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Promotion of family wellness and prevention of child maltreatment

Which programs are effective?[1]

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The high reported incidence of child maltreatment has led to a wide range of programs aimed at promoting family wellness and preventing child maltreatment. A number of these programs have been evaluated to determine their effectiveness and to identify factors that contribute to their success. This information sheet describes the results of a meta-analysis of 56 evaluated programs designed to promote family wellness and prevent child maltreatment.

Meta-analysis: A comparison of study results

Meta analysis is a statistical technique that enables the results from different studies to be compared. This meta analysis included 56 evaluations conducted between 1979 and 1998 of prevention programs that target children 12 years of age or younger, used a control group, and measured outcomes related to child maltreatment (e.g., out-of-home placement, injuries, hospitalization) or family wellness (e.g., positive interactions, stimulating environment, affection). Therapy, treatment interventions, and sexual abuse prevention programs were excluded.[2]

Program effectiveness

Overall, the meta-analysis found that most interventions aimed at promoting family wellness and preventing child maltreatment are effective. Proactive multi-component, home visiting, and mutual aid programs that begin prenatally or at birth were most effective at promoting family wellness. Only research on home visitation has examined

Proactive and reactive programs

The study used the Rae-Grant classification system (1994)[3] of proactive and reactive programs.

Proactive programs are those that strive to prevent child maltreatment and promote family wellness in families that have not experienced child maltreatment. The types of proactive programs that were examined in the meta-analysis include the following:

- home visiting of mothers by nurses or lay visitors providing support and information
- multi-component, including family support, preschool education or child care, and community development elements
- social support/mutual aid to develop parents' social network
- media interventions providing parenting information, such as newsletters or magazines.

Reactive programs are for families after child maltreatment has occurred. The types of reactive prevention programs that were examined include the following:

- intensive family preservation services (IFPS) to prevent out-of-home placement and/or reoccurrence of maltreatment
- multi-component
- social support/mutual aid
- parent training.

The researchers note that although 56 studies is an adequate sample size for a meta-analysis, sub-classifying these programs into the eight categories listed above resulted in small samples of only one or two studies in some subcategories. Therefore, the results should be interpreted with caution.

child maltreatment outcomes, and these programs were found to be successful in preventing child maltreatment. In fact, the positive results of proactive interventions were sustained or even increased over time.

On the other hand, the positive effects of reactive programs tended to fade over time. This may indicate the importance of intervening while children are very young and before maltreatment has occurred. Proactive programs tend to start when children are very young, while reactive programs tend to serve families with older children. In addition, proactive interventions may be able to initiate, stimulate and encourage positive behaviours that foster family wellness over the long term. Reactive interventions, on the other hand, are initiated after child maltreatment has occurred and focus on addressing immediate needs. These programs were found to have positive impacts in the short term, but these positive outcomes diminish over time.

More significant outcomes were found for the promotion of family wellness compared with preventing child maltreatment. In other words, greater gains were made in boosting competencies rather than in reducing negative outcomes. The meta-analysis found that proactive multi-component initiatives have larger impacts than home visitation and mutual aid programs. Also, reactive IFPS that embrace a strengths-based empowerment model show greater positive outcomes than those without this orientation. But this result was not found for home visiting and multi-component programs. In terms of duration and intensity, the shortest (1 to 6 months) home visitation interventions and those with fewer than 12 visits were the least effective in preventing maltreatment.

Proactive home visiting interventions that include social support for families had a smaller effect in preventing child maltreatment than interventions that did not include this. (However, reactive intensive family preservation services with a component of social support showed lower incidence of child maltreatment.) Perhaps home visiting with a social support component results in more scrutiny of a family's situation leading to higher detection and reporting of maltreatment.

Furthermore, programs that offer practical and financial assistance were less effective than those that did not. This may be because practical support is offered to families who demonstrate a clear need for it, indicating a higher level of crisis and poverty than families who do not receive concrete support. In the same vein, IFPS and home visiting interventions that included families from a mix of socio-economic backgrounds were more effective than programs targeting only low socio-economic status.

The overall results of this meta-analysis suggest that IPFS interventions with an empowerment, strengths-based focus are more effective than expert-driven, deficit based programs. Also, the results of the meta-analysis strongly suggest that home visitation programs should last longer than six months and provide more than 12 home visits.

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1. This information sheet is based on the following peer-reviewed scientific article: MacLeod, J., & Nelson, G. (2000). Programs for the promotion of family wellness and the prevention of child maltreatment: A meta-analytic review. *Child Abuse & Neglect*, *24*(9), 1127–1149.
2. For the meta-analysis of reviews of sexual abuse prevention programs, see: Rispens, J., Aleman, A., & Goudena, P.P. (1997). Prevention of child sexual abuse victimization: A meta-analysis of school programs. *Child Abuse & Neglect*, *21*, 975–987.
3. Rae-Grant, N.I. (1994). Preventive interventions for children and adolescents: Where are we now and how far have we come? *Canadian Journal of Community Mental Health*, *13*(2), 17–36.

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