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Healthy Generations

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Inside this Issue

An Overview of Child Abuse

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Historical literature is filled with accounts of child maltreatment, incest, and infanticide[1]. However, it was not until the 1960s, when academics began to study children from this perspective of abuse and neglect that the impact of physical maltreatment on children was "recognized" in the United States. Kempe, Silverman, Steele, Droegemueller and Silver[2] defined the battered-child syndrome, resulting in a dramatic increase in public awareness of the impact of overt physical abuse on children. Within the next decade, awareness of alarming rates of sexual abuse emerged, previously considered a rare phenomenon. Gradually, research and public policy broadened to include other forms of maltreatment. Neglect andemotional maltreatment were documented by studies beginning in the late 1980's, which suggested neglect was more prevalent, with comparable consequences to physical abuse[3, 4, 5]. Most recently, other forms of community violence, and ritualistic abuse, although not reviewed here, have received more attention in research, treatment, and policy discussion[6, 7 ,8].

Prevalence of Maltreatment

A recent report from the 1998 National Child Abuse and Neglect Reporting Systems (NCANDS) estimated 903,000 (12.9 per 1000) children nationally were victims of maltreatment. Physical abuse, which often gains the most public attention, was not the most common form of maltreatment reported. Children were most likely to experience neglect, involving poor parental supervision,

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I am pleased to be co-editing this fourth edition of Healthy Generations with Laurie L. Meschke, Ph.D. This issue on child abuse comes to you as a collaborative effort between the Maternal and Child Health program and the Child Abuse Prevention Studies (CAPS) certificate program. In addition to being the fourth issue of the Healthy Generations series, this publication and accompanying videoconference is also part of a new collaborative effort among University of Minnesota faculty called Child Abuse Prevention: Building an Interdisciplinary Perspective. For more information about this project, visit http://www.mincava.umn.edu/CAPS/bip.asp. In this issue, Terrie Rose provides an overview of the prevalence and etiology of child abuse. Jane Gilgun explores the impact of abuse on children and identifies specific protective factors that help them overcome trauma associated with the abuse. Chuck Oberg discusses how certain programs are demonstrating exemplary approaches to primary, secondary, and tertiary child abuse prevention in our communities. The Partners in Health article features the Greater Minneapolis Crisis Nursery, which responds to parents in crisis by providing short-term care for their children. This article is written by Carrie Crook. Also featured in this issue are highlights of Sheila Wellstone's February 16 th speech, Developing a Collective Voice for Children. This speech marked the beginning of a two-year seminar series showcasing child abuse research and education at the University of Minnesota. For information about future seminars in this series, visit http://www.mincava.umn.edu/CAPS/seminars. Online PowerPoint presentations and fact sheets pertaining to this issue are located at http://www.epi.umn.edu/mch/HealthyGenerations/Hgres4.html. The videoconference associated with this issue will be held on June 7th from 1-3 p.m. (see page 2 of this issue). To register, contact Jan Pearson (pearson@epi.umn.edu or call 612.626.8644). Please check out our website (http://www.epi.umn.edu/mch/mchsite/eventshg.html#childabusevidconf) for any possible changes and updates. Tapes of the previous conferences on adolescent tobacco use, childhood obesity, and women's reproductive health are also available. Again, contact Jan Pearson if you are interested in a copy. I welcome your feedback about this issue and invite you to participate in our child abuse prevention activities here on campus. I can be reached at (612) 624-3471 or cmichaels@che.umn.edu. Laurie L. Meschke can be reached at (612) 625-4891 or meschke@epi.umn.edu. It is an exciting time to be involved with this work! I look forward to continuing our efforts to build an interdisciplinary perspective.

Cari Michaels, M.P.H.
Co-Editor

Healthy Generations Videoconference

Child Abuse

June 7, 2001
1-3 p.m.

Chisago County
313 North Main St,
Room 358, Center City

Ramsey County
MDH Distance
Learning Center
130 East 7th Street,
3rd Floor, Metro Annex
St. Paul

Douglas County
809 Elm Street, Alexandria

Freeborn County
203 W. Clark Street,
Room 241, Albert Lea

Koochiching County
715 4th Street,
International Falls

Marshall County
208 E. Colvin Avenue,
Warren

Renville County
500 E. DePue - 3rd Level,
Olivia

Rock County
204 E. Brown, Luverne

Roseau County
606 5th Avenue SW,
Room 20, Roseau

Stearns County
Room 21, 705 Courthouse
Square, St. Cloud

Winona County
202 W. 3rd Street, Winona

Registration is limited by site. To register please contact Jan Pearson by phone (612.626.8644) or email (pearson@epi.umn.edu). Please visit http://www.epi.umn.edu/mch/HealthyGenerations.hga.html for any changes to these sites.

omission of care, or inadequate physical protection, nutrition, or health care. Fifty-four percent of all reported children suffered from neglect, with 25% comorbidity with other types of maltreatment. In fact, while other types of abuse declined from 1990 statistics, the rate of neglect reportedly increased from 6.3 (per 1000) to 7.2 in 1998[9].

