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Practical Strategies

The dollars and senselessness in failing to prioritize childhood maltreatment prevention

Christine Wekerle

Department of Pediatrics, HSC 3A, CAAP 3N10, McMaster University, 1200 Main St. W., Hamilton, ON L8N 3Z5, Canada

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ABSTRACT

Childhood maltreatment captured medical attention almost 50 years ago. Reviews considering the evidence for published maltreatment prevention programming emerged about 20 years ago. In the second decade of the 21st century, evidence-based maltreatment prevention is a reality for at-risk groups; however, the research-to-practice and policy gap remains in most countries. This article considers the importance of personal financial health and how that is necessarily the building blocks of national health. It argues for the primacy of the goal of problem prevention—the prevention of childhood maltreatment. A twofold approach is suggested: (1) broad-scale adoption of evidence-based prevention and (2) and on-going commitment to refining the evidence base for effective, promising, and novel intervention.

Introduction

Maltreatment is a multi-layered, common insult to the developing child and adolescent (e.g., Finkelhor, Turner, Ormrod, & Hamby, 2009). Maltreatment-related impairment to child, adolescent, and adult mental health is clear (e.g., Gilbert et al., 2009; Kessler et al., 2010). Maltreatment has been shown to cluster with other adverse childhood events and predict onset of DSM-IV disorders (Green et al., 2010), as well as persistence of disorders (substance, mood, anxiety; McLaughlin et al., 2010). Challenges to on-going health and well-being are mounting. Studies point to increased likelihood of hospital-based treatment for pediatric asthma, infection, and inflammation (e.g., Lanier, Jonson-Reid, Stahlschmidt, Drake, & Constantino, 2010); adolescent liver injury and lung/heart symptoms (Clark, Thatcher, & Martin, 2010); lung disease (e.g., Brown et al., 2010); heart disease (e.g., Fuller-Thomson, Brennenstuhl, & Frank, 2010); overweight-obesity status (e.g., Knutson, Taber, Murray, Valles, & Koeppl, 2010; Thomas, Hypponen, & Power, 2008); pain disorders (Tietjen et al., 2010a, 2010b, 2010c); and what yet remains to be discovered. The coherence in physical illness findings is striking and is a loud, resonating call to action for intervention research and the broad-scale use of known effective preventions (MacMillan, 2010; MacMillan et al., 2009).

Over the last decade, studies have shown that child maltreatment and related aversive events can have a combined impact on physical and mental health. Indeed, maltreatment bodes poorly for a long life. For example, individuals with 6 or more aversive child events (ACEs) are over twice as likely to die at or before age 65, and die about 20 years earlier than persons with no childhood ACEs (Brown et al., 2009). Of the 8 ACE categories, 4 represent child maltreatment (physical, sexual, emotional abuse; exposure to violence toward the mother). Notably, in a randomly selected sub-population from the Behavioral Risk Factor Surveillance System, nearly 60% of US persons reported one or more adverse childhood event [Centers for Disease Control and Prevention (CDC, 2010)]. Many of the maltreatment-linked health diseases are responsible for premature morbidity at levels as high as 1 in 5 to 1 in 10 of all early deaths (Danaei et al., 2010). The cost of productivity loss due to premature death is sizable (estimated at $114 million, for 2007 Australian data; Taylor et al., 2008). When multiple maltreatment types co-occur, as is often the case in child welfare and socioeconomically disadvantaged samples,

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psychological risks would seem to be less readily overcome (e.g., Cicchetti, Rogosch, Sturge-Apple, & Toth, 2010). A substantial number of maltreatment cases in child welfare are re-openings within a family (e.g., Public Health Agency of Canada, 2010). Childhood adverse events (maltreatment included) account for a substantial amount of the propensity toward mental illness across developed and developing countries (Kessler et al., 2010). For developed countries, maltreatment in the home is the equivalent to a nation at war.

Beyond premature death and impairment, maltreatment-related events effect the national, community and individual financial health (e.g., Oswald, Heil, & Goldbeck, 2009). Socioeconomic disadvantage is typically elevated among adults with a child maltreatment history. Controlling for confounds, childhood victimization was linked to adult social assistance, poverty, and unemployment rates (Zielinski, 2009). Maltreatment victims and their on-going burden of suffering to manage daily living are represented in high healthcare and sickness allowance costs (Tang et al., 2006; Taylor et al., 2008). Compared to matched controls, maltreated children find that, as adults, their peak earnings are about $5,000 less per year. Over time, this inequity results in a sizeable impairment in financial health (Currie & Widom, 2010). Females would seem to bear a greater burden as compared to maltreated males, showing significantly lower grade attainment, income, IQ test score (at young adulthood), and capital ownership (e.g., vehicle, home, bank account).

Taken together, the weight of evidence points to the under-recognized societal and national cost burden for the volitional, adult act of maltreatment. Initiatives of the World Health Organization's violence, injury and disability prevention division (http://www.who.int/violence_injury_prevention/en/), and the US Centers for Disease Control and Prevention (CDC) violence prevention strategy recognize that public health is linked with public good and, inevitably, public finances. Solutions are nested within these: violence prevention coupled with health promotion. For example, the CDC prioritizes the prevention of violence (to children, partners, and to the self) and, in parallel, the promotion of safe, stable, nurturing relationships (in home, school, community). Safe, stable and nurturing relationships are considered akin to a vaccine to prevent maltreatment-related impairment and illness, as well as promote broad-scale well-being (www.cdc.gov/violenceprevention/pdf/CM_Strategic_Direction–OnePager-a.pdf). Signs of safety need to reflect routine caretaking practices and not minimal standards, as "good enough" parenting does not curtail neglect and abuse from occurring to children. There are effective preventions, although they are not disseminated widely, and many promising interventions are in need of replication (e.g., MacMillan et al., 2009).

In closing, one goes back to the beginning: investment strategies and financial health. While children and adolescents may not be voters, in developed countries, the current beneficiaries of governmental pension funds, having completed some or all of their work life, are dependent on the financial wellness of work generations behind them. Truly, investment strategy is a developmental under-taking across the lifespan, and the child "sector" is critical to nurture and resource. To forge ahead in maltreatment prevention, research funding needs to be funneled into intervention research. Also, prevention science requires on-going epidemiological study of maltreatment and associated risks, particularly in child welfare populations, to be in a position to find population-wide trends. Research that targets mechanisms underlying maltreatment and maltreatment-related impairment are necessary for prevention refinements and intervention innovation. The available evidence is the foundation for child safety practices; strategic investment for children would seem to make good sense for all.

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