# HOME VISITATION AND CHILD ABUSE: The British Experience

—by Kevin Browne

In the past twenty years there has been much debate on what services can be delivered to minimize the maltreatment of children. This debate has been limited by a poor understanding of intervention strategies for child abuse and neglect and of what constitutes a desirable outcome. Reviews on the causes of maltreatment (e.g., Browne, 1988) have emphasized a growing recognition that child abuse and neglect is a product of a poor parent/child relationship. This interactive perspective places less emphasis on individual problems of the parents. Therefore, interventions that strengthen the parent/child relationship are considered to be more promising for prevention than those aimed at parental psychopathology (Wolfe, 1993).

Wolfe (1993) observes that there have been promising developments in early interventions which address parental competency and family support to promote more positive parental knowledge, attitudes, skills, and behavior. He claims that personalized programs such as home visits over a period of one to three years stand out as the most successful interventions in achieving desired outcomes in terms of fewer child injuries, emergency room visits, and reports to protective agencies.

*It has often been emphasized that such "health visiting services" could be used to prevent child abuse and neglect at a primary and secondary level. However, few countries have systematically used home visitation practices in this way, and even fewer countries have evaluated the effectiveness of home visits on the incidence and prevalence of child maltreatment.*

A number of countries have statutory, government-sponsored home visitation programs, usually using health professionals such as community nurses. Most of these programs were set up with the aim of preventing ill health in families and reducing the rates of morbidity and mortality in young children. It has often been emphasized (e.g., Browne, 1989a) that such "health visiting services" could be used to prevent child abuse and neglect at a primary and secondary level. However, few countries have systematically used home visitation practices in this way, and even fewer countries have evaluated the effectiveness of home visits on the incidence and prevalence of child maltreatment.

Studies that evaluate the success of home visitation on reducing child abuse and neglect are mainly North American in origin with the exception of some investigations which have been carried out in the United Kingdom. In a previous article in this volume David Olds has extensively reviewed the North American literature. This paper will review the work carried out in Britian reflecting the experience of the health (home) visiting statutory services and voluntary agencies in the prevention of child maltreatment.

## Historical perspective

Health visiting began in Britain in 1867 by the Manchester and Salford Ladies Sanatory Reform Association which employed "respectable" women to go from door to door giving advice on health and hygiene (Hale and Loveland, 1968). Formal training of health visitors followed soon after on a national basis. In 1946, the National Health Service was established in the U.K. and health visiting was incorporated into the Service. Since then, every British family with a newborn child has received home visits by a community nurse, free of charge, for the first five years of the child's life (see Luker and Orr, 1992).

During the past 126 years, there is little doubt that health visiting has limited the amount of physical neglect and malnutrition suffered by British children. Nevertheless, the reported incidence of child abuse in the U.K. is higher than most other countries in Western Europe. About 1% of U.K. children are seen by professionals for physical, psychological, and sexual abuse combined (Browne, 1989a;1993a). Some may argue that this amount reflects the success of health visitors at detecting children who are abused, or are likely to be abused. However, the number of child deaths from non accidental injury in the U.K. contradicts this viewpoint.

In 1991, British newspapers reported that 99 children under the age of 16 years of age died of non-accidental injury (Browne, 1993b). This figure represents 14% of all homicides and 33% of domestic homicides in 1991 (Browne, 1993b), and is consistent with claim that in England, Scotland and Wales, a fatal injury occurs to two to three children each week (NSPCC, 1985). The homicide rate in the U.S.A. (10 per 100,000 - FBI, 1991) is eight times that of the U.K. (1.3 per 100,000, - Home Office, 1991). The number of children who die of non-accidental injury in the U.S.A. is also much higher, but as a percentage of the overall and domestic homicide rates the percentage figures for the two countries remain remarkably similar (Gelles and Cornell, 1990). In both Britain and the U.S.A., child maltreatment is one of the top five most common causes of death to young children. The youngest children are the most vulnerable to fatal abuse, with 80 per cent of serious head injuries occuring to children under five years of age and 50 per cent to those under one (Crieghton, 1992). These horrific statistics demonstrate the need for early prediction and prevention and this article will address the successes as well as the failures of British home visitation schemes.