Even more alarming was the age of children reported as victims of maltreatment. Infants and toddlers had the highest rates of reported maltreatment (14.8 per 1000). These young children, unable to speak for themselves, were most likely to experience neglect during a time in development when security and predictability of relationships were key ingredients to laying the foundation for later competence and well being. Neglect and lack of parental supervision had devastating consequences for this population, including non-organic failure-to-thrive and accidental injuries. In the NCANDS report, 78% of all documented abuse-related fatalities occurred in children ages 4 or younger[9].

Gender and ethnicity also accounted for variation in incident reports. Girls were more likely to experience maltreatment at older ages and more likely to have reported sexual abuse than boys. However, a recent meta review by Holmes and Slap[10] concerning sexual abuse in boys concluded that sexual abuse was underreported and under recognized in this population, which may account for the reported differences. Variations were also found among ethnic groups. However, confounding environmental, social and parental variables known to be related to maltreatment were not taken into account in the summary statistics.

Accurate understanding of the etiology of maltreatment in the United States is critical to prevention and intervention efforts, legal decision-making, and policy development. Statistics on maltreatment, generally collected via aggregated studies, reports by professionals, and case level analysis, are highly variable because of discrepancies in data collection, disagreements on what constitutes child maltreatment, and lack of coordination among the involved professionals. However, even with these limitations, it is clear that maltreatment is most likely to begin in the very early years of a child's life.

Etiology

Determining etiology of child abuse is complicated because of the interwoven tapestry of parental, environmental and child behaviors that interact over time. There does not appear to be one set of risk factors that sufficiently explain the etiology of child abuse. Rather, research suggests protective and risk attributes with multiple origins. Variables related to maltreatment have been identified within individuals (e.g. developmental delays or mental illness); relationships (e.g. domestic violence or parenting skills); local communities (e.g. religious support, crime); and broader society (e.g. poverty, racism)[11]. Understanding the multiple sources of vulnerabilities and resources is essential for appropriate service delivery and policy development.

With alarming rates of neglect for our youngest and most vulnerable children, it is essential to view maltreatment within a developmental and historical context. Susan Hrdy[1] documents neglect, abandonment, and infanticide of infants across eras, cultures, and economic changes. She describes this type of maltreatment by mothers of newborns as a strategy for women under extreme destitution, with no alternative care providers, and self-delusion ("my child will be better off"). We see this scenario as a teenage mother with few social supports and no kin, who after the birth of her second child, abandons her baby in the hospital or uses illicit drugs, which leaves her baby in unsafe circumstances. Hrdy's premise is that these scenarios may represent the extreme end of maternal ambivalence under dire circumstances and are qualitatively different in etiology from maltreatment occurring between a mother and an older child who have a reciprocal relationship and attachment.

Impact on Children

Maltreatment not only affects children's physical health and safety, but also their view of the world and of themselves, social relations, psychological adjustment, and academic success[3, 4, 11, 12]. Abuse occurs in the child's immediate environment, most often within their own home, shaking their sense of personal safety and self worth, their expectations for others, and often their outlook on the future.

The impact of maltreatment must be analyzed in the context of the child's ability to successfully negotiate the central developmental tasks of their age and the family's ability to

support typical development. For example, when a toddler moves out into the world with a growing sense of autonomy, she must be supported by relationships that allow for safe play, independent exploration, and the ability to cope with frustration. Research has found that maltreatment at this age makes it difficult for children to be successful in learning and exploration activities and that these toddlers show increased expressions of anger and noncompliance[13]. Because development builds upon previously learned strategies, stunted resolution of these toddler tasks may ultimately contribute to poor peer relationships in preschoolers or limited academic success in school. In addition, maltreatment most frequently involves recurring episodes that may influence multiple stages of development. The spiral effect of maltreatment influencing developmental competency and compromised development affecting future success reveal how child abuse can have devastating consequences that may last well beyond the period of exposure.

Future Directions

Early environments provide the building blocks for healthy development. With maltreatment occurring early in life, it is imperative that we identify the personal and environmental resources that mediate these experiences and promote healthy development. It is essential that we identify resources that offer the child and the family supportive, invested, pre-intervention and intervention services directed towards developmental success for both child and the parent.

