Prevention & Protection Brainstorming Workshop

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Written Materials

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Connecting our Understanding of Child Maltreatment (Root Causes, Facilitating Conditions) to the Design of Effective Prevention & Protection Approaches

Quality Improvement Center ON EARLY CHILDHOOD

Key Trends in Prevention

Report for the National Quality Improvement Center on Early Childhood (QIC-EC)

Deborah Daro
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Brianna English

Quality Improvement Center ON EARLY CHILDHOOD

Key Trends in Prevention: Report for the National Quality Improvement Center on Early Childhood

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Introduction

An important component of planning for the National Quality Improvement Center on Early Childhood (QIC-EC) involves an assessment of current literature on prevention and implementation trends in child abuse and neglect. Over the past 20 years, a broad body of research has emerged which highlights the first 3 years of life as a particularly important intervention period for influencing a child's trajectory and the nature of the parent-child relationship.[1] The key policy message from this body of research is that learning begins at birth and that maximizing a child's developmental potential requires more comprehensive methods to reach newborns and their parents. Individuals may debate how best to reach young children; few dispute the fact that such outreach is essential for insuring a child's healthy development and for reducing the risk for child abuse.

By initiating a review of this research and its related innovations, the QIC-EC will be in a stronger position to both understand the gains in knowledge this work represents as well as identify a generative set of operating hypotheses or testable strategies to guide its future investments. With this objective in mind, this review focused on identifying characteristics of program models that have been shown to successfully reduce the incidence and recurrence of child abuse and neglect and other negative outcomes for young children, as well as highlight the contextual factors that have facilitated or limited the ability of promising interventions to be implemented, replicated, and scaled up.

Reflecting this dual emphasis, we segmented the relevant literature and related material into two groups that were simultaneously reviewed. The first group of material included peer-reviewed articles, meta-analyses, and evaluations that assessed the structure and content of various primary and secondary prevention programs that targeted young children and their families.[2] To augment this information, we

[1] Shonkoff, J. & Phillips, D. (2000). *From Neurons to Neighborhoods: The Science of Early Childhood Development*. National Academy Press, Washington D.C.

[2] To construct our inventory of literature for programmatic components, we searched seven academic databases [Academic Search Premier, ERIC, Child Development & Adolescent Studies, Social Work Abstracts, Elsevier Science Direct, PsychINFO, and Sage Complete] using the following of descriptors: child abuse, neglect, prevent*, early, intervention*, program*. Our search yielded 152 results which were then reviewed to determine their relevance to our stated objectives.

also documented key characteristics of successful/promising prevention programs as indicated by web-based clearinghouses and relevant literature.[3] The results were clustered under a set of specific program dimensions including: programmatic intent or focus; timing; frequency; duration; personnel; target population; promising practices; and supportive systematic and organizational reforms. The second group of material included current literature related specifically to the capacity of programs to successfully replicate their efforts across communities and to sustain their impacts over time. Again, the findings from this review were clustered into a set of subtopics including: participant engagement and retention; workforce development; organizational culture; information and performance monitoring; dissemination and replication of innovation; and systemic change.[4]

The scope of our review was limited to early interventions for children aged 0-5, including those targeted to parents with infants and/or very young children, early education programs, and home visitation programs; secondary prevention (selective population prevention) models were primarily considered. To be considered "successful" for the purpose of this review, programs had to satisfy the following criteria:

- Programs had to reflect relevant theory that draws on a descriptive etiologic framework.
- Programs had to be evidence-based, demonstrating significant results in the core domains of interest (e.g., promoting optimal child development, increasing protective factors, reducing risk and preventing child maltreatment).
- Where applicable, programs had to be rated as "promising" or "proven" by at least one independent review system.

The purpose of this introduction is to summarize our core findings and to identify unanswered questions or knowledge gaps suggested by the review. A complete summary of the key patterns and issues that emerged from the review as well as the relevant citations are presented in subsequent sections. Before presenting these findings, we revisit a point made in our initial outline of the review, namely the challenges ecological theory presents to those attempting to craft and implement effective prevention programs and policies.

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[3] To construct our inventory of programs, we focused on relevant "proven" and "promising" programs featured in the Promising Practices Network (topics: child abuse and neglect, family support) and The California Evidence-Based Clearinghouse for Child Welfare (topic: prevention/secondary).

[4] To construct our inventory of literature for implementation, we searched the same seven academic databases using the following descriptors: implementation, program quality, systemic barriers to practice, engagement and retention, going to scale, system of care and workforce development. We also utilized articles from the Harvard Business Review.

The ecological framework

Since Henry Kempe's early work in the late 1960s, the dominant theoretical framework for understanding the casual pathways to maltreatment has been ecological theory. Rather than assuming that a single cause triggers abuse or neglect, ecological theory recognizes that most maltreatment stems from a complex web of factors within a person's personality, family history and community context.[5] In addition to articulating a nested set of domains governing human behaviors, ecological theory identifies a set of risk factors as well as protective factors. The theory underscores the importance of crafting prevention strategies that seek to reduce the interpersonal and environmental challenges families face and to build a network of protective or supportive factors that can help families cope with risks that are not easily eliminated or modified.

Although the theory has strong heuristic capabilities and is useful in outlining the array of factors that contribute to abusive and neglect behavior, it has demonstrated more limited utility as a policy and practice framework for several reasons:

- Although many prevention programs recognize the complex pathways that lead to maltreatment, the more successful efforts are generally those that have clear objectives and a well stated logic model. Interventions that attempt to directly impact too many variables in multiple domains often suffer from mission drift. This notion of focusing on a limited, clearly stated set of outcomes is, in some ways, counter to the multi-factorial structure embedded in ecological theories.
- Responsibility for health, education, economic well-being, housing, and child protection are distributed across myriad federal and state agencies, each of which define core outcomes and standards of best practice within their own disciplines and sphere of influence. Developing, managing and sustaining programs that cut across these defined areas in the manner suggested by an ecological framework is, at best, challenging.
- Measuring outcomes and success is easier at the participant level than at a population level. As such, the prevention response has been more focused on creating a series of interventions that target a distinct population rather than efforts to alter community context or normative values in the manner suggested by the ecological framework

[5] Belsky, J. (1980). Child maltreatment: An ecological integration. *American Psychologist*. 35: 320-335;

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press, Cambridge; Garbarino, J. (1977). The human ecology of child maltreatment: A conceptual model for research. *Journal of Marriage and the Family*. 39: 721-735; Cicchetti, D., & Rizley, R. (1981). Developmental perspectives on the etiology, intergenerational transmission, and sequelae of child maltreatment. In: Rizley, R. and Cicchetti, D. (eds.), *New Directions for Child Development: Developmental Perspectives in Child Maltreatment*. Jossey-Bass, San Francisco, pp. 32-59.

In short, we have a theoretical framework that many in the field embrace at direct odds with the programmatic initiatives and public policy that currently constitutes the child abuse prevention field. Although there have been notable gains in both the field's awareness and understanding of maltreatment, the current prevention system has failed to achieve a deep reach into the at-risk population and has not created the contextual and normative change necessary to maximize the safety and healthy development of the nation's children. These limitations have been particularly acute among prevention strategies targeting very young children, children living in poverty, and children living with caretakers struggling with substance abuse or mental health issues.

As outlined below, our review found that much has been learned in how best to structure prevention programs in ways that enhance their potential for successful impacts and replication. Although many barriers exist in replicating programs with quality and extending the availability of services to those families facing the most difficult circumstances, prevention planners are becoming increasingly astute in grounding their efforts in strong theories and rigorous empirical evidence. In addition, greater attention is being paid to how individual programs link together into effective systems of early intervention and how education, health care, and other relevant economic and social sectors can more effectively support and nurture this emerging effort.

Program development lessons

At its core, our review of successful trends in the prevention of child abuse and neglect programming underscores the importance of a clearly defined theory of change as the basis for any intervention. Although the individual programs we examined vary greatly in their intents and methods, all follow a clear logic model: definition of the problem, examination of etiology and context, identification of measurable goals, and construction of an intervention with a cohesive structure. We found that in most cases, the pivotal element for success was not the effective execution of individual program components but rather the conceptual framework on which the program rests. Importantly, our review notes that program developers should identify both a time horizon for the intervention and the level of sustainability the program seeks to achieve at the onset of the program planning process.

We discovered that the best child maltreatment prevention programs rely on both individual-level and family-level theories to inform their efforts.[6] Although many programs attempt to address individuals and families disparately (e.g. parent education courses, school-based child empowerment modules), the most successful interventions recognize the salience of a dyadic perspective and seek to impact the bi-directional interaction between individuals and their families. Indeed, our review indicates that successful

[6] Portwood, S. G. (2006). What we know - and don't know - about preventing child maltreatment. *Journal of Aggression, Maltreatment & Trauma*, 12(3-4), 55-80.

programs approach prevention with the view that both children and parents (as individual actors) and the family (as a cohesive unit) should be served by interventions.