## Home Visitation Schemes in the U.K.

### Statutory

During pregnancy, birth and early childhood care, parents are by necessity in contact with the maternity and child health services of the U.K. National Health System. This offers health professionals the opportunity to prepare and support parents in the care of their children. The health visitor's

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role is unique because, as a fully qualified nurse and midwife, s/he offers unsolicited home visits. The work is concerned with health education and promotion of the family as a whole, with visits to families in need being made over a long period of time. Health visitors are trained to recognize health and relationship problems within families and are well placed to assess need and initiate action at an early stage. They encourage parents to take a responsible attitude to the care of their children and to seek appropriate help and support. It is suggested that this approach may reduce the chances of child maltreatment in the family (DOH, 1988a).

The U.K. Department of Health (DOH, 1988b) gives guidelines on the responsibilities of community nurses in relation to the recognition and referral of families under stress, and of families where child abuse and neglect is suspected. They are recommended to:

1. Set up a communication system with social work services and family practitioners about current concerns.
2. Review case loads regularly with colleagues and family practitioners to ensure all the information about the child and family is available.
3. Set up a system of formal notification and participate in case conferences.
4. Collect information about missing families and no-access visits, where there is cause for concern because a child has not been seen.
5. Ensure that there is effective communication with the hospital midwife involved with the family, especially during the hand-over of responsibility at approximately ten days after birth.
6. Take adequate legal advice when required to submit statements or appear as witnesses in court.
7. Prioritize the time necessary to assist in prevention work with families.
8. Establish appropriate systems of record keeping and reporting.
9. Give professional advice and information to other professionals and agencies about the detection and prevention role of health visitors in cases of child abuse.

The above guidelines are necessary as there is no mandatory reporting of child abuse and neglect in the U.K. and some health (home) visitors feel that their involvement in child protection threatens the ethical basis of their health promotion role in the family (e.g., Taylor and Tilly, 1989).

A study carried out by Gilardi (1991) shows that 97% of health visitors had been directly involved in a least one case of child abuse and neglect and over 70% in five cases or more. In 42% of cases the health visitor was the first to suspect abuse and 40% had been involved in the preparation of court proceedings. However, the study also found that a majority of health visitors felt their initial training in child protection was less than adequate.

**Voluntary Agencies**

Volunteers who visit families as a part of a organized plan for the prevention of family problems often have a close liaison with the statutory services. For example, the NEWPIN plan of home visiting and befriending in an inner-city community has shown this liaison to be effective in helping women who are unsupported in their task of motherhood (Pound and Mills, 1985).

The Home Start program (Harrison, 1981) offers the help of non-professional volunteers to intensively support families with small children in their own homes. The organizers claim this home help goes some way to prevent the possibility of child maltreatment. They give meticulous preparation and support for their volunteers in this work. However, the influence of such voluntary work on the prevalence and incidence of child maltreatment has yet to be established.

The two examples of voluntary work with families cited differ from the work of the National Society for the Prevention of Cruelty to Children (NSPCC) by offering support and help before any evidence of damage to the child can be seen. In contrast, the NSPCC works in a similar way to the statutory social services, intervening only after child abuse has occurred. This form of family intervention and treatment, at a tertiary level of prevention, is effective for approximately 60% of physical abuse and neglect cases involving a child under five (Hyman, 1978). Nevertheless, it may be too late for those children who die or who are crippled for life before the physical marks of child abuse and neglect are recognized. The aim for all those involved with child protection work must be secondary and primary prevention of violence to children, and not just inadequate control of the problem at a tertiary level of crisis intervention (Browne and Lynch, 1992).

## Research on the Health Visitor Approach to Prevention

The successes and failures of the statutory health visiting service in detecting and preventing child abuse and neglect has been investigated only over the past five years. Research evaluating health visiting practices can be divided into studies of (1) health visitors detecting the possibility of child maltreatment with the view of secondary prevention; and (2) health visitors intervening to ameliorate parenting problems with the aim of primary prevention.

**Detecting the possibility of child maltreatment**

A number of articles have been written on the prediction of child abuse (see Leventhal, 1988), many of which have presented a list of characteris-

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tics common to abusing parents and to abused children. Community nurses have been significantly influenced in their work by such articles, using the characteristics as "early warning signs" ever since they were first published on a British sample (Lynch, 1975; Lynch et al, 1976; Lynch and Roberts, 1977)

However, recent reviews of the relative value of these characteristics for the practical and routine monitoring of risk in potential child abusing families has emphasized a need for caution (Barker, 1990; Howitt, 1992). Nevertheless, health visitors commonly use checklists of risk characteristics both officially and unofficially. The aim of this risk strategy is to give special attention to those in greatest need of help in parenting before child maltreatment occurs and to distribute the now scarce community resources to their maximal effect. This approach could be regarded as secondary prevention.