Focus on the Family…

Interested in family focused courses, research, and outreach at the University of Minnesota? Searches by your topic of interest can be conducted at www.family.umn.edu

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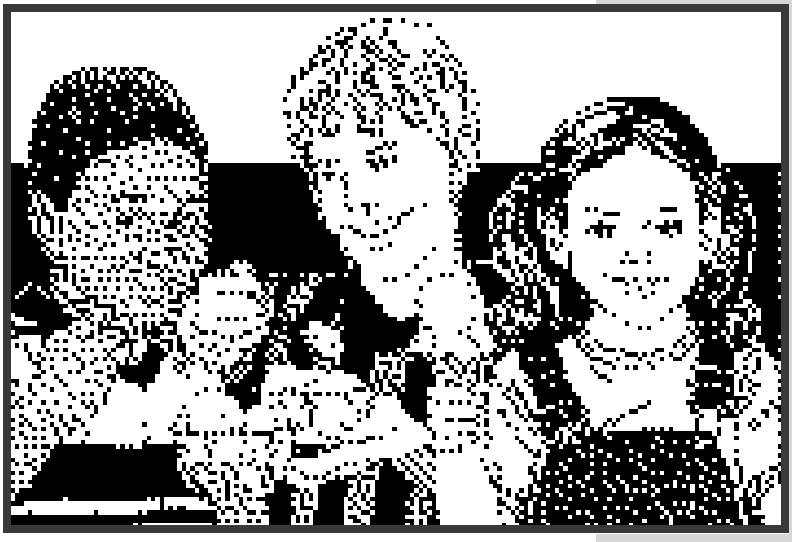

Protective Factors, Resilience and Child Abuse and Neglect

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Slow but perceptible changes are taking place in how we think about outcomes when persons have experienced risks such as child abuse and neglect. Professionals, policy makers, and researchers are beginning to build notions of protective factors into their everyday activities. For example, health researchers now report not only on the risks for various diseases such as breast cancer and hardening of the arteries, but they also identify factors that appear to be protective against disease.

Likewise, persons concerned with childhood abuse and neglect are paying increased attention to protective factors. Though maltreatment is a serious, documented threat to the well-being and optimal development of children and adolescents, researchers and practitioners have also shown that a percentage of children and youth who have experienced abuse and neglect can function quite well[1,2,3,4,5,6,7,8,9]. They are able to cope with, adapt to, or overcome the effects of maltreatment. That is, they appear to be ***resilient***.

Developmental Psychopathology

Developmental psychopathologists examine patterns of human development leading both to adaptive and maladaptive outcomes by studying high-risk groups, usually longitudinally[10]. This research has shown that not all persons with risk factors have adverse outcomes. Among the risks examined are low socio-economic status, childhood maltreatment, mental health of parents, war, dangerous neighborhoods, homelessness, natural disasters, and a range of other stressors, such as illness, mother absence, family relocation, and physical punishment of children[11,12,13,14,15,16].

Vulnerability and Dysregulation

When persons experience risks such as childhood abuse and neglect, they have been hurt emotionally, psychological, and sometimes physically. These hurts can be thought of as psychic wounds that may create a sense of the self as defective and helpless. Psychic wounds can lead to dysregulation, where the person at least temporarily experiences a sense of unmanageability of their thoughts, emotions, and behaviors[11].Their autonomous nervous systems,too, may be dysregulated. Children may become anxious, fearful, depressed, withdrawn, lethargic, hyperkinetic and show bouts of crying, sleep disturbances, bed wetting, and oppositional behaviors.

Coping with Dysregulation

When dysregulated, hurt children seek to re-regulate; that is, to regain self-efficacy, control, and mastery over themselves and their various environments[17]. Re-regulation can occur in three general ways: pro-social, anti-social, and self-injurious.

- ***Pro-social*** efforts to re-regulate include seeking comfort and affirmation from attachment figures, talking to someone about the hurt and confusion, channeling the negative affect into positive behaviors such as physical exercise and artistic expression, and seeking ways to reinterpret meanings of the hurt away from the self as bad and helpless to a sense of self as good and competent.

- ***Anti-social*** efforts to re-regulate include effacement and destruction of property such as destroying toys or writing on walls, picking on other people, bullying, physically attacking others, acting in sexually inappropriate ways, stealing and other oppositional behaviors. School shootings are extreme examples of young people using anti-social methods of re-regulation.

