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Essentials for Childhood: Planting the Seeds for a Public Health Approach to Preventing Child Maltreatment

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Abstract

Public health addresses child maltreatment and other adverse childhood experiences by focusing primarily on preventing them from happening in the first place; understanding and addressing their individual, relational, community, and societal causes using the best available scientific evidence; and engaging in large-scale, multi-sector partnerships. Such large scale efforts require bringing together a compelling narrative, relationships, and strategy. This article describes how the Centers for Disease Control and Prevention used a public health approach to develop a narrative, relationships, and strategy to prevent child maltreatment.

Keywords

Centers for disease control and prevention; Child abuse; Child neglect; Child maltreatment; Prevention

Violence, including violence against children, has been recognized as a public health problem for decades because of its frequency and health burden (Mercy and O'Carroll 1988; U.S. Department of Health and Human Services 1980). Children experience particularly alarming rates of violence. A systematic review of national estimates of violence against children in 96 different countries suggests that a minimum of 50% of children in Asia, Africa, and North America experienced violence in the past year (Hillis et al. 2016). Decades of research have shown a robust, dose-response relationship between violence against children and other forms of adverse childhood experiences (ACEs) and health problems. The health impacts of ACEs include: health risk behaviors such as smoking (Felitti et al. 1998; Ford et al. 2001); alcohol abuse (Dube et al. 2002); substance abuse (Dube et al. 2003); sexual risk-taking (Hillis et al. 2001); sexually transmitted diseases (Felitti et al. 1998); mental distress (Gilbert et al. 2010) and depression (Chapman et al. 2004); intimate partner violence (Whitfield et al. 2003); suicide attempts (Dube et al. 2001); chronic disease (Felitti et al. 1998; Gilbert et al. 2010); cancer (Brown et al. 2010); and

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Conflict of Interest

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increased risk for premature mortality by as many as 19 years (Brown et al. 2009). More recently, ACEs have been found to increase the risk for dropping out of school, being unemployed, and living in poverty (Metzler et al. 2017).

Child maltreatment (CM) has historically been viewed as the responsibility of child protective services agencies in the United States. Given however its prevalence, the serious consequences, and preventability of CM, public health could play an important role in addressing this issue (Hammond 2003). Public health's mission is assuring the conditions in which people can be healthy (Institute of Medicine 1988). Addressing a problem such as CM and other ACEs with a public health perspective means a strong focus on preventing its occurrence (i.e., primary prevention; Mercy & O'Carroll, 1988). Public health (a) defines the problem (i.e., establishes case definitions and demographic, temporal, and geographic characteristics of the problem), (b) identifies its determinants and causes, (c) develops and evaluates interventions, (d) and implements interventions based on the best evidence (Mercy et al. 1993).

Given public health's understanding of the individual, relational, community, and societal causes of CM (i.e., the social-ecological model; Dahlberg and Krug 2002), preventing CM involves large scale, multilevel, and cross-sector efforts. Such large scale efforts require bringing together a compelling narrative, relationships, and strategy (Ganz 2011). What follows is the history of how the Division of Violence Prevention at the Centers for Disease Control and Prevention (CDC) developed a narrative, relationships, and strategy to prevent CM that incorporates this public health approach.

Narrative

In 2004, CDC learned about the dominant narrative around CM when Prevent Child Abuse America brought to our attention research on the public's understanding of CM (Frameworks Institute 2004). This research showed that while 9 out of 10 adults thought CM was a problem, they did not see it as *their* problem. It was about "those people" who were "bad parents". In turn, the public saw the solution as reporting and "fixing parents" (Frameworks Institute 2004). These perceptions make the prevention of CM difficult using a public health approach that addresses societal and community-level factors. However, the Frameworks Institute (2004) research also showed that, when CM is framed in terms of promoting and supporting positive child development, the public was supportive of preventive policies.