Unlike the large number of assessment tools available in North America which have been assessed for reliability and validity for the detection of child maltreatment (see review by Ammerman, 1993), the checklists used by health professionals in the U.K. have not been systematically evaluated. Recently, however, Browne (1993a) prospectively evaluated a typical checklist completed by midwives and health visitors around the time of birth. The checklist was developed from a number of demographic and epidemiological studies carried out in the U.K. with special reference to nonaccidental injury to children in Surrey, England (Browne and Saqi, 1988a).

***At a primary preventive level, health visitors have the unique position of being in contact with all families with a newborn. Thus they can offer help and support to parents without stigmatizing the family as a problem family. They may intervene to halt the progression of underlying family processes that lead to the physical and emotional abuse and neglect of children.***

To facilitate ease of administration, no more than twelve items of information were selected on the basis that they could be routinely and easily obtained by the health visitor and her nursing colleagues. Items included age of mother, time period between pregnancies, post-delivery separation, evidence of prematurity/low birth weight/handicap, family with separated or single parent, socio-economic problems, history of violence, record of psychological problems or socialization difficulties. Characteristics that were more difficult to assess, such as prenatal experiences, were omitted from the checklist to enhance reliability, and not because they were unimportant.

The concept of the checklist was that, when applied to all families with a newborn child in a given locality, exceptional families with a high number of adverse characteristics (risk factors) were identified as "high risk" and offered intervention. It was assumed that the higher the number of factors present, the greater the intervention required and the more "at risk" the child. Evidence for the predominance in abusing families of the characteristics used for screening had been already well established (Browne and Saqi, 1988a).

Health visitors in conjunction with professional colleagues completed the twelve item checklist outlined above on all children born in 1985 and 1986 in three health districts of Surrey, England. In total, 14,252 births were screened for the potential of child abuse and neglect and seven per cent (964) were indentified as "high risk." The full population of 14,452 children was then followed up for five years and in 1991, 106 families had attended a case conference for suspected or actual maltreatment of their newborn child, giving an incidence rate of 7 children in every thousand. This figure is slightly higher than the national estimate of 5 per 1000 for children under five years (DOH, 1992). Table 1 presents the percentage of abusing and non-abusing families that possessed the checklist characteristics (risk factors), in order of relative importance for prediction.

***TABLE 1:*** *Relative importance of screening characteristics for child abuse (as determined by discriminate function analysis)*

| Checklist Characteristics | % Abusing families (n=106) | % Non-abusing families (n=14,146) |
|---|---|---|
| History of family violence | 30.2 | 1.6 |
| Parent indifferent, intolerant or over-anxious towards child | 31.1 | 3.1 |
| Single or separated parent | 48.1 | 6.94 |
| Socio-economic problems such as unemployment | 70.8 | 12.9 |
| History of mental illness, drug or alcohol addiction | 34.9 | 4.8 |
| Parent abused or neglected as a child | 19.8 | 1.8 |
| Infant premature, low birth weight | 21.7 | 6.9 |
| Infant separated from mother for greater than 24 hours post delivery | 12.3 | 3.2 |
| Mother less than 21 years old at the time of birth | 29.2 | 7.7 |
| Step parent or cohabittee present | 27.4 | 6.2 |
| Less than 18 months between birth of children | 16.0 | 7.5 |
| Infant mentally or physically handicapped | 2.8 | 1.1 |

(From Browne 1993a.)

It was found that fully completed checklists, with the relative weighting for each factor taken into account, could correctly classify 86% of potential

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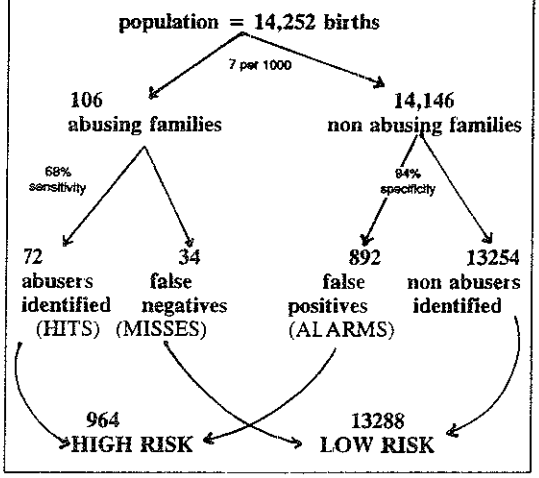
cases. The screening procedure was sensitive to 68% of abusing families and correctly specified 94% of the non-abusing families. Surprisingly, nearly a third of the abusing families had few risk factor characteristics of any weight and were incorrectly indentified as "low risk" around the time of birth. The most worrying aspect of the checklist is that 6% of the non-abusing families were incorrectly identified as high risk for potential child abuse as they were found to have a number of heavy weighted risk factors. Figure 1 shows the grave implications of these statistics in terms of the number of families affected in the population studied.