- ***Self-injurious*** efforts to re-regulate include cutting, anorexia, bulimia, use of drugs and alcohol, suicide attempts, recklessness, and playing with guns and other weapons.

Protective Factors

Protective factors are resources that individuals actively use to manage, adapt to, or overcome risks. Researchers and practitioners have identified many factors that are protective for some persons under certain conditions[4,18,19]. Examples of protective factors are

Interested in more information on child abuse? PowerPoint presentations, website links, and factsheets are available. Check out the resources on the webpage of the Maternal and Child Health Program at
http://www.epi.umn.edu/mch/HealthyGenerations/Hgres4.html

- ***Close, long-term relationships*** with other persons who (1) model pro-social behaviors, (2) are emotionally expressive and facilitate emotional expressiveness in the at-risk person, (3) praise and encourage pro-social behaviors in the at-risk person, (4) know and understand the risks experienced by the at-risk person and maintain closeness when the complexity of these risks is disclosed;
- ***A confidant***(e) whom the at-risk person makes efforts to emulate, and with whom s/he reciprocates a sense of closeness, seeks support and counsel during times of stress and fear, and freely shares painful personal issues;
- ***A strong desire to be pro-social***, including appropriate emotional expressiveness and a determination to do well;
- ***A favorable sense of self*** that challenges images of the self as bad and powerlessness;
- ***The ability to engage in self-soothing behaviors***; for example listening to music, engaging in affirming self-talk, and imagining a fulfilling future;
- ***An affirming ethnic and cultural identification***;
- ***Hope*** for a more positive future, along with the capacity to imagine a positive future and seeking and using resources that help build toward that positive future

No one factor is likely to be protective against the many adversities that children and youth may have experienced. However, a combination of the factors listed above are associated with persons overcoming, coping, and adapting to risks. Stable long-term relationships are central because of the "hot buttons" associated with vulnerability; when the hot buttons are stimulated, at-risk persons who cope well seek confidant(e)s to help them work through their dysregulation. Confidant(e)s can be parents, other adults within or outside of families, siblings, and peers.

Resilience

Resilience is a process that occurs over time. Many types of resources in many different settings over time promote resilience in children and youth. Resilience requires on-going, affirming relationships that guide young people toward self-efficacy, pro-sociality, and self-regulation. Persons can be considered resilient when they demonstrate capacities for coping with, adapting to, and overcoming risks and can re-establish or maintain their equilibrium when "hot buttons" are pushed. Resilience is not an all or nothing process. Persons can be resilient in some situations and be overcome with vulnerabilities in others[4].

Overcoming the odds is difficult. To do so, young persons must want to overcome adversities in pro-social ways. Adults, in our roles as parents,policy makers, program planners, prevention specialists, and direct practitioners, have the task of providing resources that childrenand youth recognize as important to them and are consistent with what they want. The most valuable resources are time and attention that eventually result in increasing young persons' capacities to regulate and re-regulate themselves in times of stress.

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Child Abuse Preventions – Programmatic Interventions

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Introduction

This issue of Healthy Generations addresses a societal issue that goes to the core of how we actually value and protect our children. The resurgence of interest in child abuse and neglect during the last quarter of the twentieth century emanates from the publication of a series of articles, which described in detail the "Shaken Baby Syndrome" and the constellations of signs and symptoms, and physical findings that characterize children who have been mistreated[1]. However, as with many public policy issues facing families with children, it is much easier to rely on partial information and perceptions rather than on research as we attempt to create programs that are intended to keep our children safe. This article outlines and highlights programs that have demonstrated success in the prevention of child maltreatment.

The search for the optimal approach to the identification, prevention, and treatment of child maltreatment relates to an inherent conflict between the desire and need to protect children in unsafe environments and the assumption that the family is the most appropriate milieu for the raising and caring of children. Though we think of this debate as a relatively recent phenomenon it is part of an ongoing dialogue that spans several centuries in the United States[2].

As we enter the twenty-first century, we need to incorporate the ever-increasing complexity of not only the etiology but the multifactorial nature of the issues facing families that experience child maltreatment intoour prevention strategies[3].

Programmatic Framework. The description of programs designed for the prevention and treatment of child maltreatment fall somewhere on a continuum, from universal population based prevention strategies to specific family intervention[4]. They tend to follow the traditional public health model from primary prevention efforts that promote family wellness to tertiary prevention strategies designed to either reunite families where abuse has occurred and/or to mitigate the effects of the child maltreatment.