Our review also indicates the effectiveness of a multi-tiered program structure. Although many interventions engage all participants at the same level of intensity, many proven/promising prevention programs stagger services so that those most in need receive an intensive level of service, while those with less need receive a decelerated level of service. This requires construction of reliable needs-assessment standards and protocols, and also a commitment to an even-handed review of individual participants' needs. Questions regarding the quality of parent-child interactions and potential abusive or neglectful behavior are sensitive and need to be raised in a manner designed to elicit information without generating a defensive attitude on the part of those being assessed. Ultimately, a staggered program design can contribute to greater program efficacy, efficiency, and cost-effectiveness,[7] and it is consistent with the public health model of "minimal sufficiency".[8]

An undercurrent in much of this literature concerns the preferred staffing arrangements of programs. Although research has been conducted on the comparative advantages of paraprofessionals versus trained nurses as service delivery agents for prevention programs, an overarching consensus has yet to be reached. Our research indicates that while professional support seems generally indicative of significant intervention effects,[9] we should not overlook the importance of alternative staffing arrangements that draw on the potential benefits of both groups of providers. For example, paraprofessionals may be better able to establish strong, trusting relationships with at-risk families,[10] whereas professionals are, at times, better able to engage with and persuade families to enroll in formal services or to alter their behaviors due to fact that families may afford them a sense of "natural legitimacy" based on the provider's professional role (e.g., a nurse, mental health professional, educator, etc).[11] Regardless of a provider's educational background or credentials, all providers are most effective when they are provided initial and ongoing targeted training. Where possible, professional staff should be trained to a post-secondary level and assigned duties that require a high standard of care; paraprofessional staff should receive high quality,

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[7] Sanders, M. R., Markie-Dadds, C., & Turner, K. M. T. (2003). Theoretical, scientific and clinical foundations of the Triple P-Positive parenting program: A population approach to the promotion of parenting competence, The Parenting and Family Support Centre, The University of Queensland.

[8] Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009). Population-based prevention of child maltreatment: The U.S. Triple P System population trial. *Prevention Science*, 10(1), 1-12.

[9] Guterman, N. B. (1997). Early prevention of physical child abuse and neglect: Existing evidence and future directions. *Child Maltreatment*, 2(1), 12-34.

[10] Portwood 2006.

[11] Olds, D. L., Robinson, J., O'Brien, R., Luckey, D. W., Pettitt, L. M., Henderson, C. R., et al. (2002). Home visiting by paraprofessionals and by nurses: A randomized, controlled trial. *Pediatrics, 110*(3), 486-496.

intensive training that is specific to the service delivery protocols of individual programs. In addition, consistency in delivering the intervention as intended requires staff to be provided ongoing reflective supervision in which participant-provider interactions are observed on a regular basis.

As a final point, it is important that program developers supplement and link prevention programs to the existing local network of social support services. By conceptualizing their programs as new components within a preexisting system, program developers can enhance both the potential impacts of their own efforts as well as increase the probability these impacts will be sustained over time as other service providers within the local service network reinforce a comparable set of concepts and behaviors. Equally important is identifying populations that are not being adequately served by existing interventions. Programs that adopt a more systematic view of how families can be assisted are in a better position to identify and create opportunities for these underserved groups. Our review indicates that many proven/promising programs are targeting their efforts to families that are not receiving support through other outlets, as these populations are most in need for support services.

Other important program development lessons:

- **Supplemental services can enhance program efficacy:** Many of the most successful programs offered a variety of service components, including child development (e.g., home visits, quality child care), family development (e.g., comprehensive health and mental health services, parenting education, nutrition education, health care and referrals, family support), and community building. These supplemental services can increase program impacts, especially for those families facing myriad stressors.[12]

- **We need to understand the dynamics of skill development:** The most successful parental education programs emphasize techniques for *skills-generalization* (i.e., how to take a set of learned skills and apply it to different circumstances) as well as *skills-maintenance* (i.e., how to retain and develop learned skills) to ensure a transfer of learning across different contexts. Skill acquisition and retention is an essential component of any prevention program, and it is important that program developers understand the dynamics of skill development as they formulate theories of change. This should include ideas of self-regulation, self-efficacy, self-sufficiency, self-management, and problem solving – all of which help parents retain the skills they develop**.**

- **Program curriculum should reinforce instruction and engage parents and children:** Programs that reinforce content (through either an interactive component between children and parents during the instructional lesson or through a homework component) are particularly effective in fostering healthy contact and communication between parent and child. Interventions should engage both

[12] MacMillan, H. L., Wathen, C. N., Barlow, J., Fergusson, D. M., Leventhal, J. M., & Taussig, H. N. (2009). Interventions to prevent child maltreatment and associated impairment. *The Lancet, 373* (9659), 250-266.

parents and children to "practice" what they learn through innovative curriculum components (including multimedia exercises) and at-home discussion. The physical participation of children in this process is an important component of behavior skills training.[13]

Implementation and replication lessons

Developing high quality prevention programs is an important and critical step in building an effective prevention response. Equally important, however, is implementing these programs in a manner that enhances their ability to engage and retain a high proportion of their intended target populations and to sustain their efforts over time. With respect to participant engagement, the voluntary nature of prevention programs place an added burden on providers and researchers to carefully examine the process potential participants follow in determining if they will seek out, enroll and remain in these programs. Our review of the literature on engagement and retention in voluntary prevention programs identified a number of strategies important for maximizing robust participant engagement. Effective engagement requires workers to demonstrate cultural awareness, respect and understanding towards the participant. Characteristics of the worker–participant relationship should also include collaborative goal setting and acknowledgement by the participant that they are aware and responsible for their situation.[14] Outside of relationship factors, program factors also influence participant engagement. Home visitor characteristics, staff turnover, program structure, program stability, length of the intervention program, program location and a match between program offerings and client need all affect engagement and retention rates.[15] A clients' previous experience in services, maternal age and level of community mobility are remaining factors that influence program completion. In order to maximize engagement, a program must consider these factors and incorporate them into their program design.

In addition to giving careful thought to the participant engagement question, successful implementation also requires attention to the ways in which service providers and the organization delivering an intervention are introduced to a given model. When new practice reforms are introduced at an agency, staff need to be given sufficient time to work with the model and build confidence in their ability to delivery the intervention with fidelity. Similarly, management of an organization adding a new service

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[13] MacMillan et al 2009.

[14] Altman, J. C. (2008). A study of engagement in neighborhood-based child welfare services. *Research on Social Work Practice, 18(6)*, 555-564.

[15] Girvin, H., DePanfilis, D., & Daining, C. (2007). Predicting program completion among families enrolled in a child neglect preventive intervention. *Research on Social Work Practice, 17(6),* 674-685,

Daro, D., & McCurdy, K. (2001). Parent involvement in family support programs: An integrated theory. *Family Relations, 50(2),* 113-121.,

component needs to consider how best to orient their staff to the new component and its relationship to other programs operated by the agency. The organization must also be ready to implement the model immediately following staff training and plan and budget for staff turnover. [16] High rates of staff turnover present serious challenges for prevention programs both on the service side and from an administration standpoint. One strategy for combating staff turnover cited in the literature was organizational mentoring. While this can be difficult to implement for a number of reasons, if done well it will produce many positive benefits including increased quality of work and enhanced motivation and learning.[17] It is important, especially in the public sector, to place a higher level of priority on developing the workforce and creating strategic plans for training and development. This will improve the ability of organizations to sustain robust services.

Developing a learning organization is another way to build organizational capacity. A learning organization is one in which staff feel supported, valued and trusted. When the culture in an organization is one that allows open reflection and collaboration, where workers truly feel their input and opinions are valued, productivity will increase.[18] Thus, it is essential when developing a learning organization to ensure that the process is open and credible. It is important for all involved to believe that decisions for which they are providing input have not already been made. This collaboration creates a shared vision between managers and workers and often results in new ways of visualizing a problem and workers' increased dedication and commitment to the projects and goals of the organization. When building a learning organization, key characteristics include: an open and inclusive management culture, strong leadership, resource stability and transparent access to data.[19] Learning organizations produce successful results because they go beyond solving the problems they face; they also reflect critically on their own behavior, learn from failure and past history, learn from the experiences and best practices of others and understand how to transfer new knowledge efficiently throughout the organization. The transfer of knowledge and new ideas is critical in enabling the leader to move the organization forward. Lastly, definitive policies and practices are important in a learning organization because they further emphasize the open and transparent culture.

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[16] Elliot, D., & Mihalic, S. (2004). Issues in disseminating and replicating effective prevention programs. *Prevention Science, 5(1),* 47-53.

[17] Hale, M. (1996). Learning Organizations and Mentoring: Two Ways to Link Learning and Workforce Development. *Public Productivity & Management Review, 19(4),* 422-433.

[18] Hicks, D., Larson, C., Nelson, C., Olds, D. & Johnston, E. Collaboration in community health initiatives: The relationship between process quality and attrition in the Colorado Nurse-Family Partnership. *Unpublished Draft Manuscript.*

[19] Daro, D. (2007). Best Practices in Prevention: The Importance of "Learning Organizations*". Presentation at the San Diego Conference for Child Maltreatment.*

There is a growing body of research on how to enhance and strengthen the replication and expansion of promising innovations. For any organization thinking about bringing their program model to scale, it is important to first clarify what they are trying to bring to scale. There are three different ways of "going to scale" identified in the literature: expansion, which increases the scope of operation; replication, which involves getting others to import the model; and collaboration, which is forming partnerships to divide the responsibility of going to scale. [20] Before initiating any of these types of scaling up, it is recommended that an organization, after clarifying what is being brought to scale, test and refine the model, conduct a needs assessment and allot enough time for the site to develop readiness and capacity. Site readiness is essential to implementation success and most replication failures can be linked to inadequate site preparation or readiness.[21] Additionally, a third party assessment of the implementation often provides other critical elements to the process of scaling up and helps accurately determine the impact made.[22] The main lesson the literature conveys is that for effective replication, it is essential for a site to develop a clear plan and allow enough time for readiness and not rush to implementation.

Taking a program to scale often raises questions about the sustainability of the program or initiative. Common sustainability challenges for home visiting programs include: securing funding that supports services and system functions without compromising quality or the program model's design; demonstrating efficacy of the model and ensuring replication with quality; and maintaining the program characteristics that made the home visiting program successful in the past.[23] In some cases the program model needs to be adapted to fit a specific population. Ensuring that the adaptation does not compromise the fidelity of the model is important to sustainability. When planning strategic implementation of an initiative, it is important to incorporate institutionalization of the program, building community ownership from the start, and securing long-term sustainable funding opportunities.[24] Insufficient funding is a common threat to the sustainability of a program or initiative, and successful implementation requires financing of start-up activities, direct services for the client, and infrastructure development.

