Prevention of Child Maltreatment

An evidence-based update and implications for reducing psychiatric impairment

Centre of Excellence for Early Childhood Development
Montreal, September 5-6, 2003
Scope of the problem

Data from the Ontario Mental Health Supplement

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Ontario Health Supplement (OHSUP)

- General population survey of Ontario residents 15 years of age and older
- Response rate was 76.5% (9953/13002)
- Few differences between respondents and non-respondents
- Analysis of relationship between child maltreatment and psychiatric disorder
  N=7,016 respondents under age 65
OHSUP Measures

• Respondents were interviewed face-to-face with the revised Composite International Diagnostic Interview (CIDI) which was used to classify psychiatric disorder

• Self-report instrument used to ask about experiences of child physical and sexual abuse
Lifetime prevalence of child maltreatment by gender

<table>
<thead>
<tr>
<th>Type of Maltreatment</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse</td>
<td>31.2</td>
<td>21.1</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>4.3</td>
<td>12.8</td>
</tr>
<tr>
<td>Any abuse</td>
<td>33.0</td>
<td>27.0</td>
</tr>
<tr>
<td>Any severe abuse</td>
<td>13.2</td>
<td>15.9</td>
</tr>
</tbody>
</table>

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Lifetime prevalence of disorder by gender

- Any anxiety disorder: Male (16.5%) vs. Female (26.5%)
- Major depressive disorder: Male (5.0%) vs. Female (11.7%)
- Antisocial behavior: Male (5.3%) vs. Female (1.4%)

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Population attributable risk (PAR)

- Relationship between the risk factor and outcome is hypothesized to be causal
- PAR compares the outcomes for the whole population to those without the risk factor (not a comparison of those with and without a risk factor)
- PAR measures the potential impact of control measures in a population
PAR for physical abuse

Anxiety disorder
- Male: 13.0
- Female: 13.2

Major depressive disorder
- Male: 14.3
- Female: 26.5

Antisocial behavior
- Male: 24.3
- Female: 54.6

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PAR for sexual abuse

Anxiety disorder  Major depressive disorder  Antisocial behavior

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety disorder</td>
<td>0.2</td>
<td>8.8</td>
</tr>
<tr>
<td>Major depressive disorder</td>
<td>2.9</td>
<td>20.3</td>
</tr>
<tr>
<td>Antisocial behavior</td>
<td>0.7</td>
<td>35.3</td>
</tr>
</tbody>
</table>

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Risk factors for maltreatment

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Correlates of physical abuse

• Male gender
• Parental factors
  – young maternal age
  – single-parent status
  – parental history of physical abuse
  – spousal violence
  – unplanned pregnancy or negative parental attitude toward pregnancy
Correlates of physical abuse

• Parental factors, continued
  – parental history of substance abuse
  – parent social isolation or lack of social support
  – maternal psychiatric impairment
  – low maternal educational level

• Social factors
  – low socioeconomic status
  – large family size
Correlates of sexual abuse

- Female gender
- Parental factors
  - living in family without natural parent
  - poor relationships between parents
  - presence of a stepfather
  - poor child-parent relations
  - low maternal age
  - parental death
Prevention of child maltreatment
Screening for risk of maltreatment

• Accurate prediction of individual cases is not possible
• “Efforts at predicting individual cases should be abandoned” (Kaufman & Zigler, ‘89)
• Efforts should be directed at high-risk communities
• Fair evidence to exclude this maneuver based on cohort studies (MacMillan with Canadian Task Force on Preventive Health Care, ‘00)
Prevention of child maltreatment

Prevention before occurrence

Prevention of recurrence

Prevention of disorder

physical abuse
sexual abuse
emotional abuse
neglect

psychiatric disorders

Effects modified by
frequency
severity
duration
relationship to perpetrator

Effects mediated by
genetics
puberty
social support
other life events

no disorder

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Prevention strategies

• Classified into two main categories
  – prevention of physical abuse and/or neglect,
  – prevention of sexual abuse

• Two forms of programs
  – universal
  – targeted

(Offord et al., 00)
Physical abuse: universal programs

- Universal programs include the provision of general services such as adequate housing and financial support
- No clinical trials have examined the effectiveness of these types of services in decreasing child maltreatment
Perinatal & early childhood programs

- Intensive pediatric contact with home visitation
- Home visitation - during pregnancy, after pregnancy, during and after pregnancy
- Extended postpartum contact - with visits, without visits
- Drop-in Centre
- Parent training program
- Free access to health care
- Comprehensive health services
Only home visitation for disadvantaged first-time mothers has been shown effective in the prevention of physical abuse & neglect
Nurse Home Visitation Program (NHVP)

- First-time disadvantaged mothers received home visits by nurses
- Began prenatally and extended until child’s 2nd birthday (weekly and then tapered)
- Nurses promoted 3 aspects of maternal functioning:
  - health-related behaviors
  - maternal life course development
  - parental care of children
NHVP benefits

- Reduction in verified reports of child abuse and neglect involving the mother
- In a subgroup of highest risk women, reduction in subsequent pregnancies, substance abuse, crime and use of welfare (Olds et al., '97; Eckenrode et al., '00)
- Benefits in associated outcomes such as health care contact for injuries/ingestions (Olds et al., '99)
NHVP Long term effects

- 324/400 participated in 15-yr follow-up
- Women who received intensive home visitation were identified as perpetrators of child abuse and neglect in fewer verified reports than comparison group
- Incidence: 0.29 vs 0.54 verified reports (p<.001)
- Effect was greater for women who were unmarried and from low-SES households (Olds et al., ‘97)
NHVP vs paraprofessional visits

- Better evidence (higher quality, replicated) for nurse home visitation than program provided by paraprofessionals
- Overall nurses produce a larger and broader range of beneficial effects (e.g. infant caregiving, language development)
  (Olds et al., ’02)
Prevention of sexual abuse

- Most programs aimed at improving safety skills and knowledge of children about sexual abuse
- There is evidence that educational programs can improve these outcomes but:
No study has produced data that education actually reduces the occurrence of sexual abuse

(MacMillan with the CTFPHC, ‘00)
Prevention of impairment following exposure to child maltreatment

- Search for preventing impairment has focused on social factors
- Genetic susceptibility factors important
- Sample of male children followed from birth to adulthood – Dunedin study (Caspi et al., ’02)
- Maltreated children with genotype for high MAOA less likely to develop antisocial behaviour
Implications for prevention of psychiatric disorder

- Programs shown effective in preventing child maltreatment may also prevent psychiatric disorder
- Adolescents born to home-visited women reported:
  - less running away
  - fewer arrests and convictions
  - fewer behavioral problems related to use of alcohol and drugs

(Olds et al., ‘98)
Future directions

• Need longitudinal studies which measure both psychosocial and biological factors in examining the relationship between exposure to child maltreatment and psychiatric disorder.

• Study of exposure to such subtypes of child maltreatment as neglect and emotional abuse is also crucial.