

# Adverse Childhood Experiences: The Case for Funding Primary Prevention

Adverse childhood experiences ([ACEs](#)) are potentially traumatic events occurring in childhood (birth to 18), increasing the risk for negative impacts on children's education, future employment, substance use, and mental and physical health. [National data](#) from CDC reveals how preventing ACEs can reduce many health conditions, including depression, heart disease, and obesity. These impacts have the additional effect of generating [high societal and healthcare costs](#) for families and communities.

In 2018, CDC reported that at least [one in seven children had experienced child abuse and/or neglect](#) in the previous year. The COVID-19 pandemic has further highlighted the gaps in ACEs prevention. Nationwide, COVID-19 has forced social isolation and increased virtual education, placing families under unprecedented stress. Families experienced a greater need for healthcare assistance, indicated by [increased](#) enrollment in Medicaid and Children's Health Insurance Program during the pandemic. Concurrently, essential child screening and mental health services have declined. Without such resources, COVID-19-related stressors put [families at higher risk for violence](#), [children at increased risk for ACEs](#), and communities of color at continued risk of suffering the [disparate impact](#).

ACEs can be reduced through evidence-based primary prevention strategies designed to enhance protective factors and reduce risk factors. This brief will provide an overview of maltreatment prevention programs that mitigate ACEs while offering a positive [return on investment](#). [Strategies in these programs](#) include building parent management skills, improving parent-child relationships, and increasing child health and development knowledge.

## Program Selection Criteria

The programs highlighted in this brief have a [promising or effective](#) rating on at least one of the following three evidence-based registries: California Evidence-based Clearinghouse for Child Welfare ([CEBC](#)), Home Visiting Evidence of Effectiveness ([HOMEVEE](#)), and [Blueprints for Healthy Youth Development](#). The programs are also supported by benefit-cost data from the Washington State Institute for Public Policy ([WSIPP](#)) and are highlighted in [CDC's technical package](#) for preventing child abuse and neglect.

## Nurse-Family Partnership

The Nurse-Family Partnership (NFP) is a [home visiting program](#) focused on providing prenatal and postnatal social and educational support to low-income first-time expecting mothers over a period of approximately 29 months. NFP seeks to improve: 1) pregnancy outcomes by helping expectant mothers improve their prenatal health; 2) child health and development by helping parents provide more sensitive and competent care; 3) parents' understanding of how their behaviors influence their health and their child's development.

One of the most researched programs, NFP is rated as "[well-supported](#)" by CEBC and a "[model program](#)" by Blueprints, while HOMEVEE has determined that NFP [meets HHS criteria](#). [WSIPP](#) reports \$1.37 in measured benefits per \$1 spent implementing NFP based on a meta-analysis of 18 studies. A [2005 RAND report](#) estimates that NFP returns \$5.70 for each dollar invested for the higher-risk population and \$1.26 for the lower-risk population.

## Parent-Child Interaction Therapy

An intervention for at-risk or abused children ages two to 12 and their caregivers, [Parent-Child Interaction Therapy](#) (PCIT) seeks to improve child behavior by increasing effective disciplinary techniques and enhancing parent-child relationships through child-directed interaction. In these sessions, parents practice implementing traditional play therapy skills to boost interactions and problem-solving skills to manage new behaviors. PCIT is conducted in two phases, described [here](#).

PCIT is rated as "well-supported" by CEBC and "promising" by Blueprints. One randomized controlled laboratory study conducted with 110 physically abusive parents of children ages four to 12 found that PCIT led to fewer reports of physical abuse and a less negative parenting style. Additionally, a [randomized controlled field trial](#) consisting of 192 parents referred to child protective services found that PCIT, combined with a self-motivation orientation, significantly reduced recidivism rates for child abuse and neglect. WSIPP performed a cost-benefit analysis of PCIT and reported \$15.10 measured in benefits for each dollar invested into implementing PCIT for families in the child welfare system.

## SafeCare and SafeCare Augmented with Motivational Interviewing

SafeCare is a home-based parent training curriculum for caregivers to children five years or younger who are at-risk or have a history of child abuse and neglect. SafeCare provides services that address poor parent-child interaction in 18-20 weeks of weekly sessions. The training includes three modules, explained [here](#), and completion of each module is required.

A statewide [cluster-randomized trial](#) tracked 2,175 maltreating parents or caregivers for approximately six years and found that SafeCare reduced recidivism to child protective services, especially when home visitors were coached in vivo to ensure fidelity to the program model. In its report, CEBC concluded that SafeCare was supported by research evidence but did not meet HHS criteria. However, one adaptation, [SafeCare Augmented](#), features a motivational interviewing component that rises to HHS standards. WSIPP [reports](#) \$20.80 in measured benefits per dollar spent implementing SafeCare from estimates based on the 2012 study described above.

## Conclusion

Though the programs highlighted do not directly fill a system's gaps, approaches that address parent management skills, improve parent-child relationships, and increase knowledge of child health and development are steps in the right direction. By focusing on primary prevention, health agencies can prevent negative health outcomes, generate cost-savings to sustain prevention programs, and prepare for emerging threats. Return on financial investment is also valuable when obtaining buy-in from both new and existing stakeholders. Health agencies should use these evidence-based programs as a starting place to determine best-suited practices to implement primary prevention of ACEs in their jurisdiction. These programs are especially meaningful in light of the COVID-19 pandemic, which will have long-term effects that disproportionately impact those at risk for a [higher prevalence](#) of ACEs, including [communities of color](#) and those whose parents have [lower socioeconomic status](#). States and territories must therefore address the potential impact of ACEs, both during the pandemic and beyond.

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