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[20] Cooley, L., & Kohl, R. (2005). Scaling up—from vision to large-scale change: A management framework for practitioners: *Management Systems International.*

[21] Elliot and Mihalic 2004.

[22] Cooley & Kohl 2005.

[23] Elliot and Mihalic 2004.

[24] Chavis, D. M., & Trent, T. R. (2009). Scope, scale, and sustainability: What it takes to create. Lasting community change. *The Foundation Review, 1(1),* 96-114.

Knowledge gaps and learning opportunities

Achieving stronger impacts with young children and their families will require continued efforts at developing and testing a broad array of prevention programs and systemic reforms. Today, as in the past, no one program or one approach offers any guarantee of success. Although compelling evidence exists to support early intervention efforts, beginning at a time a woman become pregnant or gives birth, the absolute "best way" to provide this support is not self-evident. Our review, as well as reviews by others, underscores the point that the most salient protective factors or risk factors to target to avoid negative outcome for children will vary across populations as well as communities. Finding the correct leverage point or pathway for change for a specific family requires careful assessment, followed by an offer of assistance commensurate with a family's level of need. Our review did not identify a single program model or service delivery system that worked for all families under all conditions. As noted above, we did identify a set of core best practices and quality standards that improve the odds for achieving outcomes. How to package these standards within the context of a given intervention, however, remains a challenge. For example, some of the questions that remain unaddressed with respect to structuring and targeting prevention services include:

- **Determining relative risk for maltreatment**: Many of the most promising prevention programs target services to families perceived as facing an enhanced risk for child maltreatment. The most common factors used to identify populations at risk include young maternal age, poverty, single parent status and severe personal challenges such as domestic violence, substance abuse, and mental health issues. Although such factors are often associated with elevated stress and reduced capacity to meet the needs of the developing child, no one of these factors are consistently predictive of poor parenting or poor child outcomes. In addition, families that present none of these risk factors may find themselves in need of preventive services as the result of a family health emergency, job loss or other economic uncertainties. Indeed there is some antidotal evidence that suggests a recent increase in the potential risk for maltreatment among middle income households. [25] In short, our ability to accurately identify those who will benefit from preventive services is limited and fraught with the dual problems of over-identification and under-identification. Building on a public health model of integrated services, some prevention strategies have addressed this dilemma by embedding targeted, intensive services within a universal system of assessment and support. The ultimate goal of such a system is to normalize the process of seeking out and accepting offers of support while enhancing the ability to effectively identify and support those families facing the greatest challenges. Although potentially promising for changing normative attitudes toward help seeking and improving enrollment rates, the strategy has not been rigorously assessed from either a cost or outcome perspective.

25 For example, the United Way's "211" parent help line is reporting a substantial increase in the proportion of calls they are receiving from suburban communities.

- **Determining how best to intervene with diverse ethnic and cultural groups**: Much has been written about the importance of designing parenting and early intervention programs that are respectful of the participant's culture. For the most part, program planners have responded to this concern by delivering services in a participant's primary language, matching participants and providers on the basis of race and ethnicity, and incorporating traditional child rearing practices into a program's curriculum. Far less emphasis has been placed on testing the differential effects of evidence based prevention programs on specific racial or cultural groups or the specific ways in which the concept of prevention is viewed by various groups and supported by their existing systems of informal support.

- **Identifying ways to use technology to expand provider-participant contact and service access**: The majority of the prevention programs we examined involve face-to-face contact between a provider and program participant. Indeed, the strength and quality of the participant-provider relationship is often viewed as one of the most, if not the most, important determinant of proximate and distal outcomes. Personal contact is certainly a key feature of successful programs, particularly with families who are extremely isolated and disconnected from formal and informal supports. Although not a replacement for personal contact, the judicial use of technology can augment the capacity of a direct service provider to offer assistance to families on their caseload. For example, we did identity one example in which home visitors used cell phones to maintain regular communication with parents between intervention visits. [26] We also identified a number of examples in which programs used video taping to facilitate providing feedback to parents on the quality of their interactions with their children[27] or used the internet to link families with an array of resources in the community.[28] Expanding the use of these technologies and documenting their relative costs and benefits for both providers and program participants seems an area worth exploring.

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[26] Bigelow, K., Carta, J. & Lefever, J. (2008). Using cellular phone technology to enhance a parenting intervention for families at risk for neglect. Child Maltreatment, 13:4 (November), 362-367.

[27] Examples of models using this technique Promoting First Relationships program developed by colleagues of Kathryn Barnard at the University of Washington to assist very high risk families with young children and Circle of Security program which integrates over fifty years of attachment research into a video-based intervention to strengthen parents' ability to observe and improve their care giving capacity (www.circleofsecurity.org).

[28] For example, Positive Parenting DuPage is a multi-faceted, county-wide collaboration comprised of dozens of organizations that work with families during the first three years of a child's life. By uniting organizations across the county with similar goals, the program coordinates educational materials, strengthens linkages and access to support for all new families. This comprehensive system includes components targeting all parents and involves the marshalling of existing resources, expanding resources and adding new resources to meet gaps in services. A central feature of this effort is a web site that maintains a "virtual" calendar of all activities supported by the partner agencies. Similarly, One Tough Job is a campaign funded by the Massachusetts Children's Trust Fund to provide parents with the expert information, tips and support they need and deserve to be the best parent they can be. Its parenting web site, www.onetoughjob.com, is available in Spanish and English and has been awarded a 2007 National Parenting Publications Award (NAPPA) in the Honors category by United Parenting Publications.

- **Achieving a balance between enhancing formal services and strengthening informal supports**: It has long been recognized that families draw on a combination of formal services (e.g., health care, education, public welfare, neighborhood associations and primary supports) and informal support (e.g., assistance from family members, friends and neighbors) in caring for their children. As prevention planners begin to focus on altering community context as well as individual behavior, the dual importance of these two approaches is gaining increased attention.[29] Some of these strategies seek to expand public services and resources available in a community by instituting new services, streamlining service delivery processes, or fostering greater collaboration among local service providers. Other strategies focus on altering the social norms that govern personal interactions among neighbors, parent-child relationships, and personal and collective responsibility for child protection. In each case, the goal is to build communities with a rich array of formal and informal resources and a normative cultural context that is capable of fostering positive child and youth development. Although many agree on the need to balance the expansion of high quality, evidence based programs while encouraging individuals to accept personal responsibility for supporting each other in caring for children, how to do this is not clear. Placing too much emphasis on creating an environment of mutual reciprocity may not create the array of formal interventions some families may want and need. In contrast, focusing only on formal services may ignore the inherent limitations to public resources and the importance of creating a culture in which seeking assistance in meeting one's parenting responsibilities is normative.

Identifying and testing a range of innovations that address all of these concerns and alternatives is important. Equally challenging, however, is how these efforts are weaved together into effective prevention systems at local, state and national levels. Just as the appropriate service focus will vary across families, the appropriate collaborative partnerships and institutional alignments will differ across communities. In some cases, public health services will provide the most fruitful foundation for crafting effective outreach to new parents. In other communities, the education system or faith community will offer the most promising approach. And once innovations are established, they will require new partnerships, systemic reforms or continuous refinement if they are to remain viable and relevant to each subsequent cohort of new parents and their children.

In short, protecting young children from abuse and neglect is a complex task and one that most certainly involves changing parental behaviors, creating safer and more supportive communities, and improving the quality and reliability of public institutions. Although several prevention programs targeted toward individual families have had positive effects on the families they serve, these effects often fade over time in part because local communities and public institutions fail to reinforce the parenting practices and

[29] For a full discussion of this issue see Daro, D. and Dodge, K. (in press). Creating community responsibility for child protection: Possibilities and challenges. The Future of Children.

choices these programs promote. They also may fade because too much emphasis has been placed on the structure and content of the intervention and too little emphasis has been placed creating a mechanism within families as well as organizations to effectively discern their needs and efficiently utilize those resources that are made available to them.

Those engaged in child abuse prevention efforts need to be more effective in how they describe their intent with respect to what they plan to provide families as well as what types of changes and investments by families they hope they realize. Any innovation, regardless of its target population and institutional auspice, needs to be guided by strong theoretical models that link program strategies to specific outcomes and to be subjected to evaluation methods appropriate for their complexity and reach. In some cases, these research methods will employ randomization procedures and follow traditional scientific methods of inquiry. Equally important, however, is enhancing our understanding about how services are delivered. Better, more robust, implementation studies are needed to document the most efficient ways to replicate programs and take them to scale. In truth, some issues will only surface after programs have been taken "to scale" and moved beyond venues where researchers control all of the critical variables. Program managers and practitioners need to be adaptable problem solvers and researchers need to engage with them in this learning process. In this respect, evaluation designs need to provide service to practice as well as scientific communities

Achieving appropriate investments in child abuse prevention programs targeting young children will require the QIC-EC to develop a research and policy agenda that recognizes the importance of strengthening the link between learning and practice. It is not enough for scholars and program evaluators, on the one hand, to learn how maltreatment develops and what interventions are effective and for practitioners, on the other, to implement innovative interventions in their work with families. Instead, initiatives must be implemented and assessed in a manner that maximizes both the ability of researchers to determine the effort's efficacy and the ability of program managers and policy makers to draw on these data to shape their practice and policy decisions.

In light of this consideration, the QIC-EC leadership may want to consider the following parameters in defining their RFPs:

- require all applicants to articulate a clearly defined theory of change, including measureable proximate and distal outcomes;
- require all applicants to demonstrate a set of qualifications and organizational characteristics that demonstration a "readiness" to adopt a specific innovation the sustain the effort over time;
- require all applicants to articulate the specific way in which their innovation or strategy will strengthen a parent's ability for self-reflection in discerning appropriate options for themselves and their children; and

- require applicants to demonstrate how their proposed innovation will complement and be supported by other local service provider and normative community standards.

