A Proposal for a Foster Grandmother Intervention Program to Prevent Child Abuse

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Synopsis

The incidence of child abuse and neglect is epidemic. Many abused children have sustained lifelong injuries. Often they become perpetrators of abuse, continuing the cycle into future generations. Studies have indicated that mothers who are likely to abuse their children can be identified by a predictive method during the prenatal and postpartum periods. Pilot studies have indicated that mothers who are identified by the method and who receive early intervention, consisting of home visits by registered nurses, show a significantly lower rate of verified cases of child abuse.

The author proposes a strategy for early intervention to prevent child abuse and neglect and to help infants and children attain their appropriate developmental milestones. The strategy calls for training and employing women from the Foster Grandparent Program. Foster grandmothers would be a valuable resource for high-risk mothers, providing role models for parenting skills in the home setting. Participating foster grandmothers would be trained and supervised in an interdisciplinary team setting.

Evaluation of the program would compare the target population of infants and children whose mothers received the proposed intervention with a similar high-risk group that received only traditional interventions.

A MILLION CHILDREN in the United States are estimated to be abused or neglected, with the number of reported incidents increasing steadily. The actual number of abused or neglected children is believed by many to be far higher than the number of reported cases because frequently child abuse and neglect are unrecognized or unreported.

A report of the Office of the Attorney General of California has described child abuse as probably the leading cause of childhood death (*1*). Many abused children sustain lifelong emotional and physical injuries. Many grow up to become perpetrators of child abuse, continuing the cycle into future generations.

Child Abuse Risk Factors

Studies have identified a group of assessment criteria to help identify mothers who may be or are likely to be involved in abuse of their children. A group of identified risk factors is used by the County of Los Angeles (CA) Department of Health Services in its Child Abuse Prevention Program. The predictive tool is a multiple choice form, High-Risk Assessment Criteria for High Priority Families (see accompanying box), used to enable investigators and case workers to estimate risks to children in the child's family environment.

Among mothers, particular risk factors for child abuse have been identified in studies (*2–5*) that have evaluated such factors as:

- the mother's family history and financial status;
- her self-perception and the effectiveness of her support system;
- her age at the birth of her first child;
- her history of substance abuse;
- the level of her knowledge of the growth and development of children;
- her perceptions of family discipline, the pregnancy state, and her feelings toward her fetus; and
- her labor and delivery experience.

Mothers who are or are likely to be a dysfunctional parent can be identified during their prenatal and postpartum periods with fair reliability using predictive tools that recognize the risk factors

High Risk Assessment Criteria for High Priority Families

1. Stress situation
Social isolation
Single parent
Inadequate access to resources
Without family support systems
Few social contacts
Family's perception of and inability to cope with finances
Other

2. Mental health problems
Mood disturbances
Suicidal ideation
Psychosis
Paranoid
Psychiatric hospitalization
Post traumatic shock
Other

3. Family discord
Hostile toward child
Rejection of child
Prolonged separation of parent and child, such as jail, foster placement, illness, hospitalization
Severe ambivalent feelings towards child
Infant abandoned in hospital
Negative concept of child
Other

4. Teen mother 16 years or younger

5. Parenting
Questionable parenting skills
Questionable bonding
Unhealthy or unsafe home environment
Unrealistic expectations of child's development
Chaotic home situation
Harsh discipline techniques
Inappropriate supervision
Child-parent role reversal
Other

6. Behavioral problem, child
School problems
Hyperactive
Precocious
Repeated involvement with the juvenile system
Destructive
Depressed
Withdrawal
Poor impulse control
Peer pressure
Other

7. Drug or alcohol abuse
Substance abuse by parent or guardian
Substance abuse by child
Substance abuse during pregnancy
Accidental ingestion by child

8. Domestic violence
Spousal abuse
Elder abuse
Sibling abuse
Involvement in illegal or criminal activity

9. Incarceration of parents
Parent on probation or parole
Previous conviction for child abuse or neglect
Previous arrest for domestic violence crime
Involvement in sales or manufacturing of illegal substances

