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Chairman Robert C. “Bobby” Scott
Subcommittee on Civil Rights and Human Services
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Witness:
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Thank you to the members of the Committee for the opportunity to speak with you today.

My name is Dr. Yo Jackson and I am a professor in Psychology as well as the Associate Director of the Child Maltreatment Solutions Network at Penn State University. I am also a research professor at the University of Kansas, and have worked for over 20 years as a board-certified clinical child psychologist and a researcher on the development of resilience for youth exposed to trauma and child maltreatment. Today, I hope to provide the members of the committee with details on the scope and gravity of child maltreatment in the United States, a view into what the data says, and a synthesis of current research in the field.

Child Maltreatment: The scope of the problem

Child maltreatment is a significant public health problem that includes physical abuse, sexual abuse and neglect. A national incidence study showed that 7.5 million children were referred to the protective service system in 2017, with 3.5 million children meeting the minimum threshold of risk to warrant an investigation (also known as being “screened in”). Of those, 674,000 children were determined to be victims of child maltreatment.[1] This translates to 1.3 children being significantly harmed every 60 seconds. The most pervasive form of child maltreatment at 74.9% is neglect (or the failure to provide basic care resulting in harm or threat of harm), followed by physical abuse at 18.3%, which is characterized as the intentional use of force resulting in or with potential to result in physical injury.[1] Sexual abuse accounts for 8.6%, and is characterized as the completed or attempted sexual act, sexual contact, or exploitation of a child by a caregiver.[1] Sadly, 1,720 children died as a result of child maltreatment in 2017, placing the United States second only to Mexico for the most intentional child fatalities in the developed world.[1,2]

Prevalence rates in the US indicate that 37% of children will, in some way, be involved with the child protective services before age 18[3] and 12.5% of children will experience
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substantiated child maltreatment.[4] This rate puts child maltreatment second in terms of the most prevalent childhood public health problem just after obesity and ahead of ADHD, prematurity, asthma, food allergies, cancer, and autism.[4] In 2015, the average lifetime public cost associated with child maltreatment is estimated to be $830,928 per victim, coming to a total of roughly $428 billion in costs for the number of victims over the course of just one year.[5].

Child maltreatment is associated with a plethora of negative and often devastating outcomes. Research consistently shows that child maltreatment (in any form or type) is related to a range of physiological, behavioral, and mental changes for children. It is important to note that most children exposed to child maltreatment are under the age of 7 years old – a time of great plasticity in the developing brain and social interaction systems.[6] Early childhood is a sensitive period for the development of healthy social relationships and the forming of secure attachments, something that is not possible in abusive and threating caregiver-child relationships. Child maltreatment can be responsible for changes to the structure and chemical activity of the brain (like decreased size or connectivity in some parts of the brain) and in the emotional and behavioral functioning of the child (like over-sensitivity to stressful situations). For example, in non-maltreating caregiver-child relations, infants will babble or gesture or cry to bring reliable and healthy reactions from their caregivers. When caregivers respond positively to these efforts, the neural pathways in the brain that are attuned to social interaction and inform the child about the consistency for getting their needs met are strengthened. However, if the caretaker is abusive or neglectful, the child's brain is likely to develop a sense of hyper-alertness for danger or not fully develop. The kind of neuronal pathway that is developed – healthy/secure or hyperalert/underdeveloped will dictate how the child is later able to cope with stressors. When a child is exposed to child maltreatment, their ability to respond to later nurturing care may be limited.

Many biological processes are affected by child maltreatment. For example, research shows that in the brain, adults who were maltreated as children have reduced volume in the hippocampus, a part of the brain critical for learning and memory.[7] Structures like the corpus callosum, responsible for processes like emotion, arousal and complex cognitive abilities are often impaired.[7] The cerebellum is also affected as youth exposed to maltreatment often show decreased volume here, which helps coordinate motor behavior and executive functioning.[8] Finally, the prefrontal cortex, responsible for behavior and decision-making, cognition, social skills, and emotion regulation is often reduced volume in youth exposed to child maltreatment.[9]

Beyond the grave neurological and biological effects, child maltreatment results in a lifetime[10-12] of negative health behaviors and outcomes. Such behaviors include early alcohol use,[13] illicit drug use,[14] tobacco use,[15] as well as risky sexual behaviors,[16] often resulting in outcomes like teen pregnancy,[17] obesity,[18] diabetes,[19] lung cancer,[20] depression and anxiety,[21] cardiovascular disease,[22] chronic pain,[23] and sexually transmitted infections.[24] Youth exposed to maltreatment may show a persistent fear response. Perhaps a result of adaptation under abusive conditions, this threat hypervigilance puts these youth at-risk for the development of future anxiety disorders

like post-traumatic stress disorder. Moreover, hypervigilance can result in difficulty benefiting from instruction in the classroom environment as hypervigilance can include an unrelenting need to monitor the environment for threats. As a result, the brains of child maltreatment victims are less able to interpret and respond to verbal cues, even when they are in an environment typically considered nonthreatening. Often youth exposed to child maltreatment are identified as learning disabled or as having ADHD, in part because their brains have developed in such a way that they are unable to achieve the relative mental calm necessary for learning.