Programmatic components

Programmatic intent or focus

Literature

- By recognizing that child abuse and neglect are risk factors for juvenile delinquency, the Safe Kids/Safe Streets program successfully implements system reform via collaboration between community partners to reduce child abuse and neglect and improve response capacity across individuals and organizations [Gragg et al 2005]
- The majority of child abuse and neglect interventions employ secondary and tertiary approaches, despite that only primary interventions are specifically geared to prevent abuse and neglect before they occur [Portwood 2006]
- Although relied on less frequently to inform prevention efforts, macro-level theories (such as the frustration-aggression hypothesis) provide practitioners with a motivation to encourage systemic change (e.g. increasing resources and supports for parents) [Portwood 2006]
- The vast majority of interventions rely on individual- and family-oriented theories to inform prevention strategies (e.g. family therapy, parent education, home visitation, support groups) [Portwood 2006]
- Support for parent education prevention models derives largely from the belief that "lack of knowledge about child development and inadequate parenting skills are fundamental causes of child maltreatment" [Portwood 2006]

Programs

- Although programmatic motivations varied across the interventions we examined, programs generally sought to:

- Investigate whether intensive early education program can have long-term, lasting effects on children's success
- Provide services to disadvantaged families not receiving support through other programs (e.g. Head Start)
- Utilize a community-based prevention method that targets outreach to families most at risk for child abuse
- Focus on improving on improving health-related outcomes, including:
    - health behaviors during pregnancy
    - competent parenting (thus improving health outcomes)
    - linkages with other health and social service organizations
    - healthy relationships within families
- Utilize the professional capacities of existing staff to deliver services that reinforce and develop competent parenting

Timing

Literature

- Further investigation is needed on the existence of a window of interventive opportunity – this may be accomplished by staggering initiation points for services [Guterman 1997]
- The most effective maternal sensitivity interventions did not always start before birth or early in life (before six months) (208) [Bakermans-Kranenburg et al 2003]

Programs

- Programs varied widely in their timing, with some starting during pregnancy, some during infancy, some during pre-school and primary school, and others at any time during childhood
- Many programs seek to offer a comprehensive model that can accommodate families with children of any age by varying the type/intensity of interventions

Frequency

Literature

- Long-term interventions are more effective when coupled with moderately frequent visits (i.e. biweekly or weekly) [Guterman 1997]
- Highly intensive maternal sensitivity interventions with numerous sessions yielded small or negative effect sizes [Bakermans-Kranenburg et al 2003]

Programs

- Nearly all of the programs reviewed included weekly intervention components, depending on level of risk/need of individual families
- Some programs were constructed so that frequency varied along an intervention continuum, such that more needy families received services more frequently (e.g. more than once each week), while others received services less frequently (e.g. twice per month)

Duration

Literature

- Contrasting ideas about duration underscore the need to clearly delineate a "time horizon by which success in child maltreatment prevention is defined" and frame duration questions around this construct [Guterman 1997]
- Both long-term and short-term durations seem promising, relative to the "time horizon" used to measure impact [Guterman 1997]
- Comprehensive programs with multilevel intervention, such as the Triple P-Positive Parenting Program, vary duration by client need and have been associated with positive outcomes [Sanders et al 2003]; these programs are both consistent with a public health model of service provision and successful at providing a "minimally sufficient level of support" [Prinz et al 2009, Sanders et al 2003]
- By offering differential levels of support to different types of clients (e.g. by varying the intensity and duration of services) and providing a "minimally sufficient" level of support, programs can achieve optimal cost-effectiveness [Sanders et al 2003]

Programs

- Programs varied widely in their duration, with some lasting only a few weeks and others spanning up to a year or beyond
- The more intensive, targeted interventions tend to have a longer duration (e.g. Head Start)

Personnel

Literature

- Paraprofessional support is most useful when employed intensively over long-term interventions [Guterman 1997]
- Professional support seems generally indicative of significant intervention effects [Guterman 1997]
- Multidisciplinary teams with "elaborate personnel arrangements" do not necessarily offer a relative clinical advantage [Guterman 1997]
- Some evaluations revealed home visitation models with service delivery by paraprofessionals to be less successful than models with trained professionals (e.g. nurses, as seen in programs like the Nurse-Family Partnership and Early Start) [MacMillan 2009]; others, such as the NFP trials, did find some positive effects for paraprofessionals, especially when longer-term effects were examined [Olds et al 2002, 2004]
- One possible explanation for the small effect sizes produced by paraprofessionals may be their lack of "natural legitimacy"; whereas nurses may have "engagement and persuasive power" with pregnant women and parents of young children, paraprofessionals may lack this skill and/or authority [Olds et al 2002]
- Although interventions that utilize paraprofessional support may be less able to accurately assess family health and development issues, they may be better able to establish strong, trusting personal relationships with at-risk families [Portwood 2006]
- Parent educations programs suffer from high levels of participant attrition and staff turnover [Portwood 2006]

Programs

- Many of the most effective programs required that personnel be experienced professionals (including teachers, nurses), and some further required graduate-level training

- Most programs are supplemented by certification/accreditation training for providers (required by program developers before the intervention can be used at a new site) that includes on-going support
- Home visitation programs seem to be less consistent with personnel qualifications than parent education or school-based programs (i.e. some home visitations hire paraprofessionals while others hire professional nurses)

Target population

Literature

- By screening participants and targeting services to only those in the highest-risk categories, interventions may screen out those who are most responsive to treatment [Guterman 1997]
- Interventions that offer services based on universalistic intake and based on specific demographic risk factors (such as teen low socioeconomic status or single/teen parenthood) may yield the greatest effect and make best use of resources over psychosocial screening [Guterman 1997]

Programs

- Because we elected to examine secondary prevention, most programs targeted their delivery to "at-risk" clients (defined differentially by program)
- Referrals to programs often came from local hospitals, clinics, and social service providers

Promising practices

Literature

- The most successful interventions "employed some form of parenting guidance or education to enhance the parent-infant interaction" [Guterman 1997]
- The most successful interventions "explicitly sought to link families with formal and/or informal supports" [Guterman 1997]
- Taken as an aggregate (meta-analysis), early prevention programs have a significant overall positive effect on reducing child abuse and neglect for at-risk families with young children under three [Geeraert et al 2004]
- Taken as an aggregate (meta-analysis), prevention programs have a net positive effect on affecting the underlying factors associated with child abuse and neglect – these include "child functioning,

interaction between parent and child, family functioning, and context characteristics" [Geeraert et al 2004]

- Targeted interventions with a narrow focus consistently improved outcomes (maternal sensitivity and infant attachment insecurity) [Bakermans-Kranenburg et al 2003]
- The most effective maternal sensitivity interventions retained their impact "regardless of the presence or absence of multiple problems in the family" [Bakermans-Kranenburg et al 2003]
- On the whole, home visitation programs have not been shown to reduce physical abuse or neglect when assessed with randomized clinical trials (exceptions include the Nurse-Family Partnership and Early Start program) [MacMillan 2009]
- The Nurse-Family Partnership program, which provides home visiting services by qualified nurses to low-income, first-time mothers, has been shown to significantly reduce physical abuse and neglect [MacMillan 2009]
- The Early Start program, which provides home visiting services to "families facing stress and difficulties", significantly reduced hospital reports of physical abuse and injuries [MacMillan 2009]
- Home visiting programs have been identified as the strongest preventative effort, as well as the most promising type of intervention [Portwood 2006]
- Intensive nurse home visitation interventions have been shown to have positive effects on parenting attitudes and behaviors and on reported child abuse and neglect [Portwood 2006]
- The two most widely-used and promising prevention models (Olds model and Healthy Families Model) both include the following components in their interventions: frequent home visiting, "the provision of care within the context of a therapeutic and supportive relationship", a set curriculum, effective parenting modeling, and linkages to community support services [Portwood 2006]
- Although most school-based child empowerment models of prevention have not been evaluated, successful components of these models are anecdotally believed to allow children to physically participate in behavior skills training [Portwood 2006]
- Among lessons learned, comprehensive community-wide collaborations can benefit from the following recommendations:
    - Schedule a long planning period (9-12 months), a long demonstration period (8-10 years), a transition-out period with stepped-down funding (1-2 years), and detailed project timelines/workplans
    - Emphasize balance among program elements and investments

- Provide technical assistance during all phases of the project (planning, implementation, and transition-out)
- Emphasize clear communication in order to form a "learning community"
- Evaluate programs locally by focusing on "results-based accountability"

[Gragg et al 2005]

Programs

- Many of the most successful programs offered a variety of service components, including child development (via home visits, quality child care), family development (comprehensive health and mental health services, parenting education, nutrition education, health care and referrals, family support), and community building
- While the best programs appear to have the flexibility to tailor services to meet individual families' needs, it is difficult to evaluate programs that offer differential levels of service
- A key element of success for many programs was the ability to link families directly to service providers within the community
- Some successful programs included interactive components, such as videotapes that encourage group discussion, problem-solving, and idea-sharing, as well as role playing for children to allow them to "try out" lessons learned
- Supplemental, less conventional support components should also be considered to enhance program efficacy (e.g. providing additional goods and services, like health check-ups/referrals, free/reduced school lunches, social support networking)
- Programs for parents that are most successful include lessons that teach techniques of skills-generalization and skills-maintenance (ensures a transfer of learning across different contexts) as well as lessons that emphasize self-regulation, self-efficacy, self-sufficiency, self-management, and problem-solving (to help parents retain the skills developed in the program)
- Small class sizes are common among the most successful/promising prevention programs
- Some successful/promising programs reinforced lessons through a homework component (encouraging parents and children to "practice" what was learned via role-playing and discussion)
- Common components of successful programs focus on:
  - Improving parents' self-esteem, communication skills, level of engagement, decision-making skills, and stress management skills