10. Parents with
Physical handicap
Developmental disability
Acute or chronic medical or psychological problems

11. Parents of child with
Physical handicap
Developmental disability
Acute or chronic medical or psychological problems

12. Perinatal
No prenatal care
Less than 3 prenatal visits
Unwanted pregnancy
No compliance with medical treatment
Wrong sex
Low birthweight
Prematurity

13. Infant care problems
Feeding disorder
Sleep disorder
Inappropriate toilet habits
Pre-failure to thrive
Other

14. Infrequent or inadequate medical care, or lack of followup of appointments
Immunizations

15. Families with children who have experienced traumatic injury or injuries

16. History of death of another child in the family

17. History of parents having been abused themselves

18. Recent relocation

19. Homeless

20. Department of Childrens Services (DCS) involvement for child abuse or neglect
Open case
Old or closed case
Repeated referral to DCS

SOURCE: County of Los Angeles (CA), Department of Health Services, Child Abuse Prevention Program.

mentioned (*2–6*). Studies show that the programs that are most successful in preventing child abuse are those in which a nurse visits a high-risk mother in her home during the prenatal and postpartum periods. The studies found that confirmed reports of child abuse and neglect significantly declined among mothers who were visited regularly by a registered nurse. Their children had higher developmental levels, fewer emergency room visits, and fewer accidents and poisonings than did comparison group children (*6, 7*).

In a program in Denver, CO, to prevent child abuse, mothers with effective parenting skills were employed as lay health visitors to make home visits to women with infants. The program was based on a concept, advanced by Dr. C. Henry Kempe, a pediatrician and noted authority on the subject of child abuse, of using lay health visitors as a means of preventing child abuse and neglect. Gray and Kaplan (*8*) described the program as one with promise in accomplishing the goal of child abuse prevention.

A significant risk factor for child abuse has been found to be a lack of family support systems (*2–4, 6, 9*). Brazelton recognized the value of grandparents as a support system for a family raising children (*10*). "When young parents are under stress—the normal stresses of child bearing and child rearing—they often don't know whom to turn to for help. If possible, I would prefer that grandparents be nearby and available," he said.

Many mothers do not have the close support afforded by biological grandparents or an extended family. However, the well accepted Foster Grandparent Program has demonstrated the potential of such programs to offer needed support. The program, which began in 1965, pairs older adults with children in institutional settings. Participants must be healthy, 60 years or older, and with incomes not exceeding eligibility guidelines. They work 5 days a week, 4 hours a day, for a tax-free stipend, using their skills and experience to benefit children (*11, 12*). The program is funded by a Federal grant administered by ACTION, the Federal Volunteer Service Agency (personal communication, Chantal Denny, Director, Foster Grandparent Program, Los Angeles, CA, February 13, 1989).

Programs that use older adults also have been successful in providing an effective support system for teenage mothers and families in situations in which child abuse has already occurred (*13*).

Objectives and Methods

The long-term objective of the proposed innovation in health promotion and disease prevention is to permit the child to develop in keeping with accepted developmental milestones. Such physical, mental, social, and psychological development does not take place in a family environment in which child abuse is a factor. The child's developmental progress depends upon the mother, or both parents, acquiring appropriate parenting skills at each stage of their child's development. The model for this program is Dorthea Orem's theory of self-care (*14*).

The proposal calls for a preventive program designed to train and employ women from the Foster Grandparent Program to provide the needed support, education, and modeling of positive parenting principles for mothers having their first child, who also are at high risk for being child abusers. First-time mothers were chosen because they are considered less likely to be established in a dysfunctional parenting pattern and more receptive to this type of intervention.

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Child Abuse Prevention Team

The proposed intervention program calls for a team approach, coordinated by a public health nurse, with the team responsible for screening, training, and evaluation activities. The team would consist of a public health nurse who has special training in maternal and child health and recent training in child abuse prevention, a licensed child psychologist, a pediatric nurse practitioner, a pediatrician, a social worker, and foster grandmothers. Nurses in community health center prenatal clinics would administer the predictive tool, the High-Risk Assessment Criteria for High Priority Families.