In order to integrate the Frameworks Institute's (2004) findings into a comprehensive public health strategy to prevent CM, a small group of CM subject matter experts at CDC's Division of Violence Prevention (DVP) considered theories and research on child development coupled with the multilevel public health model and proposed an approach to CM prevention that focused on positive child development. The phrase "safe, stable, nurturing relationships and environments" was devised in order to shift the narrative from a deficit-based conversation to a positive one that focused on providing *all* children what they need to thrive. Safe, stable, nurturing relationships and environments were the antithesis of CM. CDC embraced this framing because it was grounded in a comprehensive public health

framework to prevent CM so the theme became DVP's strategic direction (Division of Violence Prevention). After focus group testing, the theme was branded as "Essentials for Childhood."

To change the narrative, DVP encouraged states to disseminate ***The Raising of America: Early Childhood and the Future of Our Nation,*** a five-part documentary produced by California Newsreel (http://www.newsreel.org). The California Newsreel documentary was in good alignment with a public health framework for preventing CM. Using a combination of purposive, snowballing, and opportunistic sampling, California Newsreel surveyed 140 advocates, practitioners, policy-makers, and researchers; conducted in-depth interviews with 87 thought-leaders, including researchers, advocates, organizers, funders, community leaders, policy makers, practitioners; conducted focus groups; reviewed and content analyzed over 200 websites; and reviewed early childhood development-related media) to prepare this documentary. In this formative research, the producers found that the dominant narrative around child development was individualistic – mostly a "blame the parents" if children were not faring well (Adelman et al. 2011). This narrative was consistent with Frameworks' (2004) findings several years earlier.

However, the producers also learned from interviews with child development experts that even the best intentioned parents may be handicapped by economic uncertainty; crowded, noisy and poor quality housing; food insecurity; segregation; unsafe neighborhoods; and lack of health care, child care and paid parental and sick leave. In order to help change the dominant "blame the parent" narrative, this documentary series reframed the conversation about childhood development in America by tapping into the shared value of the nations' future prosperity (Frameworks Institute 2005). The documentary explained the importance of investing in early childhood to prevent ACEs and suggested some policies that might protect children from adversity such as high quality childcare and early education.

Relationships

Relationships are key to children's healthy development but they are also important in building support and action for prevention. Multi-sectoral engagement is critical in solving a complex public health problem such as CM. In 2004, CDC provided funding to three national organizations (i.e., Prevent Child Abuse America, National Alliance of Children's Trust and Prevention Funds, and Parents Anonymous) through the Building and Enhancing Community Alliances United for Safety and Empowerment (BECAUSE) Kids Count cooperative agreements (CE06–603 and Funding Opportunity Announcement 04142) to expand their capacity to address CM by sharing the social-ecological model and evidence-based strategies focused on primary prevention and fostering effective collaboration. Over several years, CDC worked with BECAUSE grantees to conduct organizational assessments of their infrastructure capabilities, staff and structural capacities; organizational definitions, understandings, and application of prevention principles and key concepts; assessments to determine organizational readiness for dissemination of CM prevention concepts and strategies and organizational barriers and facilitators with emphasis on prevention of CM before it occurred; inventory initiatives and review organizational data related to the prevention of child maltreatment; and develop, implement, and evaluate a prevention plan.

Assessments of the prevention work implemented by these organizations not only helped inform the development of Essentials for Childhood (see section on strategy), but it also pointed to the need to focus on how to improve use of the existing scientific evidence.

In 2006, CDC convened a group of non-governmental partners to get input on where to take CM prevention strategies next and to identify opportunities for collaboration. One of the overarching issues identified by partners was the need for the field to develop a unified message and approach to CM prevention. Participants suggested CDC serve as a convener and assist with the development of a unified message and strategy for the field, including work on a national initiative for CM prevention.