Head Start: A Primary Prevention Approach. Increasing financial pressures for parents, the rates of family break-up, deepening child poverty rates and cuts in programs all have added to family stress. In addition, child abuse "potential" is inter-related with family stress, limited resources and a lack of social support[5]. If we are to attempt to address the safety of children from a global perspective, we must place the child in the context of the family in safe communities. This requires that families are able to achieve a livable wage to meet their basis needs. These needs include affordable and safe housing, and having nutritious food and adequate clothing. In addition, it implies having access to affordable and quality childcare and/or early intervention services as well as quality schools in the child and adolescent years. It implies affordable health care with limited barriers based on class, ethnicity, employment and culture. The Head Start program is an exemplary example of a primary prevention approach to child abuse. Head Start has four major components that provide an enriched experience for economically disadvantaged preschoolers - education, health and nutrition, parental involvement and social

service intervention. Intervention activities are designed to reduce stress in families that, in combination with other risk factors, increase the likelihood of maltreatment. Conceptually, Head Start fits into the concept of promoting "social capital" and the benefits that are implicit as society seeks to establish personal social relationships within both families and communities.

Home Visitation: A Secondary Prevention Strategy. Secondary prevention consists of providing services for a selected at-risk population in attempt to ameliorate the chance of at risk families from moving toward an abusive environment. One of the most utilized approaches to secondary prevention is "home visiting" in which new parents are visited by a professional, paraprofessional, and/or trained layperson who provides support, advice, referrals and general encouragement. The effectiveness of home visitation in child abuse prevention was first documented in a randomized control trial conducted over 20 years ago in Elmira, New York. Home visits significantly reduced the rate of documented child maltreatment cases among a sample of poor, unmarried adolescent mothers when their children were two years of age, compared to families who did not receive home visits[6].

A more recent fifteen-year follow-up study of the original sample again demonstrated that nurse-visited families had half as many child maltreatment reports as other at-risk families who did not receive home visitation[7]. Table 1 lists nine key ingredients that are important in successful home visiting programs[8].

Table 1.

Key Ingredients in Effective Home Visitation Programs

- Visits begin before or shortly following birth
- Visits extended over a significant period of time
- Home visitors form an alliance with the parent
- Home visitors watch for early signs of maltreatment
- Home visitors teach effective parenting skills
- The focus is on the child
- Services are specific and practical
- Visits gets the fathers involved when appropriate
- Services are adjusted as the needs of the families change

Family Centered Services: Tertiary Prevention & Intervention. Family centered services consist of an array of tertiary prevention and intervention programs. Family support initiatives have an intent to provide services that help stressed families to prevent child maltreatment and enable families with serious child rearing problems to help to stabilize the home environment. Family preservation efforts are employed after abuse or neglect has occurred. They seek to rehabilitate and hopefully to reunify families. The emphasis in family centered services is family preservation. It attempts to combine direct crisis and counseling assistance with a case management strategy in an attempt to intervene and to break the cycle of child maltreatment[9].

There are times when the situation is so unsafe that no amount of primary, secondary and tertiary prevention is adequate to assure the safety of a child within a family. It is then that we transition to traditional intervention approaches. Historically, the approach has been the utilization of Child Protective Services (CPS) and foster care placement. However, with an exponential increase in both reported and documented cases, as well as a reduction in the number of families interested in providing foster care and a shift toward the importance of the preservation of family, a new approach to intervention has now entered the field. This consists of a movement toward immediate and extended family as an alternative placement resource.

The shift toward kinship foster care affirms the importance of family as a resource and the strength of the extended family. Some states and their child welfare authorities utilize kinship care as an alternative to traditional foster care, but only if participants first become licensed and participate in training similar to other foster care families[10]. Evidence suggests that children in kinship foster care require less external support, utilize fewer services, and have less contact with child protective services compared to other foster family arrangements[11].

Summary

The research literature contains a few truisms that hold fast as we look across the entire

continuum from primary care prevention to therapeutic intervention. A recent meta-analysis demonstrated that proactive preventive interventions have larger lasting effects than more limited reactive approaches. In addition, programs that reach across economic distinctions and appreciate the complexity of the multitude of factors that contribute to child maltreatment appear to be most successful[12].

In developing future interventions, we must consider the lessons learned by these effective programs and place them within a broad, culturally appropriate context. We must also incorporate related areas of research, including the connections between child abuse and domestic violence. An estimated 25-30% of women in the United States are subjected to abuse and at least 3.3 million children witness domestic violence annually[13]. As one might expect, the research demonstrates that these same children are abused at a significantly greater rate. Effective prevention strategies must promote strengths within families, communities, and the broader child's world, as demonstrated by the Head Start, Home Visitation, and Family Centered Services programs.