The professional team members would be responsible for screening foster grandmothers. Requirements for selection would be practical knowledge of parenting skills, or experience in working with children; character references; and police clearance. A health screening would be provided by the community health center, consisting of a physical examination, a tuberculin skin test, a rubella titer, and a psychological evaluation to include evaluation of attitudes about parenting and discipline.

The professional members of the interdisciplinary team would train foster grandmothers in specific aspects of child care. The curriculum would include early detection of child abuse, either emotional, physical, sexual, or neglect; child growth and development; principles of positive parenting for infants, toddlers, and preschool children; providing a safe and secure environment; appropriate responses to emotional, nutritional, health, and hygienic needs of children; appropriate discipline; and cultural differences in child rearing. The initial training would involve 3 hours a day, 4 days a week, for 4 weeks, for a total of 48 hours. Two

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hours a month of continuing training would be provided.

The pediatrician or the pediatric nurse practitioner, or both, would evaluate the infants and children in the program every 6 months in order to monitor growth and development. The child psychologist would be available for consultation and evaluation of infants and children.

Foster Grandmother Program

During the 20th week of pregnancy, mothers would be screened in the prenatal clinic by nurses using the High-Risk Assessment Criteria to assess their potential for child abuse. A numerical rating scale for the predictive tool is being developed for the county Department of Health Services.

Those mothers identified as at risk would be introduced to the idea of having a foster grandmother to help them in their homes with the new baby. Those who agree to participate in the program would meet the foster grandmother in the clinic setting. An appointment would be made by the foster grandmother to visit the mother in the home, prior to the birth of the child, to establish rapport. After the birth, the foster grandmother would visit the mother and infant in the hospital. She would be able to observe how the mother and infant were bonding, reinforce the prenatal teaching, and answer the mother's questions related to infant care.

The foster grandmother would begin home visits within a week of the mother's hospital discharge. She would spend about 2 to 4 hours a week in the home, depending on the needs of the family. The frequency of visits might be adjusted, depending upon circumstances. She would assist the mother in the care of the infant, modeling skills in bathing, feeding, and handling and providing sensory and emotional stimulation. She also would be available to care for the infant for short periods of time to allow the mother to do errands or have time for respite. The foster grandmother would be directly responsible to the public health nurse, who would supervise her in the home at regular intervals.

The foster grandmother visitation program would be designed to augment available community resources. The mother would be encouraged to use such resources as food stamps, hotlines, parenting classes, parent support groups, and the community health center. As the child grows, the foster grandmother would teach and model principles of responsible parenting, home safety for children, nutrition, health and hygiene, growth and development, and appropriate discipline consistent with developmental needs of the child.

Project Significance

The project would contribute to the body of knowledge related to positive measures for the prevention of child abuse. The specific intervention in this project is the use of the foster grandmothers, who would be trained by the interdisciplinary team to provide a support system by modeling and teaching sound parenting skills during home visits.

Young mothers are believed to be receptive to learning and practicing improved parenting skills through an intervention of the foster grandmother type. Improved parenting skills would be a major factor in enabling young mothers to cope with parenthood, and in lessening factors which are known to contribute to child abuse and neglect. An improved home environment would further the child's development and reduce physical disabilities, learning deficits, and emotional trauma. The program has the potential to help break some of the generational cycles of abuse.

Budget Estimate

Costs of the proposed intervention are based on annual estimates for one team, consisting of 6 health professionals, working with 60 high-risk mothers. The project would pay for one full-time and two part-time professionals. The other three would be staff members of the supporting community health center, not paid by the project.

Costs shown are on the basis of one team supervising 15 foster grandmothers, each of whom would be helping 4 mothers. Additional groups of foster grandmothers and mothers would be in addition to costs shown here. Project costs are projected on the annual basis. Ideally, each mother

would be involved with the program until the child was 5 years old.