Youth exposed to child maltreatment are at great risk for a range of emotional, behavioral, cognitive and social delays that some may be able to adapt to, but most will never overcome. Neglect is another good example of this process. Neglect is not only failure to meet the child's basic physical needs like for food and safety, but it also can be a failure to meet a child's cognitive, emotional, or social needs, not allowing the child to develop the systems that are necessary for adequate physical and mental health. For children to master developmental tasks, caregiver support and encouragement is a necessity. If this stimulation and care is lacking during a child's early years, the child may not achieve the usual developmental milestones.

Beyond the kinds of delays seen in early childhood, maltreatment is consistently associated with higher rates of all forms of clinical mental health diagnoses including an increased risk for self-harm as the child gets older. Youth exposed to child maltreatment who have contact with child protective services are three times more likely than their non maltreated peers to fail in school, (e.g., about 50% leave high school without a degree) be consistently unemployed, become a teen parent, experience chronic physical and mental health problems in adulthood, and are more likely to be incarcerated or homeless, or living below the poverty line as adults.[25] Moreover, children who experienced maltreatment in childhood are at greater risk for substance abuse disorders later in life.[26-29] Compared to youth in the general population, youth with formal child welfare system involvement report higher rates of lifetime marijuana use (18% vs. 14%), lifetime and current inhalant use (12% & 5% vs. 6% and 2%, respectively), and lifetime and current hard drug use (e.g., cocaine, heroin) (6% and 3% vs 4% and 2%, respectively)[30].

In summary, the emotional, behavioral, and cognitive limitations common to youth exposed to maltreatment are numerous. Although this information presented here is not meant to be exhaustive, it does provide a summary of the kinds of common deficits and challenges that result from all types of child maltreatment. We also know that the negative effects of maltreatment are significantly increased with each revictimization, making what was a hard-to-treat problem much worse and increasing the odds of long-term mental and physical maladjustment due to abuse. Given that the average number of re-referrals to the child protection system for the same child is 2.98,[31] the impact of child maltreatment on development is likely underestimated by the research presented here.

It is also important to note that child protective services referrals, regardless of substantiation status, increases the risk for negative health and behavioral outcomes in later life. A recent analysis using causal inference methods demonstrated that involvement with the child protective services increases a child's risk for teen motherhood, HIV infection, and substance use.[32]

Although child maltreatment is pervasive and too-often fatal, it is also preventable. Given the scope and grave consequences, child maltreatment requires a comprehensive prevention strategy.[33]

Child maltreatment has many possible causes. It is important to remember that child maltreatment is not a unitary construct, it is not one effect linearly related to one cause. Because child maltreatment has multiple forms, strategies to prevent child maltreatment must also be varied. For prevention efforts to be effective, an evidence-informed, multi-faceted approach is necessary. Child maltreatment also develops over time. That is, perpetrators who neglect, physically injure or sexually abuse a child do not do so without presenting some evident risk factors for this behavior before the abuse is perpetrated. So too then, prevention strategies must include a range of pre-abuse risk factors in the effort to prevent the dangerous behavior on the part of the caretaker.

Given the high cost of child maltreatment and sheer number of children involved in protective services, the problem of child maltreatment is in dire need of effective and sustained prevention efforts. Currently, there are several approaches to prevention. *Primary prevention*, sometimes also referred to as 'universal prevention' is a population-based strategy designed to stop maltreatment before it occurs in communities, schools, and institutions. These programs raise public awareness, provide education about how to recognize the signs of abuse, and provide practical skills and support for taking action to get help or report abuse. Other programs provide one-on-one skills training, usually to parents, focused on positive parenting practices, reducing household stressors, and larger family advocacy needs. *Targeted or indicated prevention,* on the other hand, focus on stopping maltreatment within high-risk groups, stopping maltreatment from happening again, and/or staving off or mitigating the harmful consequences of maltreatment. These programs specifically target aspects of abusive and neglectful parenting or are focused on reducing behavior problems, post-traumatic-stress symptoms, and other aspects of mental and psychosocial health in victims.

The bulk of *primary prevention* efforts currently fall under the definition of 'home visiting'—where nurses, other professionals, or paraprofessionals visit parents in their homes, some starting in the prenatal period, and focus on the wellbeing of children aged 0 to 5. Several of these primary prevention programs have been shown to reduce reports of maltreatment to social services and proxies of maltreatment such as hospitalizations. A recent paper published in 2018 reported the cost benefit of universal, primary prevention programs, ranging from $1.73 (or $1.73 of benefits for every $1 of program costs) to $6.37.[34]