  - Strengthening parents' awareness of community-based support mechanisms
  - Encouraging parents to develop age-appropriate expectations for their children
  - Teaching parents to utilize nurturing, non-violent strategies/techniques when they establish family discipline
  - Increasing parents' awareness of self and others in developing positive patterns of communication and establishing healthy, caring relationships

- Our review of successful/promising programs has indicated that the following should be taken into consideration as we think about prevention models:
  - It is difficult to ascertain whether results from programs implemented in communities with strong linkages to social service agencies are replicable in other settings
  - Need to distinguish which programmatic components are driving overall effectiveness so that we know which should be consistently delivered
  - Need to untangle the effect of using professionals versus paraprofessionals in interventions (especially home visitation)
  - Evaluations of home visiting showed that nurses tended to focus more on personal health and parenting than did paraprofessionals (this is more consistent with the goals of the program)
  - Need to consider how to balance the focus of nurses versus paraprofessionals with a sense of cost-effectiveness
  - Role playing practice for children can greatly enhance the success of a program
  - Possible weakness of school-based programs: outcome measures did not examine actual decrease in child abuse or neglect, but rather children's own attitudes and behavior in ways that could lead to a reduction in abuse and neglect

Supportive systematic and organizational reforms

Literature

- The prevention of child abuse and neglect may be positively impacted by collaborative efforts among advocates and community partners, including:
  - Increasing organizational capacity to respond to reported child abuse and neglect
  - Increasing personal/professional capacity to respond to reported

  - Expanding and bolstering services for children and families
  - Enhancing greater interagency communication, cooperation, and collaboration
  - Increasing cultural sensitivity and competence
  - Increasing capacity to collect and utilize data
  - Increasing prevention education and public awareness
  - Supporting changes in legislation, state policy, and resource distribution

  [Gragg et al 2005]

- Factors that may positively impact outcomes include:
  - Creating an adaptable program design
  - Adapting a flexible timeframe
  - Securing strong commitment to goals
  - Confirming the availability of technical assistance and support
  - Emphasizing the notion of a "learning community"
  - Selecting a credible lead agency
  - Recruiting skilled project leadership and staff and sustained commitment from key partners

  [Gragg et al 2005]

- Examples of community-based prevention programs for child abuse and neglect are rare; future work should target interventions to help families escape poverty and step-up components that enhance social support networks that connect families to the resources they need [Portwood 2006]
- Systematic and social reform should include the provision of high quality child care which can both directly and indirectly reduce child abuse and neglect [Portwood 2006]

Programs

- Programs may readily address cost effectiveness by ensuring that interventions are tailored to individual families' needs and risk levels (e.g. upon the completion of an intervention level, each family should receive a detailed assessment to determine if further intervention is necessary)

Implementation

Participant engagement and retention

- Examples of program attributes that contribute to parent enrollment and retention decisions include:
    - Staff fluctuation
    - Location of services
    - Program auspices
    - Staff training requirements
    - Average staff caseload
    - Stability of program funding

  [McCurdy & Daro 2001]
- "Researchers report that substance abuse, depression and domestic violence may challenge parents' abilities to complete services that target parenting (Guterman, 2001; Navaie-Waliser et al 2000)". However, contradicting evidence proves that these 'difficult' clients facing problems with substance abuse and depression do not necessarily drop out of preventive interventions (Daro et. al, 2003; Duggan et al, 1999) (682). Girvin et al (2007) developed a study which attempted to build a predictive model of completion, which provided tentative support for the notion that clients with complex and difficult problems can complete preventative services.
- Studies indicate it is difficult to predict which clients will leave programs before completion [Daro et al., 2003]
- Daro and Harding (1999) report that factors linked to attrition include: maternal age, high mobility in some communities, refusal of partner or another adult in home to allow regular visitor access and the stability and tenure of the sponsoring agency. (675)

- Elements of effective engagement include collaborative goal setting, good communication, maintaining a positive hopeful outlook and acknowledgement by parents that they are aware and responsible for the situation they are in. [Altman et al 2007]
- It is important for workers to demonstrate cultural awareness, respect and understanding to maintain levels of engagement. [Altman et al 2007]
- "Findings exist that engagement may be related to clients' past and current experience in services, their personal networks or their readiness to change (Daro et al., 2003)" (563)
- Other research and studies confirm that the match between the services provided and the clients needs and the alliance between the social worker and the family members matter significantly in retention rates.
- "Other studies indicate premature exit of a program is linked to clients feeling that services offered are not what they need (Epperson, Bushway & Warman, 1983; Weiss, 1993). [Girvin et al 2007]
- Enrollment and retention rates are also influenced by home visitor characteristics, program structure and length of the intervention program (easier to complete services for a shorter program). [Girvin et al 2007]
- We know very little about how individual characteristics determine what services parents seek, whether specific program structures and policies attract providers with common attributes, whether some programs flourish in particular communities or whether some level of neighborhood functioning needs to be in place before a parenting program can attract and maintain its target audience. (118) [McCurdy & Daro 2001]
- Engagement studies in the future will need to capture more information surrounding why participants seek help, the perceptions of the help they are getting, strategies workers are using to form relationships with them and the 'help seeking values' of their community. [McCurdy & Daro 2001]
- Programs should make more of a concerted effort to create an employment environment that conveys to direct service staff a sense of their value by regularly offering staff development opportunities, creating forums in which direct service staff can offer their input into program direction and offering regular opportunities to discuss difficult cases with supervisors and colleagues. (119) [McCurdy & Daro 2001]

Workforce development

- Serious challenges in implementation of a model with staff include a lack of time working with the model (building confidence), and high rate of staff turnover. [Elliot and Mihalic 2004]

- Agency managers and staff need to be skilled in effectively using information and notions of "best practice" to guide their specific service implementation. [Daro 2007]
- It is important to have a leader who is committed to excellence and continuous program improvement somewhere in the organizational structure. [Daro 2007]
- "Frequent turnover of administrative staff makes it harder to apply one policy systematically because administrators often feel compelled to set themselves apart from their predecessors by terminating programs associated with the former regime" (Slavin & Maddin, 1995, p.81) [McDermott 2000]
- With regard to staff training, recommendations that emerged from the Blueprint study were to:
    - Be firm regarding the formal eligibility requirements for program staff
    - Hire all staff before scheduling training
    - Conduct a general orientation of the program with staff before training
    - Encourage administrators to attend training
    - Plan and budget for staff turnover
    - Be ready to implement the program immediately after training (49)

  [Elliot and Mihalic 2004]
- Collaboration has the greatest potential where various organizations have different and complimentary skills or resources, have shared or overlapping objectives and have a high level of mutual trust. (13) [Hicks et al]
- Developing learning organizations and organizational mentoring can be used to develop the workforce and build capacity in public organizations [Hale 1996]
- Organizational mentoring can be challenging to implement but if done well will produce positive benefits including: increased quality of work, enhanced motivation and learning and inculcating norms, values and opportunities in organizations. [Hale 1996]
- Two barriers to workforce development are: the low level of priority given to developing the workforce and creating strategic plans for training and development and second, the nature of the work makes it difficult to measure the return on investment of human capital development in the public sector ("process over results orientation"). [Hale 1996]

Organizational culture

- Two mistakes in a company's effort to become a learning organization are: 1) defining learning too narrowly as 'problem solving' and neglecting to reflect critically on their own behavior or learn from failure, and 2) focusing too much on creating incentives to make people feel motivated and committed. Learning is not simply connected with how people feel, it is also a reflection of how people think. [Argyris 1991]
- Learning organizations are skilled at five main activities:

    1. Systematic problem solving
    2. Experimentation with new approaches
    3. Learning from their own experience and past history
    4. Learning from the experiences and best practices of others
    5. Transferring knowledge quickly and efficiently throughout the organization

    [Garvin 1993]
- Senge defines learning organizations as organizations in which: norms are determined by personal values, the meaning of one's work comes from relationships with professional colleagues, not one's manager and the focus is on problem finding and problem solving. [Hale 1996]
- For an organization to teach its members how to reason effectively, managers must examine critically and change their own theories-in-use. They must also learn to connect the problem to concrete examples. [Argyris 1991]
- To become a learning organization, an organizations must "begin to use systems thinkers and develop collaborative learning capabilities 'among different, equally knowledgeable people'". [Hale 1996]
- Open reflection produces greater productivity and awareness that improves performance. [Argyris 1991]
- Definitive policies and practices form the building blocks of learning organizations. [Garvin 1993]
- Successful ongoing programs dedicated to experimentation also require an incentive system that favors risk taking. Employees need to see that the benefits of experimentation outweigh the costs. [Garvin 1993]
- Chrislip and Larson (1994) identify two features common to highly successful collaborative initiatives: 1) Strong process leadership and 2) An open and credible process. [Hicks et al]

- Learning will only occur in receptive environments. Managers must be open to criticism and can not be defensive. [Garvin 1993]
- An open and credible process means that stakeholders perceive the process to be fair and authentic, and that decisions have not already been made in advance. [Hicks et al]
- If people do not perceive they are being treated fairly, they will not engage in collaboration, and are less likely to commit to the groups' projects and goals. If they do feel valued, respected and cared for, their will see their individual identity in terms of the group membership and contribute to the collaboration. [Hicks et al]
- Reports and personnel rotation programs are the most popular medium of transferring knowledge; personnel rotation programs are one of the most powerful methods of transferring knowledge. [Garvin 1993]
- Four characteristics that are critical to building a learning organization are: strong leadership, open and inclusive management culture, resource stability and transparent and accessible performance data. [Daro 2007]
- Successful organizations need a mechanism to spread new ideas. Without this, no leader will be able to move any concept forward. [Daro 2007]
- Chrislip and Larson (1994) argue that the aim of collaboration "is to create a shared vision and joint strategies to address concerns that go beyond the purview of any particular party" (p5). [Hicks et al]
- Collaboration is more than simply coordinating; it is a communicative activity that results in new ways of seeing and understanding social problems
- Strong process leadership brings everyone to the table for discussion, making sure that all parties feel competent, trusted and valued throughout the process. (Chrislip and Larson 1994 p.53) [Hicks et al]