***FIGURE 1:*** *Screening effects on a population*




The low prevalence of child abuse combined with even the most optimistic estimates of screening effectiveness implies that a screening program would yield large numbers of false positives (Daniel et al, 1978). The checklist detection rate would mean that for every 14,252 births screened it would be necessary to distinguish between 72 true risk cases and 892 false positives in the 964 cases identified as high risk. This would indicate the requirement of a second screening procedure to be carried out with high risk families based on the significant differences found between abusing and non-abusing parent — child relationships (Browne and Saqi, 1987;1988b). Thus, health visitors might be trained to assess the following characteristics of violent parent — child relationships:

- An evaluation of caretaker's knowledge and attitudes to parenting the child.
- Parental perceptions of the child's behaviour and the child's perceptions of the parent.
- Parental emotions and responses to stress.
- The observation of parent/child interaction and behavior.
- The quality of the child's attachment to his or her parents.

A more difficult problem would be to distinguish the 34 missed cases from the 13,254 correctly identified non abusers as they would be mixed up in a population of 13,288 low risk families.

Therefore, when the checklist is applied prospectively to a large population of births, seven per cent of English families with a newborn child show a high number of "predisposing" factors of child abuse. On follow-up, only 1 in 13 of these "high risk" families went on to abuse their children within five years of birth (Browne, 1993a). On the basis that approximately half of all abused children are under five years of age (Creighton, 1992) this figure should have been considerably higher in order to prevent child maltreatment. However, it must be recognized that risk factors, which are thought to predispose families to child abuse, are not a sufficient causal explanation (Browne, 1989b). The chances of these situational stressors resulting in child abuse and other forms of family violence are mediated by and depend on the interactive relationships within the family and other compensatory factors such as social support.

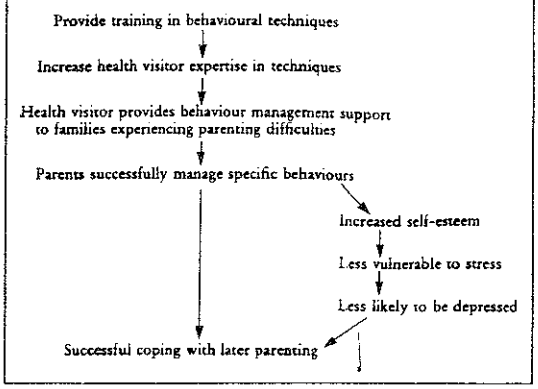
For systematic screening for child abuse and neglect to be successful the health visitors require significant resources to develop reliable and valid methods for detecting risk factors, receive training in methods of screening and the interpretation of risk characteristics, and to implement intervention strategies to prevent or ameliorate undesired outcomes.

Indeed, is it ethical to identify families as high risk without the resources to offer them help and support in reducing their problems?

**Intervening to ameliorate parenting problems**

At a primary preventive level, health visitors have the unique position of being in contact with all families with a newborn. Thus they can offer help and support to parents without stigmatizing the family as a problem family. They may intervene to halt the progression of underlying family processes that lead to the physical and emotional abuse and neglect of children. It is argued by Stevenson et al (1988) that interventions which develop parenting behavior will help directly with coping skills and

***FIGURE 2:*** *Intervening to ameliorate parenting problems*

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indirectly by improving the parents' self esteem (see Figure 2).

It is not surprising that parents require intensive support over a number of visits. Parents cannot assimilate information during one clinic appointment or home visit and translate this into parenting skills. Hence, a number of systematic programs of home visiting by trained nurse health visitors in conjunction with other professionals has been used in the U.K. for the following behavioral interventions: treatment of severe and persistent crime in young children (Pritchard, 1986); treatment of severe feeding problems and non-organic failure to thrive (Iwaniec et al., 1985); intervention involving a set of materials on aspects of child care, nutrition and development which encourages parents to engage in a program of activities with their child (Barker and Anderson, 1988).