In general, *targeted prevention* is thought to yield more 'bang for the buck' because those who are in most need of intervention are identified and provided services. In 2017, over 3% of children were referred to protective services for a child abuse investigation. Research shows that children and families who have been referred to protective services constitute one of the highest risk populations to target for prevention given that the risk for re-referral for these children is approximately 50%,[35] most occurring within 6 months.[36] Moreover, 20% of child maltreatment victims are re-victimized within 5 years.[37] As a result of these findings, a host of programs are now implemented within protective services organizations in attempt to improve home environments and protect children from re-referral or another instance of maltreatment. A cost benefit analysis conducted by the independent Washington State Institute on Public Policy (WSIPP) found that two of the most widely lauded targeted prevention programs, SafeCare ®[38] and Parent Child Interaction Therapy (PCIT[39]), returned $21.60 and $15.97 respectively in benefit for every dollar spend on implementation.[40]

Given cost estimates showing that each new instance of child maltreatment results in $830,928 in lifetime public cost for non-fatal victims and $16.6 million for fatal victims, the cost-benefit of implementing primary or targeted prevention is an obvious worthwhile investment.[5] In fact, one recent analysis estimated that if these programs were implemented in all 50 states, the combined cost savings would be an approximately $16B over the lifetime of each annual cohort of child victims.[34]

However, despite public health approaches to child maltreatment prevention, national rates have not fluctuated substantially over the past 15 years. In fact, the most recent reports show that the number of children investigated for child maltreatment has actually increased by 10% over the past five years and the number of substantiated child maltreatment has increased by almost 3%.[41]

However, we do know that prevention efforts work best when there is a community-level response and where available services are identified and disseminated in a coordinated fashion[45]. For example, the Positive Parenting Program (PPP)[46] and Family Connects Durham[47] are among the most effective child maltreatment prevention programs by showing reductions in actual rates of child maltreatment. These both bring together and coordinate various evidence-based prevention services within communities to promote healthy families, including reducing risk for maltreatment. While these efforts are promising, there are substantial challenges that limit the coordination of services at the community-level and only a few models that have been effective at reducing overall rates of child maltreatment.[45, 46]

Several recent meta-analyses of the most common primary prevention home visiting programs (Early Head Start, Healthy Families America, Nurse Family Partnership, and Parents as Teachers) find their impacts on child maltreatment rates to be modest,[42] with several implementation factors, including provider training, supervision, and program fidelity having a significant effect on program outcomes.[43] Similarly, although 1.9 million children receive targeted prevention each year[1], these targeted prevention strategies have shown only small to moderate effects[44,45] and the extent to which these programs

reduce rates of child maltreatment varies widely.[44,45] It is important to remember that none of these programs were designed to prevent child maltreatment directly, so the fact that they have any impact on child maltreatment is important and promising for programs that actually target the multi-faceted causes of child maltreatment. For example, Nurse Family Partnership was developed to target prenatal health, Parents as Teachers was designed to target child development outcomes, and Early Head Start was developed to enhance school-readiness.

Because child maltreatment is not linear, not one cause leading to one effect, the approach to prevention has to be multi-pronged and coordinated across systems of care (e.g., parents, caregivers, teachers). Because the effects of child maltreatment are not always immediate, nor are the effects of intervention, prevention programs have to be implemented and evaluated over the long-term. Currently the field is in the early stages of documenting the success of the effective programs, but much more research is needed to show long-term gains. The rates of child maltreatment have not changed in over a decade and thus there is a significant need to increase implementation of prevention programs, to create and test innovation in prevention, and provide rigorous evaluation and research on outcomes for youth and families so that the impact of child maltreatment specific prevention programs is clearer.

It should also be noted that, with very few exceptions (e.g., Triple P, SafeCare®), these large programs neither access nor track changes in actual RATES of child maltreatment. In fact, a recent U.S. Preventive Services Task Force report designated the existing research on child maltreatment prevention to be incomplete due to a failure in research methods linking intervention effects to reductions in actual cases of child maltreatment.[46]

Finally, the impact of primary and targeted prevention on rates of child sexual abuse is largely unknown because they are rarely reported and are often included in aggregate reporting of 'referrals to child protective services. This is likely due to the fact that the most widely disseminated home visiting and parenting programs are not designed to prevent child sexual abuse. Instead they focus mainly on targeted parenting behaviors linked to physical or psychological abuse and neglect, like reducing harsh parenting and ameliorating poor knowledge of child development. They do not target risk factors linked to child sexual abuse such as identifying grooming behaviors and recognizing the emotional and physical signs of sexual abuse.[47]

While the situation is dire for the state of child maltreatment, the reauthorization of the Child Abuse Prevention & Treatment Act (CAPTA) is an opportunity to better support the systems that protect children from maltreatment.

Through CAPTA, we can seek to better coordinate our efforts across the patchwork system of federal, state and local agencies and services, in order to seek out efficiencies and best practices that are supported by a strong evidence-base. To do this, we need to invest in data-driven approaches that are scalable and transferable across populations. Improved data sharing standards aimed at promoting collaboration across

the system are vitally needed. We also need to seek and lift up innovative solutions to foster coordinated efforts that facilitate the feasible and sustainable involvement of schools, parents, adults, government agencies, and service providers.

Coordination. Data-focus. Innovation. These frames are vitally important, because what we know is that our current efforts have shown little to modest impacts to stem the tide of child maltreatment.

Thank you.

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