Information and performance monitoring

- Organizations need to establish a framework for tracking performance in order for leaders to measure the results and impact of change. [Daro 2007]
- As organizations pursued their systems change objectives, they discovered that "even when they identified better ways of doing business and spending money the service-delivering entities that might be willing to entertain the better behavior that is requisite to 'real' system change often lacked adequate local infrastructure to do so" (2) [Brown 2005]
- Intermediary organizations were introduced as a solution, to provide infrastructure and give money in a way that ensures the building of organizational capacity. [Brown 2005]

- Analysis of the Riverside and Portland Welfare to Work programs suggested that program design and site characteristics were factors contributing to success; contextual features played a large role which makes replication complicated and the chance of obtaining identical effects unlikely if contextual features are different. [Greenberg et al, 2005]
- Looking single-mindedly at whether a program worked or not does not address how it worked, or what factors affect the generalizability.
- Four changes in the approach to evidence in health care would help accelerate the improvement of systems of care and practice:
    - Embrace a wider range of scientific methodologies
    - Reconsider thresholds for action on evidence
    - Rethink views about trust and bias (vigorously attacking bias can have unanticipated perverse affects)
    - Be careful about mood, affect and civility in evaluations

    [Berwick 2008]
- The Harlem Children's Zone Asthma Initiative (HCZAI) demonstrates that community-based interventions that target elements of the built environment such as poor housing conditions may have great potential. [Spielman 2006]

Dissemination and replication of innovation

Implementation

- Few programs identified as model programs have been successfully implemented on a wide scale.
- A commitment to developing site capacity and allotting enough time for developing site readiness must become routine for successful implementation of initiatives.
- Elements of successful implementation include:
    - Conduct a needs analysis
    - Identify champions

    [George 2008]

- "Partial implementation of several different reforms produces many winners of small-scale competitions, thus spreading the benefits much wider than declaring one winner of a large-scale contest for influence and prestige". [McDermott 2000]
- By implementing many small scale reforms, schools are able to gain some of the benefits of the reform without paying all of the associated costs. [McDermott 2000]
- Critical elements in site readiness related to successful implementation are:
    - a well connected and respected local champion
    - strong administrative support
    - formal organizational commitments and organizational staffing stability
    - up front commitment of resources
    - program credibility within the community potential for program routinization

    [Elliot and Mihalic 2004]
- Important factors in implementation of evidence-based practices are: funding, work climate, shared-decision making, coordination with other agencies, formulation of tasks, leadership, program champions, administrative support, staff skill proficiency, training and technical assistance. (8) [Elliot and Mihalic 2004]
- "The available research demonstrates that fidelity is related to effectiveness and any bargaining away of fidelity will most likely decrease program effectiveness" (Battisctich *et al.*, 1996; Blakely *et al.*, 1987; CSAP 2001; Fuchs & Fuchs, 1989; Gottfredson, 2001; Gray *et al.*, 2000; Kam *et al.*, 2003) (51) [Elliott and Mihalic 2004]

Going to scale

- Communications campaigns can amplify impact without organizational expansion, achieving a different manner of going to scale. [Kramer 2005]
- The Blueprints program is an example of a program that has evolved into a large scale prevention initiative, identifying model programs and providing technical support to aid in implementation. [Elliot and Mihalic 2004]
- The claim of a programs effectiveness based on experimental trials cannot be logically sustained in the face of substantive adaptations. (51) [Elliott and Mihalic 2004]
- Successful scaling up begins with good planning; it is important to clarify what you are scaling up first. [Cooley & Kohl 2005]

- Before scaling up a model or a project, sufficient testing, clarifying, refining and simplifying of the model should take place. Third-party assessments often provide elements essential to the scaling up process, including credible verification of impact. [Cooley & Kohl 2005]
- The three types and methods of scaling up are expansion, replication and collaboration. Expansion increases the scope of operation, replication involves getting others to implement the model and collaboration falls in the middle, creating formal partnerships and networks and dividing responsibility for going to scale. [Cooley & Kohl 2005]
- The easiest pilot efforts to scale up are those that involve a clear and replicable technology and that self-generate financial resources needed for expansion. [Cooley & Kohl 2005]
- Organizational factors are most responsible for pilot-scale success, but the broader social and political context in which the projects are located also substantially impacts the scaling-up process. (21) [Cooley & Kohl 2005]
- "Because change often represents a significant break from tradition and requires shifts in attitudes and actions, it is important that there be 'legitimizers' or 'champions' who enjoy widespread credibility". (29) [Cooley & Kohl 2005]
- Transfer of formal and informal knowledge is one of the most neglected aspect of scaling up. [Cooley & Kohl 2005]
- The Scaling Up Management Framework (SUM) has 3 steps and 10 tasks, as follows:
    - Step 1: Develop a Scaling-up Plan
        - Task 1: Create a Vision
        - Task 2: Assess Scalability
        - Task 3: Fill Information Gaps
        - Task 4: Prepare a Scaling-up Plan
    - Step 2: Establish the Pre-conditions for Scaling Up
        - Task 5: Legitimize Change
        - Task 6: Build a Constituency
        - Task 7: Realign and Mobilize Resources
    - Step 3: Implement the Scaling Up Process
        - Task 8: Modify Organizational Structures

- Task 9: Coordinate Action
- Task 10: Track Performance and Maintain Momentum

[Cooley & Kohl 2005]

- Success factors related directly to designing an initiative that will feasibly scale up include:
  - Clear articulation and measurement of desired community change results – assess the threshold, have specific statistical benchmarks
  - Creating the capacity for scale – understand what scale means and what it takes to get there
  - Use of data to drive the initiative and influence policy change

Barriers to effective replication and sustainability

- Lack of clarity or agreement on what to sustain and a misalignment between how programs are structured and funded in the beginning vs. the long term present barriers to sustainability. [Trent and Chavis 2009]
- Barriers to change in the urban school district sector include the difficulty of building trust or civic capacity, political conflict; there is as much pressure to improve certain enclaves of the district as to improve the district as a whole. [McDermott 2000]
- Implementation staff cited lack of time working with the model as the major barrier to feeling more confident in implementing it. (49) [Elliott and Mihalic 2004]
- Most replication failures can be traced to limited site capacity, inadequate site preparation or readiness. [Elliot and Mihalic 2004]

Sustainability and routinization

- Common sustainability challenges for home visiting programs include: securing funding that supports services and system functions without compromising quality or the program model's design, demonstrating the efficacy of the home visiting model, ensuring that the program model can be replicated with quality and maintaining the program characteristics that made the home visiting program successful in the past. [Elliot and Mihalic 2004]
- Success factors in a comprehensive community initiative's ability to achieve sustainable community level outcomes include:
  - A single entity acting as the broker and keeper of the vision
  - Clear, well defined roles and responsibilities

- Alignment between goals, strategies, institutional interests, resources and geography
- Meaningful community engagement
- Competent leadership and the right staff capacity
- Strategic connections between the community and the public sector

Related to this, three key elements that are key for sustainability are: **Institutionalization** (building community ownership of the initiative from the start), **Financing** (building long-term sustainable funding) and **Capacity** (building and sustain the capacity of institutions rather than programs)

[Trent and Chavis 2009]

- Program sustainability is important in four basic ways:

1. Sustainability maintains program effects over a long period of time
2. Because programs often attempt to change behavior, they must endure over a long period of time for changes to occur
3. There is often a lag between the start of programs and the time at which their effects may be felt
4. When programs are not sustainable, "organizations and actors lose what they have invested" and resist future investment

[Pluye et al 2004]

- There are four basic characteristics of organizational routinization:

1. Memory: "organizational memory" may be understood as "shared interpretations of past experiences that are brought to bear on present activities"; organizational memory requires stable resources, and consists of three major components: social networks, paper-based manuals, and computerized memory
2. Adaptation: routines are often adapted to fit with current context
3. Values: routines in organizations reflect collective values and beliefs
4. Rules: routines conform to governing rules in organizations, and these rules "account for 'the way things are done around here'"

[Pluye 2004]

- Further, a study of organization routines indicates four degrees of program sustainability: "the absence of any activity derived from programs, the presence of unofficial activities, the presence of remaining official activities, and the presence of routinized activities" [Pluye 2004]
- Three general measures guide our understanding of program sustainability:

    1. Individual-level outcomes
    2. Organizational-level implementation of activities
    3. Community-level capacity

    [Scheirer 2005]

- Sustainability is influenced by "a coherent set of factors primarily related to its organizational context and the people behind it, both within and outside the implementing agency"; programs that achieved sustainability often had an organizational 'champion', a person who is strategically placed within an organization, to advocate for the program [Scheirer 2005]
- Many programs lack a cohesive definition of "sustainability", which makes it difficult to assess whether or not a program will be sustainable; one way to address this is to construct a logic model that can define which specific program activity components are essential to achieving a given outcome; then, the successful maintenance of these components will constitute a "good operational definition of program-level sustainability" [Scheirer 2005]

Resources

- For most prevention programs, "resources" include financial resources, human resources and partners. Resource stability and diversity determine how much flexibility in implementation a program/organization will have. [Daro]
- Successful implementation of evidence-based programs requires financing of three critical components:

    - Start-up activities to explore the need, feasibility and installation of program or practice
    - Direct service provided to consumers
    - The infrastructure needed to successfully implement and sustain the quality of the evidence-based program

    [George 2008]

Innovation

- Studies that focus on innovation within the health care industry have demonstrated that innovation in one part of an organization can be difficult to replicate in other parts – this is generalizable to other disciplines [Berwick 2003]
- There are three primary "clusters of influence" that correlate with the speed at which an innovation is disseminated (each is discussed at length below):
    - How people perceive the innovation
    - Characteristics of the people who adopt (or do not adopt) the innovation
    - Other factors that may affect context, such as communication, incentives, leadership, and management