In the last few years a number of health districts have used an approach developed by the child development program in Bristol consisting of semi-structured home visits and activities carried out by health visitors. Checks on progress are followed up on a monthly basis. Barker and Anderson (1988) claim that the rate of child abuse and neglect can be reduced in any area by bringing about changes in aspects of the home environment and improving the child's development However, their evaluation is undermined by difficulties in the design and analysis of their data (Stevenson, 1989a).

### Evaluating Health Visitor Interventions

There have been few studies on the outcome of health visitor interventions Unfortunately the studies that have been carried out (Stevenson et al, 1988; Weir and Dinnick, 1988; and Nicol et al, 1984) have failed to identify significant effects of health visitor interventions. Weir and Dinnick (1988) give the following possible reasons for this failure:

(1) The possibility that behavior modification is not effective in treating the problem they were concerned with, namely sleep disturbance.

(2) The health visitors were insufficiently trained in behavioral techniques.

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(3) The rate of spontaneous remission was too high and the sample size too small to show a significant difference in changes between the treated and control groups.

In addition Stevenson et al. (1988) suggest that their lack of significant results may have been due to the health visitors not being supported during their work, and to the evaluation's taking place too soon after the initial training period, before the nurses could use the techniques effectively.

In the U.K. researchers have yet to convincingly demonstrate that nurse health visitors can work effectively by themselves using behavioural management techniques with a wide range of children (Stevenson, 1989b). However, in conjunction with other professional colleagues they show more success (e.g., Pritchard, 1986).

### Conclusion

The research of Olds et al. (1986) in the U.S.A. provides a good example of effective interventions in promotioning parental competence and self confidence in dealing with the care and the management of the child. These interventions improve mother/child play and reduce physical punishment and the incidence of child abuse and neglect. However, Ayoub et al. (1993) claim from their work in Boston that certain families do not benefit from intervention. Families presenting with depression, withdrawal, low self-esteem, limited parenting skills and unrealistic expectations of their children, are most unlikely to show change with home-based interventions. There is a tendency for these families to deteriorate even further in the presence of family violence or chemical dependency. Like researchers in the U.K., Catherine Ayoub and her colleagues argue against a quick fix approach to child abuse and neglect and suggest that continuous long-term early intervention is the only way for family function to be improved, and that in some families, the child's safety must be carefully monitored.

Child maltreatment is a complex problem, but the majority of facets appear to respond better to prevention rather than treatment. In the U.K. at present, resources are not available to implement prevention ideas in a way that will maximize their success. Indeed Wolfe (1993) states that "the transition from a reactive to a proactive child protection strategy will be gradual and no doubt expensive in the short term." Unfortunately, the current British Government has chosen to place less emphasis on health visiting, rather than to develop the service further and provide more appropriate training in child protection for community nurses. In future, written and visual information may be provided to parents to compensate for the decreasing contact with families (e.g., Percy and Barker, 1986).

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# NTPETA Begins Model Program with Sites Throughout the Nation

The National Training Program on Effective Treatment Approaches in Child Sexual Abuse (NTPETA) has developed and will be presenting a state-of-the-art curriculum for therapists who treat sexually abused children. Twenty sites from across the country have been chosen as training sites for this model program

Topics covered during the training include language skills to enhance communication with children and adolescents; expressive techniques; assessment and treatment planning; specific treatment provider issues, such as needs and approaches for self-care and assuring culturally sensitive practices; working with sexually reactive children; appropriate termination of treatment; and serving non-offending parents and siblings.

The dates and sites for the programs are January 10-12, Syracuse, NY; February 15-17, Las Vegas, NV; March 7-9, Boise, ID; March 14-16, LaPlata, MD; March 22-24, Swainsboro GA; March 28-30, Sacramento, CA; April 4-6, Plano, TX; April 18-20, Arvada, CO; May 12-14, St. Louis, MO; May 16-18, Spokane, WA; May 23-25, Kalamazoo, MI; June 6-8, Houston, TX; June 20-22, Philadelphia, PA; June 27-29, Ogden, UT; July 18-20, Akron, OH. For more information about any of these training programs contact: NTPETA, 107 Lincoln Street, Huntsville, AL 35801; (800) 239-9939.