In 2008, CDC, the three national organizations from BECAUSE, and the Office of Child Abuse and Neglect led the Knowledge to Action Child Maltreatment Prevention Consortium (K2A) to prioritize, stimulate, and integrate research, policy and practice by transferring evidence-based knowledge regarding community and societal level actions that promote safe, stable, nurturing relationships and environments for children. The K2A initiative brought together a select group of both traditional and non-traditional partners (e.g., researchers and practitioners in the CM field; human systems dynamics and social norms research experts; National Council of State Legislators; foundations; media; public health; and parent leaders) to learn together, explore sectors with the greatest opportunity and leverage, and discuss ways to engage new partners in addressing the public health issue of CM and the contexts in which it emerges. For example, K2A identified the business sector as an important partner to assure safe, stable, nurturing relationships and environments. This led to the Division's development of strategies to engage the business sector (Division of Violence Prevention, 2017a, b). A number of the K2A members formed new relationships with other members and went on to partner in promoting safe, stable, nurturing relationships and environments in different ways. For example, many K2A members are involved in leadership and partnership roles in both the funded and self-supported Essentials for Childhood state work.

In the Essentials for Childhood funding opportunity announcement (CE13–1303), CDC required that states use a collective impact approach. Collective impact, which will be discussed in the strategy section, involves building a cross-sector partnership that commits to a common agenda for solving a complex social problem. Of relevance here is that building relationships is key for success in collective impact (Lynn et al. 2018). Strong, trusting relationships facilitate alignment of activities and elimination of duplicative efforts. Relationships are also important in engaging non-traditional partners (e.g., the business sector, media) in understanding the return on investment in prevention and the roles that they can play in helping to assure safe, stable, nurturing relationships and environments (Division of Violence Prevention, 2017a).

Strategy

With safe, stable, nurturing relationships and environments identified as CDC's vision and strategic direction to prevent CM, we needed to develop guidance on how that could be achieved. Several CM and communication subject matter experts in DVP (henceforth

referred to as “the team”) identified the critical actions that would most likely lead to achieving this vision. Based on DVP’s work of building the evidence base around programs, the first inclination was to disseminate specific programs that could help prevent CM. In 2009, however, CDC Director Frieden (2010) brought attention to a broader vision with his health impact pyramid and emphasis on changing the context and addressing socioeconomic factors. Although this broader vision was in line with our multi-level social-ecological approach to prevention, a focus on socioeconomic factors had not been attempted in the field of CM prevention but we recognized the opportunity for achieving population-level change. This analysis led the team to propose a more comprehensive approach including a focus on community and societal level conditions (e.g., social norms and policies) that create the context for CM to occur or that prevent it from happening.

There was little research on CM preventive interventions at the community or societal levels (Klevens and Whitaker 2007). CDC’s work with the three national child abuse prevention organizations (Prevent Child Abuse America, National Alliance of Children’s Trust and Prevention Funds and Parents Anonymous) also revealed that most of the hundreds of different programs they delivered were focused on changing individual behavior, thus potentially reinforcing the dominant narrative of “bad parents” as the problem. The social ecological framework and Frieden’s (2010) pyramid suggest that programs focused on individual behavior change alone would not suffice and that, in addition to programs, we needed strategies, not just programs, that address the broader context in which families live (Melton 2013).

The first step in writing the guidance to implement Essentials for Childhood was to identify key goals and possible steps that, when implemented together, were more likely to build the comprehensive foundation for safe, stable, nurturing relationships and environments for all children. Considering the importance of the outer levels of the social ecology where we were more likely to see population-level impacts, we settled on four key goals: (a) raise awareness and commitment to promote safe, stable, nurturing relationships and environments; (b) use data to inform actions (a basic public health premise); (c) create the context for healthy children and families through norms change and programs; and (d) create the context for healthy children and families through policies (Division of Violence Prevention 2012). The guidance document explains what each of the four goals imply and provides examples and resources to assist states’ and communities’ work in each goal. During the writing process, members of the K2A reviewed drafts and provided input. K2A members brought important perspectives from practice and research in the CM field as well as parent groups and the business sector.