    [Berwick 2003]

Perception of an innovation [Berwick 2003]

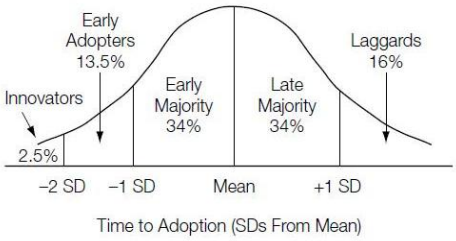
- According to research on innovation in health care, how people perceive the innovation "predict[s] between 49% and 87% of the variance in the rate of spread"
- Five key perceptions (or properties) influence whether an innovation will be adopted:
    1. Perceived benefit: if people think an innovation will positively impact them, they may be more willing to adopt it
    2. Compatibility: the proposed innovation needs to be consistent with potential adopters' values and beliefs, as well as with what people believe they need
    3. Complexity: simpler, easy-to-understand innovations spread quicker than complex innovations
    4. Trialability: it is important that implementers are able to try smaller-scale, pilot projects before implementing a universal innovation
    5. Observability: if potential implementers are able to watch others try the innovation first, they may be more receptive to implementing the change themselves

Characteristics of adopters (or non-adopters) [Berwick 2003]

- The "historic" classification model (derives from a 1943 study of Iowa farmers' adoption of hybrid seed corn) sorts adopters into five categories, distributed normally by time to adoption (see figure below, reprinted from paper):
    1. Innovators

2. Early adopters
3. Early majority
4. Late majority
5. Laggards

Figure 1. Classification of Adopters[30]



Other contextual factors [Berwick 2003]

- The type of environment – i.e. whether an organization is receptive to new ideas or if it "regard[s] those who propose change as troublemakers" – can have an important impact on the rate of dissemination
- Another important facet of perception concerns spread vs. reinvention:
    - As we think about scaling-up an intervention, it is important to think of dissemination as a "reinvention" of new ideas rather than the "spreading" of pre-existing ideas
    - It is important to remember that adaptation (which often involves the simplification of an original model), is "nearly a universal property of successful dissemination"; even if a change to the model is not what original developers (or disseminators) had envisioned, we must recognize that adaptation is both a natural part of dissemination and an integral part of innovation
    - Indeed, just as "no two problems are the same" we must remember that "neither are any 2 solutions"
- There are seven "rules" for disseminating innovations (derived from descriptive observations in the health care field):
    1. Find sound innovations: a "formal, deliberate, organized system of search for innovations" allow organizations to identify practicable innovations

[30] Reprinted from Berwick 2003

2. Find and support innovators: individuals who look outside the current local context to solve problems should be supported
3. Invest in early adopters: investing in the ideas of within-organization innovators can decrease resistance to the spread of innovation
4. Make an early adopter activity observable:
5. Trust and enable reinvention: adaption is key to successful innovation
6. Create slack for change: innovation is not an immediate outcome; investment in time, energy, and money will facilitate change
7. Lead by example: "leaders who want to spread change must change themselves first"

- Understanding the full context of a theory-driven intervention is essential to ascertaining its replicability [Campbell et al 2007]

Lessons from health promotion

- The Ottawa Charter for Health Promotion characterizes the term *health promotion* as a process through which people increase their control over and improve their health [WHO 1986]
- Health promotion is supported by three prerequisites: advocacy for health, equity in health, and mediation of "differing interests in society for the pursuit of health" [WHO 1986]
- The Ottawa Charter outlines six action areas for health promotion, many of which are transferrable to other disciplines (such as child abuse/neglect):
    1. Building healthy policy: places health on the agenda of policymakers at all levels
    2. Creating supportive environments: recognizes that health cannot be separated from other goals, and that the "inextricable links between people and their environment constitute the basis for a socio-ecological approach to health"
    3. Strengthening community actions: health promotion is feasible when communities are empowered to set their own priorities, make their own decisions, and plan and implement strategies to achieve better health
    4. Developing personal skills: effective health promotion fosters personal and social development by providing education about health and life skills
    5. Reorienting health services: the responsibility of effective health promotion is shared among "individuals, community groups, health professionals, health service institutions, and

governments"; the health sector must embrace health promotion as a goal and "support the needs of individuals and communities for a healthier life"

6. Moving into the future: health is created within the settings of individuals' everyday life; "caring, holism and ecology are essential issues in developing strategies for health promotion"

[WHO 1986]

- An analysis of complex interventions in health care demonstrated that "for an intervention to have a credible chance of improving health or health care, there must be a clear description of the problem and a clear understanding of how the intervention is likely to work" [Campbell et al 2007]
- A comprehensive view of health promotion should emphasize both individual-level efforts (development of personal-level knowledge and skills to improve individual health outcomes) and organizational-level efforts, including the development of health promotion skills in settings such as schools, workplaces, and hospitals, "which aim to enable and support healthy behaviour"; as a consequence, assessment of health promotion must move beyond measuring individual behaviors and outcomes [Speller et al 1997]
- Given that we need to move beyond evaluation of individual-level data in assessing the effectiveness of health promotion programs, models of process evaluation (a study of the process by which an intervention is implemented; process evaluations typically aim to answer questions like: "Was the intervention applied in the manner intended?", "Did other factors come into play that may have affected the result?", "What did the participants think about the process"?) may hold more promise for understanding whether multi-level health promotion initiatives succeed once they are implemented
- A review of health promotion literature suggests that routinization, which commonly refers to sustainability in organizations, "is the primary or fundamental process in the sustainability of health promotion programs" [Pluye et al 2004]

Systemic change

- Principles for evaluation are:
    - Clarify the evaluation's audiences and intended uses for evaluation findings
    - Base evaluation decisions on the initiative's focus
    - Use theories of change to facilitate systems initiative evaluations
    - Identify an appropriate level of methodological rigor

- Factor investment levels for both systems initiatives and their evaluations into evaluation decisions
- Establish the necessary timeframe for results
- Measure and value interim outcomes
- Hold some systems initiatives accountable for demonstrating beneficiary impacts (but not all)
- Be clear about the initiative's role in addressing inequity and reducing disparities
- Account for and examine all externalities
- Make continuous feedback and learning a priority

[Coffman 2007]

- Well articulated and persuasive early benchmarks of progress are important for two reasons: they provide useful discipline for broad and ill-defined initiatives and outcomes buy time and political support while waiting for the systems change to take effect. [Walker & Kubisch 2008]
- A systems change initiative might focus on one or more of five areas: context, components, connections, infrastructure or scale. These five areas can act as a framework that can help define and construct the theory of change and design the systems change evaluation. [Coffman 2007]
- In thinking about systems change evaluation, it is important to ask questions regarding infrastructure development. These questions should cover the following categories: planning capacity, operational capacity, workforce capacity, fiscal capacity, communication capacity, collaborative capacity, community and political support and evaluation capacity. [Hargraves 2009]
- Systems change efforts are more likely to succeed when they "permeate multiple levels and niches with a system, creating compatible changes or conditions across system components". [Hargraves 2009]
- The two factors that describe the variation in dynamics of social systems are the degree of agreement and the degree of certainty. The interaction between certainty and agreement create three dynamics within a social system: organized, unorganized and self-organizing. [Parsons et al, 2007]
- There are six goals sites needed to work on to achieve "system transformation". These include access to care, choice and control, quality management, technology, financing, and coordination. Under each of these, there are six steps to improvement. [Abt Associates 2008]
- Initiatives attempting to scale up a system usually require a high level of funding. This funding can come from both public and private investments, but if the goal is to scale up the system statewide it is beneficial to have significant public investment. [Coffman 2007]

References

Altman, J. C. (2008). A study of engagement in neighborhood-based child welfare services. *Research on Social Work Practice, 18*(6), 555-564.

Argyris, C. (1991). Teaching smart people how to learn. *Harvard Business Review, 69*(3), 99-110.

Bakermans-Kranenburg, M. J., IJzendoorn, M. H. v., & Juffer, F. (2003). Less is more: Meta-analyses of sensitivity and attachment interventions in early childhood. *Psychological Bulletin, 129*(2), 195-215.

Berwick, D. M. (2003). Disseminating innovations in health care. *Journal of the American Medical Association, 289*(15), 1969-1975.

Berwick, D. M. (2008). The science of improvement. *Journal of the American Medical Association, 299*(10), 1182-1184.

Brown, L. D. (2005). *Developing local infrastructure: The salience of muddling through / lessons from the urban health initiative*: Urban Health Initiative.

Campbell, N. C., Murray, E., Darbyshire, J., Emery, J., Farmer, A., Griffiths, F., et al. (2007). Designing and evaluating complex interventions to improve health care. *BMJ, 334*, 455-459.

Chavis, D. M., & Trent, T. R. (2009). Scope, scale, and sustainability: What it takes to create. Lasting community change. *The Foundation Review, 1*(1), 96-114.

Coffman, J. (2007). *A framework for evaluating systems initiatives.* Paper presented at the Evaluation Symposium, Pittsburgh.

Cooley, L., & Kohl, R. (2005). *Scaling up—from vision to large-scale change: A management framework for practitioners*: Management Systems International.

Daro, D., & McCurdy, K. (2001). Parent involvement in family support programs: An integrated theory. *Family Relations, 50*(2), 113-121.

Elliot, D., & Mihalic, S. (2004). Issues in disseminating and replicating effective prevention programs. *Prevention Science, 5*(1), 47-53.

Garvin, D. (1993). Building a learning organization. *Harvard Business Review, 71*(4), 78-91.

Geeraert, L., Noortgate, W. V. d., Grietens, H., & Onghena, P. (2004). The effects of early prevention programs for families with young children at risk for physical child abuse and neglect: A meta-analysis. *Child Maltreatment, 9*(3), 277-294.

