sharing (Frederico, Jackson, & Dwyer, 2014). It often seems hard to connect people working in very disparate areas. They often do not talk to each other or understand each other's terms. For example, child maltreatment professionals in talking to mental health professionals need to ask the right questions. In other words, asking about a diagnosis may not be particularly helpful. But asking, "What are the parents' strengths?" and "What are the parents' weaknesses, their moods, thoughts and behaviors, and what are the implications of these for day-to-day functioning?" may be good questions. Language is an important way to connect people and help to understand how others think and act. This might help in prevention.**

Dr. Leventhal: You also have to figure out who is the patient. The patient may be the person you are counseling or you are prescribing for, but that patient may have children, and it helps to know how those kids are doing and what the risk factors are for those kids. You have to extend your view of what it means to be a clinician.

**Dr. McCarroll: What is your view of treatment options for children by developmental stage and type of maltreatment?**

Dr. Leventhal: Certainly school age children and even younger ones with appropriate treatment can be helped. There are parent-child interventions that are thought to be helpful and there are good evidence-based approaches to treat traumatized kids and sexually abused kids. We want to treat them early-on. Sexual abuse is part of a child's being. Parents and children themselves have many questions and concerns (Leventhal, Murphy, & Asnes, 2010). These experiences can affect the child when he or she is an adolescent or when the young adult leaves the home. I think children who have been sexually abused need some active checking in — not necessarily mental health treatment, but some way of re-connecting with someone who can help them through the various phases of their life. I think of sexual abuse as a chronic disease and try to work with the pediatricians and ask them, as they follow these children, to think that at critical stages they need to re-connect with these children. They could then get the child into short-term counseling for three or four sessions to help the child or adolescent move on.

*In the group, we discuss topics such as post-partum depression, what it is like to have frustration, and how to care for babies more effectively.*

*Maltreatment changes your experience. One experiences neglect, one experiences abuse, one experiences parents fighting. It becomes part of you in some way.*

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# ***Prevention of Child Maltreatment through Home Visitation and Child Advocacy: A Pediatric Approach***

*By James E. McCarroll, PhD, and Robert J. Ursano, MD*

*Dr. Leventhal has been a tireless advocate for child maltreatment prevention, a field that for many has seemed hopeless. Through his research, teaching and writing, he has never lost hope that prevention can be successful.*

Dr. Leventhal has been a tireless advocate for child maltreatment prevention, a field that for many has seemed hopeless. Through his research, teaching and writing, he has never lost hope that prevention can be successful. He has monitored developments promoting prevention and periodically updated his review of progress. Child maltreatment prevention can occur through (1) general programs to support parents (good housing, financial support, available and affordable child care) and (2) targeted programs such as home visiting (Leventhal, 1996).

Home visiting to prevent child abuse in the U.S. was proposed by Henry Kempe (1976). He suggested a system of lay home visitors on a national level that would have contact with mothers-to-be prenatally and then visit in the home until the child reached school age at which point Kempe believed that the teacher could take over. His ideal home visiting candidate was the successful mother, one who could act as a bridge between the families and the health care system. This seminal article provided many of Kempe's observations on the parent-child relationship prenatally and postpartum, as well as the importance of positive family circumstances, and special care for high risk families. His observations are still current. A review of Kempe's vision and the current state of child prevention emphasized Kempe's major themes: recognition of the rights of the child, including identification of children at risk in standard pediatric care, and widespread adoption of child maltreatment prevention (Chaiyachati & Leventhal, 2014).

Since Kempe's time, home visitation has been implemented in many locations both as research and as service. Dr. Leventhal has long been an advocate for home visiting as a means of preventing child maltreatment as well as for improving the lives of children and families. [See boxes (1) Elements Necessary for a Successful Home Visiting Program and (2) Challenges Facing Home Visiting Programs.]

The interest in home visiting has advanced internationally since Kempe suggested it as a means of preventing child maltreatment. As interest has increased, so have the approaches. However, as with all new programs, research is

necessary to test effectiveness (MacMillan, Wathen, Barlow, Fergusson, Leventhal, & Taussig, 2009).