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Developing a Collective Voice for Children*

Sheila Wellstone
Nationally Recognized Advocate for Children and Families

I recently heard a story that among the East African Maasai people, the traditional greeting isn't "Hi, How Are You?" or "What's New?" rather, "So, how are the children?" They know that if the children are well, safety and peace prevail in the community. Asking this question asserts that the well being of all our children is a crucial indicator of the health of our entire society. If we choose to greet one another by first asking about our children, that would go a long way toward building stronger, better communities - ones where the ultimate priority is our children. Perhaps if we knew that we always had to first answer for their welfare, we would live our personal and communal lives with much different priorities.

I begin by asking, "So, how are the children?"

Leave No Child Behind

We work every day to make children as safe, as healthy, and as vibrant as we can. We represent a wide range of issues, agencies and actions for our children, including children with disabilities, parent-child attachment, child protection, childhood sexual abuse, mental health, and so on, which together make up the totality of a child's life. During his campaign for the presidency, George W. Bush appealed to Americans' best instincts when he declared that no child should be left behind. I think we can all agree with that premise. President Bush appealed to our best hopes for our children. Now that we have seen

our tax cut proposals, weighted to the wealthiest Americans, I am concerned that there will not be meaningful investments in early childhood education, child care, children's health care, special education, head start and other much-needed programs — we will be leaving our children behind.

It is imperative that our policymakers follow closely the cutting edge research on our children's well being. Brain research tells us that the first years of a child's life are crucial to his or her development. Research on domestic violence tells us that over 3 million children witness domestic violence in their homes each year. The Children's Defense Fund tells us that every 56 seconds a child is born into poverty. Right now one in every six children is poor and one in three children of color is poor.

I don't think President Bush's proposed $1.6 trillion in tax cuts will make a significant difference in the lives of these children. In fact The Center onBudget and Policy Priority recently came out with a striking report. They tell us that "An estimated 12.2 million low- and moderate-income families with children -- 31.5 percent of all families would not receive any tax cut from the Bush proposal"[1]. They go on to cite even more alarming statistics for families of color. "While one-third of all children would not benefit from the Bush tax plan, more than half of black and Hispanic children would not receive any assistance.

We hear of children being left with siblings too young to care for another child. We know that children are often left in unsafe environments or with relatives and neighbors who aren't responsible. Where are these families when we talk about leaving no child behind? Where are the 1200 children who are homeless every night in Minneapolis when we talk about leaving no child behind? Where are the children who go to school hungry every day when we talk about leaving no children behind?

Our Own State of Minnesota

In Minnesota, 3400 families are currently on the waiting list for child care assistance. The Governor's budget proposes to eliminate these waiting lists by limiting a family's eligibility for assistance. This will translate to 6,000 working poor families without child care assistance. We simply cannot afford to leave our working poor families dangling without child care assistance — it will be these children who suffer. Who will be caring for these children? Who will be there to see that they are safe and protected? And where is the support for children who are being neglected and abused? The Welfare Reform bill is coming up for reauthorization next year and so many of these questions are yet unanswered.

We are at a time of sustained economic prosperity, but we know that for too many children they are not seeing this prosperity. In Minnesota last year, 45 women and six children were murdered. This left 70 children without mothers. In 1998, over 10,000 Minnesota children were the victims of reported abuse or neglect. Every 49 minutes a child is reported abused or neglected in our state. These children are not benefiting from our overflowing economic cup. The current proposed budget for the biennium is hitting children hard. In our own state we are aware that we sit at a crossroads. We can't sit silently by and not speak or act for the children. We need a vision that assures our children will receive the greatest resources that we can give to them.

Prevention Programs that Work

Although we have great economic wealth and we know that prevention and intervention programs do work - too often those are the programs that land on the cutting room floor. For example, Minnesota is at risk for losing the At Home Infant Care Program. This is a wonderful program that saves the state money and allows a working poor parent to stay home with newborns for up to a year. Instead of receiving a full child care subsidy, the state pays that mother 75% of her child care assistance to stay home. During this time, the parent has additional access to resources on parenting - she learns the skills needed to be the best parent she can be.

Research tells us that prevention programs are a significant way to reduce child illiteracy, abuse and neglect, domestic violence and so many other important barriers to success. Although we are at a time when the coffers overflow, prevention programs are getting less access to resources. We know that just as we can't focus on exclusively K-12 education for our children. We can't afford not to focus on child abuse prevention. We know that the cycle of violence repeats itself. Yet with the guidance of research, very successful child abuse prevention programs do exist.