At the time, the team was aware of a small number of state public health agencies that had developed comprehensive work with a group of partners to integrate data and research into new programs and policies. To identify the states leading the way in these efforts and their core components, in 2009, DVP surveyed state health departments (Division of Violence Prevention n.d.). Although 69% reported seeing CM as a public health issue, only 39% had a program or staff person working on preventing it; 41% reported having a state plan to prevent CM but in 24% of the states with plans, the health department had no role in developing the plan. Six percent of state health departments received Community-Based

Child Abuse Prevention (CBCAP) funding from the Department of Health and Human Services; 14% reported not knowing what agency received CBCAP funding in their state (Division of Violence Prevention n.d.). As a result, CDC saw an opportunity to build capacity in state public health departments to prevent CM using the Essentials for Childhood Framework.

In order to support states in implementing the Essentials Framework, CDC released a funding opportunity announcement (CE13–1303) in 2013 to fund five state health departments for 5 years. The funding announcement required state health departments to partner with their state affiliate of Prevent Child Abuse America, National Alliance for Children's Trust and Prevention Funds, or Parents Anonymous. Other required partners were their state CBCAP lead, their Core Injury Program (if there was one), and a representative from the business sector (Division of Violence Prevention 2013). Partnering with other organizations and non-traditional partners was also encouraged. They were also required to use a collective impact process and work in all four goal areas.

Collective Impact

Assuring safe, stable, nurturing relationships and environments is complex and requires a multi-sectorial effort. This fit with the concept of adaptive problems that Kania and Kramer (2011) believed a collective impact process was best suited to address. They defined collective impact as "long-term commitments by a group of important actors from different sectors to a common agenda for solving a specific social problem" (p. 39). In addition to a common agenda, their research suggested that having a shared measurement system, engaging in mutually reinforcing activities, having ongoing communication, and a backbone organization (i.e., "dedicated staff separate from the participating organizations who can plan, manage, and support the initiative through ongoing facilitation, technology and communications support, data collection and reporting, and handling the myriad logistical and administrative details needed for the initiative to function smoothly."; p. 40) were characteristics of successful efforts.

Developmental Evaluation

The Essentials for Childhood Framework suggests ways communities might go about promoting safe, stable, nurturing relationships and environments but the Framework had not been tested. CM is a complex public health problem; its prevention would require engaging many sectors and organizations. Given the limited evidence base for effective prevention approaches at the outer levels of the social ecology, there was a high degree of uncertainty about what would work. In order to build this evidence, it was important for funded states to experiment with different approaches and activities that are grounded in the Essentials for Childhood Framework. The public health approach requires data and continuous feedback to decide next steps. As a result, the team encouraged state evaluators to conduct developmental evaluation. Patton (1994) defines developmental evaluation as "Evaluation processes and activities that support program, project, product, personnel and/ or organizational development (usually the latter). In developmental evaluation, the evaluator is part of a team whose members collaborate to conceptualize, design, and test new approaches in a long-term, on-going process of continuous improvement, adaptation, and intentional

change. The evaluator's primary function on the team is to elucidate team discussions with evaluative data and logic, and to facilitate data-based decision-making in the developmental process" (p. 317).

Bringing in Health Equity

Addressing social determinants (i.e., the conditions in which people live and work; Commission on the Social Determinants of Health 2008) is a central focus in the Division's strategic direction around safe, stable, nurturing relationships and environments, especially CM's inequitable distribution by class and race. CDC recognized that CM and safe, stable, nurturing relationships emerge from and are sustained within the social contexts that help create and support them (Division of Violence Prevention). In 2009, CDC received funding from the Doris Duke Charitable Foundation to explore the policies that create poor living conditions for some families (i.e., the social determinants of CM). Policies can be powerful tools for prevention given their potential to affect living conditions that can improve population-level health (Commission on the Social Determinants of Health 2008; Frieden 2010). This work focussed on state-level policies for two reasons. First, states and local governments contribute to two thirds of all public spending on children (Isaacs et al. 2011) and therefore, state-level public policies could have substantial impacts on children. Second, the variation across states and small but measurable change over time in the selection and implementation of policies offered multiple "natural experiments" which could facilitate our evaluation of the impact of policies. Building the evidence base for prevention strategies is a key step in the public health approach.