In addition to the challenges noted by Dr. Leventhal, there are many other challenges in implementing home visiting. For example, Eckenrode et al. (2000) found that when women who were home visited had more than 28 incidents of intimate partner violence (IPV) during the study period of 15 years, the effectiveness of home visiting was substantially reduced. The harmful effects of violence on children were further shown in a study of Child Protective Services (CPS) reports of families who participated in home visiting (Duffy, Hughes, Asnes, & Leventhal, 2014). Of a total of 1,125 families studied, 15.6% had at least one CPS report in the period 2006-2008. A risk score was constructed for each family member based on six risk factors (histories of CPS, IPV, mental health, sexual abuse, substance abuse and criminal involvement) and the number of caretakers in the home. Families with a substantiated report (25.2%) were compared to those with an unsubstantiated report. Families with a substantiated first report had a higher number of paternal risk factors, maternal and paternal IPV, and maternal criminal history.

Prevention of child maltreatment can also occur through advocacy. Dr. Leventhal has emphasized the need for funding for research, funding for successful programs to reach families in need of services such as through home visitation, and for legislation to support child maltreatment prevention (Leventhal, 2002). More specifically, to promote prevention he suggested that clinicians (1) should recognize early signs of abuse and neglect and report them to child protective services agencies, (2) advocate for prevention during early childhood in order to prevent adult mental health problems, (3) educate the public about the complexities of child maltreatment and successful models of prevention, and (4) advocate for more funding focused on prevention and the consequences of maltreatment.

Dr. Leventhal has said that continued advocacy for prevention needs to include strengthening current practices, developing innovative approaches to prevention, and encouraging



*Dr. Leventhal has said that continued advocacy for prevention needs to include strengthening current practices, developing innovative approaches to prevention, and encouraging the federal government to develop an agenda for child maltreatment prevention.*

the federal government to develop an agenda for child maltreatment prevention (Leventhal, 2005). There are many other issues for which advocacy is necessary. Krugman and Leventhal (2005) noted historical and chronic fundamental issues leading to shortcomings in the child protective system: low levels of funding, inadequate training of child protection workers and clinicians, overburdened child protective workers, poor supervision of workers, poor quality of clinical work, inadequate communication among providers about children at risk, failure to consider the diagnosis of child maltreatment, failure to focus on the child's safety and the child's and family's need for therapeutic services, and criminalization of the child protection process.

There have been many developments in the field of pediatrics that have benefited the recognition and prevention of child maltreatment. Recently, two of these occurred to further the prevention and treatment of child maltreatment protection (Giardino, Hansen, Hill, & Leventhal, 2011). First was the recognition of the subspecialty of Child Abuse Pediatrics by the American Board of Pediatrics, a three year graduate medical education training program. Board certification was awarded to 191 pediatricians in 2010. A second major change was the development by the National Association of Children's Hospitals and Related Institutions (now called Children's Hospital Association) of a framework to highlight and characterize the

role of child abuse protection teams at children's hospitals.

Dr. Leventhal and colleagues have studied the functioning of hospital-based child protection teams in order to improve their effectiveness (Kistin, Tien, Bauchner, Parker, & Leventhal, 2010). This work included a self-evaluation tool to assess the functioning of a child protection team (Kistin, Tien, Leventhal, & Bauchner, 2011).

Dr. Leventhal has taught and published on a wider variety of child maltreatment topics than prevention. One of these topics is child sexual abuse. Two recent articles dealt with children's disclosures of sexual abuse (Schaeffer, Leventhal, & Asnes, 2011) and practical clinical strategies for evaluation of parent and child concerns about sexual abuse (Leventhal, Murphy, & Asnes, 2011). The aim of the former article was understanding children's willingness to disclose sexual abuse as protocols for forensic interviewing do not include what prompted children to disclose or what made them wait to tell about it. The latter article described six concerns of parents and four of children when children are evaluated for sexual abuse.

Dr. Leventhal (2001) reviewed the progress of the development of home visiting programs and suggested three important issues in research as well as in implementation: replication of the findings, influence of family factors, and variability in the application of the models. These issues are still important in any home

## **Challenges Facing Home Visiting Programs — Bringing Programs to Scale**

- Costs
- Maintaining quality
- Flexibility and adaptability to fit the strengths and needs of communities
- Societal changes that may affect parents' availability and willingness to participate
- The need for community-based services for other problems such as depression, IPV, substance abuse, illiteracy, and other issues brought to light through home visiting
- Attracting fathers to participate in caretaking and in home visiting, and
- Research and evaluation to test effectiveness, modifications, different populations and program strengths and weaknesses.