Healthy Generations Event

The Minnesota videoconference on child abuse is on June 7, 2001 from 1-3 p.m. This event is free of charge. To register, contact Jan Pearson (612.626.8644 or pearson@epi.umn.edu). See the sites listed on page 2.

In Washington County, a group of concerned citizens is developing a flyer to be distributed at local businesses urging parents not leave children unattended in vehicles.

In St. Cloud a consortium of parents, health care providers, educators and social service providers are forming an initiative to look at how witnessing family violence impacts children's lives.

In Duluth the local Early Childhood Education Instructors go twice a week to the battered women's shelter to provide parent education and parent-child interaction with families.

In South Hennepin County the PAVE program, through Cornerstone, is in our schools teaching children non-violent methods of communication. The advocates talk with children about child abuse, about boundaries and about respect for one another.

Asian Women United in St. Paul has a staff that speaks 12 languages to reach out to families in crisis and they just opened Minnesota's first battered women's shelter designed to meet the needs of Asian women and children.

These are the programs that work. We know they work. These are the programs that make an impact in the lives of parents and their children. Most of the time, we aren't even aware of how far reaching this work is. This is what excites me about our work in Minnesota. It is our commitment and passion for our children that inspires me. Having an interdisciplinary perspective on the safety of our children is not only key, but visionary. We all have different skills and experiences. Our collective voice is strong. Our collective voice is loud. Our collective voice will be effective. We will reprioritize. We will put our children's needs above all else.

Investment analysts have long explained to us the importance of compounding interest. It is simple. The more you invest early-on, the greater your reward in the end. We should have this same investment philosophy for our greatest portfolio - our children. So I ask you "How are the children?" "Are the children well?"

* This article is adapted from Sheila Wellstone's speech, "Developing a Collective Voice for Children," given at the University of Minnesota, St. Paul, MN on February 14, 2001.

References:

1. Shapiro I, Dupree A, Sly J. An Estimated 12 Million Low and Moderate-Income Families — with 24 Million Children — Would Not Benefit from Bush Tax Plan. The Center on Budget and Policy Priority [On-line], Available http://www.cbpp.org/2-7-01tax.htm; 2001.

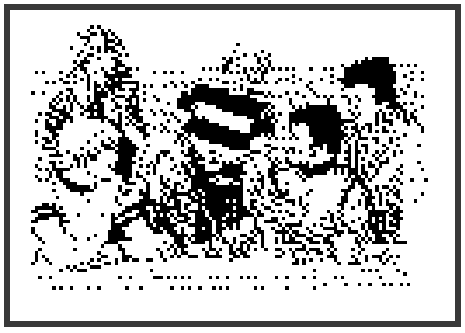
Teens across America could use your help.

- Adolescents (ages 15-19) represent less than 16 percent of the population of reproductive age (ages 14-44), yet account for almost 27 percent of new STI cases (4 million of 15 million new STIs)
- Of rural 10 th graders, 30.4% report cigarette use in the past 30 days
- Among the world's developed countries, the United States has one of the highest teen pregnancy rates–double the rate of France, and nine times the rate of the Netherlands and Japan
- The risk for sexually transmitted diseases in African-American and American Indian adolescents is almost twice as high as that of European-American adolescents.

Teens face a variety of challenges and opportunities in the United States. Public health workers, including maternal and child health professionals, are working to develop programs, policies, and surveillance methods to promote optimal health for all adolescents and their families.

If you have an interest in public health—especially adolescence—consider applying your talents and your passion to a career in Maternal and Children Health. One- and two-year Master's in Public Health (MPH) training is provided through the Maternal and Child Health (MCH) Program in the Division of Epidemiology, School of Public Health at the University of Minnesota. The program of study integrates practical experience with scientific and methodological content.

What does an MCH professional do? MCH professionals, at the master's and Ph.D. level, focus on developing individual- and community-level programs, policies, and surveillance systems that promote and preserve the health of families, including mothers, children, and adolescents.



Who should apply for an MPH in Maternal and Child Health? People who want to positively influence heath outcomes of mothers, youth, and families in the United States should apply. Students may be interested in program development and evaluation, policymaking, assessment, surveillance, teaching, or research. Individuals with degrees in MCH work in multidisciplinary collaborations in health-care organizations, community-based programs, public health departments, and private or public research organizations. The Master's in Public Health in MCH is an appropriate degree for individuals interested in applying to PhD programs in behavioral or biological epidemiology, such as those offered in the Division of Epidemiology, where the MCH Program is housed.