To identify state policies that might affect the social determinants of child abuse and neglect rates, the first author (J.K.) consulted with policy experts from different sectors (i.e., child and family welfare, economics, public health, health care, and environment). For these policy experts, we defined social determinants as the circumstances in which people are born, grow, live, work, and age (Robert Wood Johnson Foundation et al. 2010). As a result, these policy experts identified over 50 state policies with potential impacts on the social determinants of CM; we identified available data sources documenting the implementation of 31 policies and utilized the available data to establish the effects of 11 policies on CM rates (Klevens et al. 2015). These policies addressed poverty, concentrated poverty, access to high quality affordable childcare, early education, and access to health care.

The Essentials for Childhood team also used the World Health Organization's Commission on the Social Determinants of Health's (CSDH; 2008) theoretical framework to organize our evaluation of the Essentials for Childhood funding initiative. Based on this framework, the team identified a range of indicators to track in order to evaluate the impact of Essentials for Childhood on promoting safe, stable, and nurturing relationships and environments. Figure 1 shows some of the indicators used to track progress. The CSDH framework has constructs representing structural determinants (i.e., social and economic policies that create hierarchies by income, race, and gender), intermediary determinants (i.e., living conditions), and outcomes plus a crosscutting box. The cross-cutting box, labeled collective efficacy, can be seen as representing organized communities changing the narrative (i.e., raising awareness around the societal factors that support safe, stable nurturing relationships and

environments) to build commitment for policies (first box on the left) that will reduce inequities by class and race (second box on the left). If we reduce inequities by class and race, we expect to see improved conditions (or safe, stable nurturing environments) for children and families (third box or intermediary determinants). Improved conditions are expected to reduce the likelihood of children's exposure to partner violence and maternal depression (third box). These improved conditions and decreased exposure to childhood adversities are expected to increase safe, stable, nurturing relationships and reduce CM, especially its inequitable distribution by class and race.

Implementing the Essentials for Childhood Framework

What follows, are four case studies from three CDC-funded states and one self-supported state that implemented the framework over a five-year period. Case studies are particularly appropriate for describing complex interventions such as the Essentials for Childhood Initiative. Many of the lessons learned emerged from the processes of exploration and incremental understandings by which solutions were proposed, refined, supported, funded, implemented, refined again, and assessed (Woolcock 2013). When a problem and the intervention are complex, the interpretation and implications of 'the evidence' from any evaluation is not self-evident; it must be interpreted in the light of our assumptions and benchmarked against reasoned expectations of when changes might occur (Woolcock 2013). As such, we did not expect reductions in CM in 5 years. In the logic model for the funding initiative (Division of Violence Prevention 2013), it shows for the short-term outcomes (i.e., 2 years) that we expected increased strategic partnerships and use of data to inform decisions; as mid-term outcomes (5 years), we expected increased awareness and commitment among partners and increased implementation of evidence-based programs and policies; in the long-term (i.e., 10 years), we expected norms change that reflects shared responsibility for children's well-being (i.e., a new narrative), an increase in safe, stable, nurturing relationships and environments and a decrease in CM. A limitation of this special issue is examining the Essentials for Childhood Initiative at 5 years, before we could reasonably expect reductions in CM.

The four case studies use a social constructivist paradigm (i.e., the researcher has a personal interaction with the case; the case is developed in a relationship between the researcher and informants, and presented to engage the reader, inviting them to join in this interaction and in case discovery; Stake 1995). The team chose this paradigm to capture the energy and emotions that were characteristic of Essentials for Childhood efforts.