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Dr. Leventhal (2001) reviewed the progress of the development of home visiting programs and suggested three important issues in research as well as in implementation: replication of the findings, influence of family factors, and variability in the application of the models.

visiting research.

While child maltreatment may be seen by some as hopeless, there is optimism as child maltreatment rates are decreasing. Home visiting program are a substantial intervention for high risk mothers and families, but home visiting has many challenges and is not a cure all for maltreatment or unhealthy life styles. However, challenges are just what they seem — obstacles to overcome.

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### **A Successful Home Visiting Program Should:**

- Begin early and include the prenatal period,
- Occur frequently,
- Build a relationship with the family,
- Train the home visitor to recognize early signs of child maltreatment and intimate partner violence (IPV) so that appropriate services can be provided,
- Provide effective guidance about parenting using an evidence-based parenting curriculum,
- Not lose sight of the child's needs while working with the parents,
- Be concrete such as help with organization, housing, and the like,
- Include fathers, and
- Make adjustments to meet the family's needs and progress.

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# Rates of Infant Abusive Head Trauma in Military Similar to Civilian Rates

By James E. McCarroll, PhD, and Robert J. Ursano, MD

Risk factors in the military cohort included male sex, premature birth, a major birth defect, young maternal age, lower sponsor rank, and current maternal military service.

## Why is this Article Important?

- Abusive head trauma (AHT) in infants can cause death and poor developmental outcomes.
- Preventing AHT and reducing its risk are key Army Family Advocacy Program (FAP) goals.
- Risk factors for AHT in a military cohort were: male sex, premature birth, a major birth defect, young maternal age, lower sponsor rank, and current maternal military service.
- Practitioners should be aware of the increased risk for AHT in families with an active duty mother or with additional care takers in the home.

## Summary

AHT rates of infants born to military families during 1998–2005 were compared to civilian AHT rates. DOD data were obtained from the DOD Birth and Infant Health Registry, which captures health care utilization data from birth to one year of age or until the infant is no longer receiving DOD-sponsored care. Military AHT cases were estimated as substantiated, probable, and possible, based on as the International Classification of Diseases-9-Clinical Modification (ICD-9-CM) and the Military Family Advocacy Program classifications. Rates per 100,000 and confidence intervals (CI) of AHT for these three classifications were 34.0 (CI=29.6-38.4), 39.2 (CI=34.4-43.9), and 44.8 (CI=39.7-49.8), respectively.

The Kids' Inpatient Databases for 1997, 2000, and 2003 were used to estimate the incidence of traumatic brain injury (TBI) in infants of civilian families (Ellingson, Leventhal, & Weiss, 2008). The Ellingson et al. criteria for estimating AHT rates were more stringent than the military classifications. Their criteria were based only on the presence of an E-code

(external injury) from the ICD-9-CM in an inpatient population. When the military rate included substantiated AHT cases (34/100,000, CI=29.6-38.4) that rate was within the confidence interval for the KIDs database for 2003, 32.2 (CI=26.9-37.4) indicating that the military and civilian rates were similar. Applying the more stringent Ellingson et al. definitions to the military reduced the military rate further to 25.6/100,000. These results suggest that (1) the military population is not at excess risk for AHT compared to civilian populations and (2) civilian data may underestimate the scope of AHT.

Risk factors in the military cohort included male sex, premature birth, a major birth defect, young maternal age, lower sponsor rank, and current maternal military service. Note that this study could not identify the perpetrator of the AHT. However, compared to families with a non-military mother, infants born to military mothers were at 3.6 times higher risk; single military mothers had 3.1 times greater odds of an AHT infant case; and dual military families had 2.5 times greater odds. It is likely that in many of the cases with military mothers, that the non-military male was the perpetrator.

## Future Research

A good project for a military researcher is to understand the characteristics of increased risk for families with military mothers and to develop prevention programs for these families.