Why Minnesota? There are two major reasons that individuals who are interested in adolescent health should come to the University of Minnesota: (1) Minnesota has taken a progressive approach to adolescent health, including several adolescent health clinics and extensive funding from the Minnesota Department of Health to promote adolescent health; and (2) the MCH Program has a large and talented faculty with a great interest in adolescence. The MCH faculty have strong community ties and national reputations for excellence in research.

The MCH Program at the University of Minnesota is nationally recognized as one of 13 federally funded training programs. Of the 21-member multidisciplinary MCH faculty, 18 are currently conducting research in the area of adolescence. The adolescent research areas include obesity, tanning beds use, alcohol use prevention, tobacco use prevention, nutrition, pregnancy prevention and sexual health. They work collaboratively with faculty throughout the School of Public Health and the University, with particular strong linkages with the Adolescent Health Program in the Medical School, the School of Nursing, the School of Social Work, the Department of Family Social Science, and the Institute of Child Development.

For further information about the MCH Program — call 612.626.8802 or 1.800.774.8636;
email gradstudies@epi.umn.edu; or check out www.epi.umn.edu/mch and http://www1.umn.edu/twincities/

"Partners in Health" – Greater Minneapolis Crisis Nursery

Carrie Crook, Acting Program Director
Greater Minneapolis Crisis Nursery

The Greater Minneapolis Crisis Nursery works in partnership with parents in crisis and the community to strengthen families and prevent child abuse and neglect. The Nursery was created out of the belief that all children deserve to live in a safe and nurturing family environment - even in times of crisis. Discussions about the Nursery began in 1978 when members of a task force representing several child service organizations found there was something missing when it came to child abuse prevention. They discovered a need for a shelter where parents could bring their children during a crisis, when the potential for child abuse and neglect is the greatest. The Minneapolis Crisis Nursery was created in order to meet this need for voluntary shelter care.

When a Hennepin County family is in crisis and needs emergency help caring for their children, one of their first calls may be to contact the Greater Minneapolis Crisis Nursery. They will talk with one of seven Family Advocates who work out of two buildings, one in North Minneapolis and one in South Minneapolis. After consulting with a Family Advocate, the parent can expect to either be referred to another human service organization that can better meet their needs, or if the children are in danger of neglect or abuse, they can expect the Nursery to provide the needed support. Funded 80% by the private sector, the Nursery will send a cab to pick up the family, bring them in for an intake interview, set short-term goals with them, and to allow them to leave their children in our care for up to 72-hours.

After opening its doors in the Phillips neighborhood as a project of the Minneapolis Junior League, the demand for Nursery services has increased every year. The Nursery has expanded a number of times to meet community need. Its two buildings can now accommodate up to 38 children - newborn through six years old. Services include: 12-hour emergency day care for up to 30 days a year, 72-hour overnight emergency shelter care of up to 10 visits per year, Pediatric Health Assessments and health care for the children, goal setting and parenting programs, 24-hour crisis counseling services, community connections, home visiting, and outreach.Through its new 4th Day Program, which is designed to help parents make long term systemic change in their lives, the Nursery provides resources and referral to clients who use services repeatedly. With this program, those in our community who are the hardest to reach and have the furthest to go can rely on hands of guidance and help.

In 2000, the Nursery was guided by 23 board members, over 1500 volunteers who participated in five programs, a Roundtable of eight Human Service organizations, and a Community Advisory Council of eight community members and parents in providing 9000 days of care for 3,355 children. In addition, the Nursery counseled and advocated for 1,551 families. In 2000, Nursery families had the following characteristics: 91% were female, 75% were single parent heads of households, 72% were people of color, 63% were from the city of Minneapolis, 37% lived in the suburbs, 45% of families were involved with MFIP, 86% had incomes under $20,000 and 37% had less than a high school education.

With a staff of 65 members, a budget of $2.8 million, and partnerships with Washburn Child Guidance Center, the Blaisdell YMCA teen parent program, and People Serving People Shelter, the Nursery is expanding its goals for growth and community service. In its new five year strategic plan, the board and staff have committed to expanding the Nursery mission to focus on Parent Programs, the 4th Day Program, and a new Hispanic Pilot Program to reach this expanding community. Through these programs, the Nursery hopes to continue meeting its mission of working in partnership with parents and the community to strengthen families and prevent child abuse and neglect.

The Child Abuse Prevention Studies (CAPS) program is an interdisciplinary, graduate-level certificate program housed at the University of Minnesota and designed for professionals and graduate students who work with children and their families. CAPS courses are designed to provide specialized, practical knowledge and skills in research, theory, program development, and special topics areas. To learn more about the CAPS program and upcomng courses, visit the CAPS website at www.mincava.umn.edu/caps or contact the CAPS office at (612) 624-0721.

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