Items	*Estimated costs*
Total	$121,170
Project staff:	
Public health nurse, full-time	$35,000
Child psychologist, part-time	17,500
Research consultant, part-time	10,000
Clerical, part-time	10,000
Foster grandmothers:	
15 at $2,200 a year each ($2.20 per hour, 20 hours a week, for 50 weeks)	33,000
Health center resources:	
Pediatric nurse practitioner	
Pediatrician	
Social worker	
Nurse, risk assessment screening	
Foster grandmothers medical and psychological screening services	
Foster grandmother police screening:	
15 at $8 per person	120
Equipment, materials, and related costs	15,550

Evaluation Methods

The project will be evaluated with a study to compare the results of the proposed intervention program to other interventions. All mothers would be screened with the predictive tool in the prenatal clinic, but only first time mothers found to be at high risk would be selected for the program.

The primipara women who are high risk for dysfunctional parenting would be divided into 2 groups of 60 each. Similar community resources would be available to both groups of high-risk mothers, such as prenatal classes, hotlines, parenting classes, parent support groups, and programs for low-income families, including food stamps and Aid to Families with Dependent Children benefits.

One group of mothers would avail themselves of the usual resources for high-risk mothers in the community. The other group would be offered the foster grandmother visitation program to augment community resources. The development and adjustment of the children of the two groups of mothers would be compared.

Criteria for evaluating the outcomes of the infants and children would be

- number of developmental milestones reached, such as height and weight, crawling, walking, and speech. The child would be evaluated every 6 months.
- number of emergency room visits,
- number of poison ingestions,
- number of accidents, and
- number of reported incidents of child abuse.

In summary, the analysis of the findings will determine whether the foster grandmother visitation program is a significant intervention in reducing indicators of child abuse and neglect.

References

1. Office of the Attorney General of California: Child abuse prevention handbook. Crime Prevention Center, Sacramento, CA, 1985.
2. Anderson, C. L.: Assessing parenting potential for child abuse risk. Pediatr Nurs 13: 323–327 (1987).
3. Josten, L.: Prenatal assessment guide for illuminating possible problems with parenting. MCN 6: 113–117 (1981).
4. Gabinet, L.: A protocol for assessing competence to parent a newborn. Gen Hosp Psychiatry 8: 263–271 (1986).
5. Larson, C. P., and Collet, J. P.: The predictive accuracy of prenatal and postpartum high risk identification. Can J Public Health 78: 118–192 (1987).
6. Woods, J.: A practical approach to preventing child abuse. Health Visitor 54: 281–283 (1981).
7. Olds, D. L., Henderson, C. R., Chamberlin, R., and Tatelbaum, R.: Preventing child abuse and neglect: a randomized trial of nurse home visitation. Pediatrics 78: 65–78 (1986).
8. Gray, J., and Kaplan, B.: The lay health visitor program: an eighteen-month experience. *In* The battered child, edited by C. H. Kempe and R. E. Helfer. Ed. 3. University of Chicago Press, Chicago, IL, and London, 1980, pp. 373–378.
9. Helfer, R. E.: An overview of prevention. *In* The battered child, edited by R. E. Helfer and R. S. Kempe. Ed. 4. University of Chicago Press, Chicago, IL, and London, 1987, pp. 425–433.
10. Brazelton, T. B.: Working parents. Newsweek 113, 66–70 (1989).
11. Dudley, A.: Foster grandparents. Nurs Mirror and Midwives J 143: 75 (1976).
12. Tice, C. H.: A gift from the older generation: continuity . . . bringing old and young together in common activities. Children Today 11: 22–6 (1982).
13. Ventura-Merkel, C., and Freedman, M.: Helping at-risk youth through intergenerational programming. Children Today 17: 10–13 (1988).
14. Orem, D. E.: Nursing: concepts of practice. Ed. 3. McGraw-Hill Company, New York, NY, 1985.