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*Neglect is a chronic problem for many families who need substantial supports. Often, mental health and drug use are also involved. Trying to figure out how to help those families is a huge, huge problem.*

*Think of a broken bone that results from a car accident versus one from physical abuse. These broken bones are the same, but the broken bone from physical abuse is a marker of how the child has been treated in the family.*

**Dr. McCarroll:** *You were a co-author on a 2009 Lancet article about child maltreatment prevention (MacMillan, Wathen, Barlow, Fergusson, Leventhal, & Taussig, 2009). That article discussed the difficulty of preventing psychological abuse as well as chronic neglect.*

**Dr. Leventhal:** This is where clinical practice needs to step up and start looking for families that are really challenged by their kids. I talk to our residents about how to engage families, and to ask families “What is it like to take care of your son?” “What do you like best about your son?” “What do you like least about him?” These are good questions to begin to understand what it is like for the parent to care for her child, but asking these sorts of questions, listening to the responses and acting on these responses takes time. “What is it like when you feed your baby?” “What is it like when you take care of your baby?” “What is it like when your baby cries?” We can then start to understand the experiences of being a parent. That becomes a place where the clinician can get some leverage and promote a different way of thinking. The time is in the listening.

I do not think anyone has figured out how to leverage adequate resources to prevent neglect, like the lack of shelter, food, clothing, supervision, and medical and dental care. Neglect is a chronic problem for many families who need substantial supports. Often, mental health and drug use are also involved. Trying to figure out how to help those families is a *huge, huge* problem.

With regard to psychological abuse, think of a broken bone that results from a car accident versus one from physical abuse. These broken bones are the same, but the broken bone from physical abuse is a marker of how the child has been treated in the family and the likely occurrence of psychological abuse and inadequate nurturing that accompanies the physical harm.

Abusive head trauma is also an important problem. There is substantial morbidity and mortality from this type of abuse. We have done a good job getting people to use infant car seats every single time they put a baby in a car. We also have done a pretty good job of “Back to sleep.” But as a society, we have done less well helping parents not shake or slam their infants. Crying and other behaviors of infants can be very frustrating and overwhelming for parents. The problem is to figure out how to help the parent so that every time the

baby cries the parent says, “I know what to do and if the baby cries, I am not going to get frustrated even if I am an impulsive guy.” A recent study compared abusive head trauma (AHT) to children of military parents to a civilian population (Gumbs, Keenan, Sevick, Conlin, Lloyd, ... Smith, 2013). When similar case definitions were applied to both populations, the rate of AHT was similar. [See separate summary for more details about this study.]

**Dr. McCarroll:** *How do you teach about child maltreatment fatalities?*

**Dr. Leventhal:** The problem is that these cases are rare. They are very rare. We focus on serious abuse and try not to miss those. We teach about how to evaluate injuries in young children. Because the fatalities are just not that common, we focus on the more commonly seen kind of injuries such as bruising, fractures, and head injuries making sure that those due to abuse do not get missed in emergency departments. We also make sure that serious neglect is not missed because that too can lead to death.

**Dr. McCarroll:** *Thank you for your time and for your work.*

**Dr. Leventhal:** Thank you. It has been a great pleasure for me.

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## What is the Prevalence of Intimate Partner Violence (IPV), its Health Consequences, and Approaches to Intervention?

By James E. McCarroll, PhD

Definitions of IPV have expanded to include stalking, control of reproductive and safe sex choices, and patterns of IPV.

### Why is this Article Important?

- This article is a summary of a substantial body of current knowledge about IPV.
- It is helpful for providers to have a current summary of the major topics in IPV that can be useful with patients, colleagues, and for practitioners outside family violence.

### Key points by the author:

- IPV affects women and men regardless of the demographics.
- One in three women and one in four men experience IPV in their lifetime.
- Health issues, not acute injuries, are the most common complaints of patients who experience IPV.
- The role of the medical provider is to acknowledge the problem, assess safety, refer when appropriate, and document medically.

Definitions of IPV have expanded to include stalking, control of reproductive and

safe sex choices, and patterns of IPV. The latter delineates IPV in terms more complex than just victim and perpetrator. It includes the concepts of situational couple violence, intimate terrorism, violent resistance, and mutual violent control. Prevalence of IPV is discussed by gender, age, race, sexual orientation, and socioeconomic status, as well as its prevalence in various health care settings: primary and specialty care, ED, obstetrics and reproductive health. There is extensive discussion of IPV health consequences, both medical and behavioral, including mental health, suicide, homicide, pregnancy, adolescent health, and injury.

Screening is extensively discussed with the pros and cons of screening and case finding. [See *Joining Forces Joining Families*, Volume 14, No. 2, Summer 2014, for an interview with Harriet MacMillan, MD, in which she discussed the difference in these two approaches to intervention in IPV. Dr. MacMillan presented a strong argument for case finding over universal screening.] In the article summarized here, Sugg presents a detailed description of current thinking about IPV screening including those changes due to the Affordable Care Act.