The aim is not to generalize from these case studies. Context and people matter and efforts such as these will unfold differently from place to place. The aim is also not to prove a causal relationship between Essentials for Childhood efforts and outcomes observed. DVP approached a complex problem with a complex solution by understanding that complexity involves interdependencies. Every stakeholder and organization, contributing what they could, may have made a difference, but no one can claim responsibility (Westley et al. 2007).

During the implementation of the Essentials for Childhood framework, the five CDC-funded states and over 30 self-supported states participated in multiple capacity building events. These included yearly in-person meetings, webinars, and calls with CDC (individual monthly, quarterly group calls with all states, quarterly calls with funded states' evaluators, and quarterly group calls with self-supported states). Topics covered in these events included how to implement collective impact, looking at CM with a health equity lens, changing the narrative, using data to inform decisions, implementing developmental evaluation, engaging the business sector, changing social norms, changing policies to reduce the inequitable burden of CM, changing policies, framing and messaging of childhood adversity and policies to reduce it, sustainability, and taking programs such as the Safe Environment for Every Kid (Dubowitz et al. 2009, 2012) and Child Parent Centers (Reynolds and Robertson 2003) to scale using Medicaid and Title I dollars, respectively.

The last article in this special issue examines the effort across the five CDC-funded sites from an external evaluators' perspective. It synthesizes the commonalities observed in the implementation of the collective impact approach, facilitators, and challenges and identifies important lessons learned based on the experience from the five CDC-funded states (California, Colorado, Massachusetts, North Carolina, and Washington) who participated in this five-year initiative.

A major accomplishment gleaned from the case studies and cross-site analysis is moving the CM field's thinking beyond "fixing parents" to changing the context, especially through systems and policies that are supportive of children and families. As several sites mentioned, public health finally "had a seat at the table" and even though it was "somebody else's table" they were infiltrating other's work with a public health perspective. The new funding cycle (CE18–18013) will provide additional support for policies and norms change based on the best available evidence (Division of Violence Prevention, 2018). CDC will continue to monitor the indicators in Fig. 1 to determine whether policy changes lead to improved conditions for children and families and whether improvement in these conditions lead to reductions in CM and other ACEs, especially their inequitable burden on children in low income households and children of color. This would show the potential for a public health approach to the prevention of CM.

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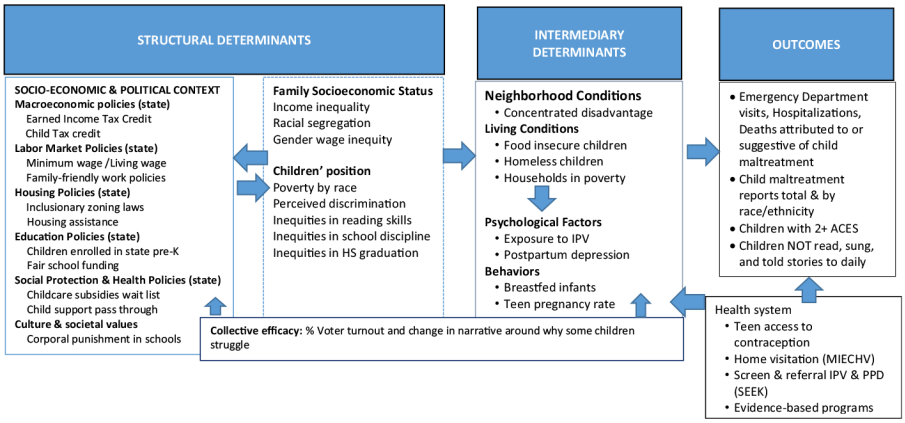

Fig. 1.

Select indicators for evaluating Essentials for Childhood based on the World Health Organization's Commission for the Social Determinants of Health Framework (2008)