The study of intervention for IPV has lacked controlled studies that point the way toward an effective approach. Research is hampered by

*Continued on page 10*

## BUILDING BRIDGES TO RESEARCH

# Meta-analysis and Effect Size

By James E. McCarroll, PhD

*Meta-analysis combines the results of many studies to identify consistent patterns of agreement or disagreement.*

*The effect size is a measure of the difference between two outcomes such as a treatment group and a control group.*

In this article, we describe two concepts that are frequently encountered in scientific and medical literature on family maltreatment: meta-analysis and effect size. Meta-analysis is a statistical technique that combines the results of several or many studies in order to identify consistent patterns of agreement or disagreement in results. In meta-analysis, the studies themselves are the units of analysis (Greenland, 1998). Meta-analysis can be controversial depending on the purpose of the analysis. One possible research goal is to look for an overall summary of an effect across studies, the so-called synthetic approach. For example, in social science, reviewers of a topic may face hundreds of studies and want to synthesize a summary position on the topic in question. A different approach is to look for study-specific effects such as the identification and quantification of differences, a so-called analytic goal.

The effect size is a measure of the difference between two outcomes, such as a treatment group compared to a control group. The effect

size, then, is the magnitude of the treatment effect. Effect size can be categorized as strong, moderate, or weak. There are different measures of effect size such as the correlation coefficient, the mean difference, and the regression coefficient. Note that the effect size is different from statistical significance, a measure of the probability of the outcome due to chance.

In reading scientific literature it is important to read the section in the paper on the limitations of the report, a necessary requirement for publication of most journals. These can alert the reader to many caveats such as selecting or excluding certain types of studies (such as those with negative results and those that appear to be too small to be meaningful), consistency in measures, and possible biases.

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*Home visiting programs are a substantial intervention for high risk mothers and families, but home visiting has many challenges and is not a cure all for maltreatment or unhealthy life styles.*

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### Prevalence of IPV, from page 9

many contingencies that involve methodology, safety, ethical, and legal issues. Nevertheless, Sugg presents four key components of intervention: when seeing patients, providers can acknowledge that IPV is a serious problem that affects health, assess safety, referral, and documentation. Legal issues vary from state to state, but Sugg gives highlights of the legal issues to be considered.

Finally, Sugg addresses the barriers that the patient in a violent relationship faces in terms of leaving or not leaving, issues that providers also must consider when considering intervention.

### Reference

Sugg N. (2015). Intimate partner violence prevalence, health consequences, and intervention. *Medical Clinics of North America*, 99(3): 629-649.

# Comparison of Army and U.S. National Child Maltreatment Reports, FY2013

By James E. McCarroll, PhD

*The overall rate of maltreatment in the Army is approximately 31% lower than in the U.S. The rate of neglect is about 43% lower than in the U.S. and the rate of child sexual abuse is less than half the U.S. rate.*

This article compares Army child maltreatment data for FY2013 with the U.S. national data from *Child Maltreatment 2013*, the most recent U.S. national data available. *Child Maltreatment 2013* is a report of child maltreatment victims reported by the 50 states, the District of Columbia and the Commonwealth of Puerto Rico to the National Child Abuse and Neglect Data System (NCANDS) as required by the Child Abuse Prevention and Treatment Act (CAPTA). Army data reported here are from the Army Central Registry (ACR) of child maltreatment.

**Victims and Rates.** There were 678,932 victims of child abuse and neglect in the U.S. for a total victim rate of 9.1/1,000 children in the U.S. for FY2013. There were 3,132 Army child victims for an overall rate of 6.3/1,000.

## Child Maltreatment Victim Rates/1,000

	U.S. National	Army
Total child maltreatment	9.1	6.3
Neglect	7.5	4.3
Physical abuse	1.7	1.4
Emotional abuse	0.8	0.7
Sexual abuse	0.8	0.3
Other maltreatment*	0.9	NA

## Most Common Maltreatments in the U.S.

In the U.S., the most commonly substantiated type of maltreatment was neglect (79.5%). Other maltreatments were: physical abuse, 18.0%; psychological abuse, 8.7%; sexual abuse, 9.0%; and other maltreatment, 10.0%. (Percentages are greater than 100% because some children had more than one type of maltreatment.)

## Most Common Maltreatments in the Army.

The most commonly substantiated type of maltreatment in the Army was also neglect (60%). Other maltreatments were physical abuse, 20%; emotional abuse, 16%; and sexual abuse, 4%.

**Substantiation of Cases.** In the U.S., approximately 3.9 million children were the subject of at least one report to Child Protective Services agencies. Approximately one-fifth of children (17.5% substantiated, 0.9% indicated, and 0.4% alternative response victims) were counted as victims.

In the Army, there were 7,662 child refer-

als. A total of 3,812 incidents (50%) were substantiated (met criteria) for inclusion in the ACR.

**Fatalities of Children in the U.S.** An estimated 1,520 children in the U.S. died from abuse or neglect for a national fatality rate of 2.04/100,000. Almost 75% of all child fatalities were less than three years old. Boys (2.36/1,000) had a higher fatality rate than girls (1.77/1,000). Almost 80% of fatalities were caused by one or both parents. (Fatality rate data from the Army are not available in the same form as reported in *Child Maltreatment*.)

## Child Victimization Rate by Child Age.

Children under one year of age in the U.S. had the highest victimization rate, 23.1/1,000. The rate for infants (less than one year old) in the Army was 8.4/1,000. For one-year olds, 7.9/1,000; for two-year olds, 7.7/1,000.

## Conclusions

1. The overall rate of maltreatment in the Army is approximately 31% lower than in the U.S. The rate of neglect is about 43% lower than in the U.S. and the rate of child sexual abuse is less than half the U.S. rate. The rates of the other maltreatment types (physical and emotional) are slightly lower than the U.S. rates.
2. The Army substantiates a higher percentage of child maltreatment incidents (50%) than the U.S. (about 20%).
3. Child maltreatment rates of children in the Army were about 31% lower than the rates in the U.S.
4. The most frequently found type of child maltreatment, neglect, is lower in the Army (60%) than in the U.S. national data (81.8%). Physical abuse maltreatment in the Army was slightly larger (20%) than the U.S. data (18%). Emotional abuse in the Army (16%) was approximately twice that of the civilian community (8.7%) and the sexual abuse maltreatment in the Army (4%) was less than half that of the U.S. (9%).

## Reference

U.S. Department of Health and Human Services, Administration on Children, Youth and Families, Children's Bureau. (2015). *Child Maltreatment 2013*. (See <http://www.acf.hhs.gov/programs/cb/research-data-technology>.)

\*Other maltreatment refers to state codes not recognized by NCANDS. These could include threatened abuse, parent's drug or alcohol abuse, safe relinquishment of a newborn, and others.

## Websites of Interest

The interview with Dr. Leventhal stresses the importance of home visiting in preventing child maltreatment. The following are the most widely supported and researched programs.

THE NURSE-FAMILY PARTNERSHIP is one of the most adopted home visiting programs in the U.S. It has very strong research support over several decades of follow-up of home-visited families.

<http://www.nursefamilypartnership.org/>.

The TRIPLE P is an internationally adopted program for parenting that includes strategies to manage children's behavior and build healthy relationships.

The Triple P has a website for practitioners <http://www.triplep.net/glo-en/home/> and one for parents <http://www.triplep.net/glo-en/home/>.

HEALTHY FAMILIES AMERICA [http://www.healthyfamiliesamerica.org/about\\_us/index.shtml](http://www.healthyfamiliesamerica.org/about_us/index.shtml) is a program for expectant mothers and new parents to receive education and support.

CENTERING PREGNANCY <http://centeringhealthcare.org/pages/centering-model/pregnancy-overview.php> (noted by Dr. Leventhal in his interview) is a form of pediatric group care that includes health assessment, education and support.

Child abuse prevention resource guide 2015-acf is a comprehensive guide to service providers to prevent child maltreatment. It includes protective factors to build family strengths and promote optimal child development. [https://www.childwelfare.gov/topics/preventing/preventionmonth/resource-guide/?utm\\_source=Gateway&utm\\_medium=Elert&utm\\_campaign=NCAPM15](https://www.childwelfare.gov/topics/preventing/preventionmonth/resource-guide/?utm_source=Gateway&utm_medium=Elert&utm_campaign=NCAPM15)

The annual Child Maltreatment publication is available at the CHILDREN'S BUREAU <http://www.acf.hhs.gov/programs/cb>. (Search under research-data-technology.) This report gives the latest U.S. national, child maltreatment statistics and additional data by states. This website also gives many references and resources for federal government programs and reports.