George, P., Blase, K. A., Kanary, P. J., Wotring, J., Bernstein, D., & Carter, W. J. (2008). *Financing evidence-based programs and practices: Changing systems to support effective service*.

Girvin, H., DePanfilis, D., & Daining, C. (2007). Predicting program completion among families enrolled in a child neglect preventive intervention. *Research on Social Work Practice, 17*(6), 674-685.

Gragg, F., Cronin, R., Schultz, D., & Eisen, K. (2005). *National evaluation of the safe kids/safe streets program: Final report executive summary*: Prepared by Westat for the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice.

Greenberg, D., Ashworth, K., Cebulla, A., & Walker, R. (2005). When welfare-to-work programs seem to work well: Explaining why riverside and portland shine so brightly. *Industrial and Labor Relations Review, 59*(1), 34-50.

Guterman, N. B. (1997). Early prevention of physical child abuse and neglect: Existing evidence and future directions. *Child Maltreatment, 2*(1), 12-34.

Hale, M. (1996). Learning organizations and mentoring: Two ways to link learning and workforce development. *Public Productivity & Management Review, 19*(4), 422-433.

Kramer, M. R. (2005). One business maxim to avoid: 'going to scale'. *Chronicle of Philanthropy, 17*(8), 30-33.

MacMillan, H. L., Wathen, C. N., Barlow, J., Fergusson, D. M., Leventhal, J. M., & Taussig, H. N. (2009). Interventions to prevent child maltreatment and associated impairment. *The Lancet, 373* (9659), 250-266.

McDermott, K. (2000). Barriers to large-scale success of models for urban school reform. *Educational Evaluation and Policy Analysis, 22*(1), 83-89.

McGregor, Jr. E. (1988). The public sector human resource puzzle: Strategic management of a strategic resource. *Public Administration Review, 48*(6), 941-950.

Olds, D. L., Robinson, J., O'Brien, R., Luckey, D. W., Pettitt, L. M., Henderson, C. R., et al. (2002). Home visiting by paraprofessionals and by nurses: A randomized, controlled trial. *Pediatrics, 110*(3), 486-496.

Olds, D. L., Robinson, J., Pettitt, L., Luckey, D. W., Holmberg, J., Ng, R. K., et al. (2004). Effects of home visits by paraprofessionals and by nurses: Age 4 follow-up results of a randomized trial. *Pediatrics, 114*(6), 1560-1568.

Organization, W. H. (1986). Ottawa chater for health promotion, *First International Conference on Health Promotion*. Ottawa.

Parsons, B., Behrens, T., Yang, H., Helstowski, L., Eoyang, G., Sherman, J., et al. (2007). *Designing initiative evaluation: A systems-orientated framework for evaluating social change efforts*: W.K. Kellogg Foundation.

Pluye, P., Potvin, L., Denis, J. L., & Pelletier, J. (2004). Program sustainability: Focus on organizational routines. *Health Promotion International, 19*(4), 489-500.

Portwood, S. G. (2006). What we know - and don't know - about preventing child maltreatment. *Journal of Aggression, Maltreatment & Trauma, 12*(3-4), 55-80.

Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009). Population-based prevention of child maltreatment: The u.S. Triple p system population trial. *Prevention Science, 10*(1), 1-12.

Sanders, M. R., Markie-Dadds, C., & Turner, K. M. T. (2003). *Theoretical, scientific and clinical foundations of the triple p-positive parenting program: A population approach to the promotion of parenting competence*: The Parenting and Family Support Centre, The University of Queensland.

Scheirer, M. A. (2005). Is sustainability possible? A review and commentary on empirical studies of program sustainability. *American Journal of Evaluation, 26*, 320-347.

Speller, V., Learmonth, A., & Harrison, D. (1997). The search for evidence of effective health promotion. *BMJ, 315*, 316-636.

Spielman, S. E., Golembeski, C. A., Northridge, M. E., Vaughan, R. D., Swaner, R., Jean-Louis, B., et al. (2006). Interdisciplinary planning for healthier communities: Findings from the harlem children's zone asthma initiative. *Journal of the American Planning Association, 72*(1), 100-108.

Walker, G., & Kubisch, A. C. (2008). Evaluating complex systems-building initiatives: A work in progress. *American Journal of Evaluation, 29*(4), 494-499.

Wulczyn, F., Smithgall, C., & Chen, L. (2009). Child well-being: The intersection of schools and child welfare. *Review of Research in Education, 33*, 35-62.

Young, G., Charns, M., & Shortell, S. (2001). Top manager and network effects on the adoption of innovative management practices: A study of tqm in a public hospital system. *Strategic Management Journal, 22*(10), 935-951.

Zegans, M. (1992). Innovation in the well-functioning public agency. *Public Productivity & Management Review, 16*(2), 141-156.

Emerging Themes in Child Abuse Prevention Research: Filling the Gaps

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Policy research that benefits children, families, and their communities

Literature Review Objectives

- To identify new developments in the characteristics of programs most successful in preventing child abuse – is home visiting still the best bet?
- To identify successful strategies that improve collaboration across state agencies or alter service delivery in ways that enhance efficiencies or improve outcomes
- To identify emerging frameworks or conceptual models in other disciplines that may have application in improving child abuse prevention programs or policies

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Core Activities

- Traditional search of promising prevention programs identified in journals focusing on child maltreatment, family support, children/youth development and public health
- A broader search to identify recent progress in other areas of study such as building "learning organizations", promoting cultural or normative change, neighborhood impacts, use of technology, implementation science and replication
- Interviews with key experts from diverse fields to highlight core topics of discussion and promising innovations

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Promising Areas of Inquiry

- New conceptual frameworks – people are thinking about the problem differently
- Advances in neuroscience and genetic research in explaining early child development and trauma impact
- Socio-economic trends impacting parental capacity and the challenges parents face
- A more focused emphasis on infrastructure building and systems development
- Innovation in research methods and data management

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New Conceptual Frameworks

- Risk versus protective factors
  - Moving from defining success simply in terms of reducing risk to measuring progress based on risk reduction and strengthening protective factors that promote resilience
  - Examples
    - Protective Factors Framework – Strengthening Families Initiative
    - Life Course Health Development – CDC's Prevention Strategy
    - IOM Report on Prevention of Mental Health Disorders
- Cultural competence versus cultural humility
  - Moving from the notion of mastering a body of knowledge to sustaining an ongoing commitment to learning and understanding

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Human Development and Trauma Impact

- Importance of early childhood on development
  - Early brain development and "executive functioning"
  - Impact of trauma and "toxic stress"
  - Limits of remediation
- Intervention potential for children 3-5
  - Attachment and Biobehavioral Catch-Up Intervention
  - Multidimensional Treatment Foster Care Program for Preschoolers (MTFC-P)
  - Tools of the Mind
- Intervention potential for adolescents
  - Attachment, Self-Regulation, and Competency (ARC)
  - Parent-Child Interaction Therapy (PCIT)

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Impact of Broad Socio-Economic Trends

- Growing income inequality and absence of upward mobility
  - May impact rates of intergenerational child maltreatment
  - Improved education and income may not exist to buffer the negative impacts of child maltreatment
- Economic Uncertainty
  - Less stable job markets/prolonged unemployment
  - Greater stress associated with instability in income and public investments
- Single parent status
  - Affecting more children from more diverse populations

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Moving Beyond Model Replication

- More fully understanding program implementation
  - Implementation science
- Building effective systems to support program development
  - Collective impacts
  - Community initiatives
- Using technology to enhance performance
  - Improving provider supervision and performance
  - Strengthening participant-provider relationship
  - Empowering participants to act on own

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Innovations In Data Management

- Growing use of administrative data and integrated data management systems
  - Monitor participant outcomes over the long term
  - Allow for a clearer understanding of an individual's experience across diverse public service systems
- Development of better program monitoring tools and fidelity systems
  - Greater clarity regarding program experiences across participants
- Use of more complex analytic packages
  - HLM
  - Propensity analysis

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Preventing Child Abuse: Next Generation

- Fewer "big" initiatives and more locally defined and managed programmatic innovations
- Self-directed strategies – strengthening the capacity of parents to access information and services on their own
- Development of a collective sense of responsibility for child outcomes
- Creating universal systems of support building on current health care and educational investments

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Ferguson's "Killer" Apps Adjusted for CAN

- Use of **modern medicine**/genetic research to determine what we can biologically address
- **Consumer culture** – teach families to demand what they need
- **Work ethic** – commitment to continuous learning; parents need to work at the job of raising their children and professionals to adapt their practice as necessary
- **Scientific revolution** – use data to improve practice and seek greater efficiency in what you deliver
- **Competition** – allow local variation and don't guarantee funding without outcomes
- **Rule of law** – expand who can do this work; don't place decisions in the hands of one professional group/one institution

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Session II

A Public Health Approach

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A Public Health Approach to Child Maltreatment Surveillance: Evidence from a Data Linkage Project in the United States

Historically, data concerning children reported for abuse or neglect in the US have been compiled by child protective service agencies and analysed independently from other sources of information. Yet these data suffer from the notable limitations of being both narrow in scope (i.e. containing a limited set of variables) and narrow in coverage (i.e. capturing data for only those children who are reported). In order to extend an understanding of children reported for maltreatment, the California Department of Social Services, in partnership with the University of California at Berkeley, is pursuing a 'public health' oriented approach to the surveillance of child maltreatment through linkages between child protective service records and population-based sources of data. As an example of the information that can be generated through linked records, this article reports results from child-level matches completed between the state's child protective service records and vital birth records. The cumulative percentage of children reported for abuse or neglect before the age of five is examined based on maternal and child characteristics at birth. This is followed by a discussion of record linkages as a means of furthering a public health approach to child maltreatment.

KEY WORDS: public health; child maltreatment; surveillance; abuse and neglect

'Data suffer from the notable limitations of being both narrow in scope and narrow in coverage'

'This article reports results from child-level matches completed between the state's child protective service records and vital birth records'

Public health efforts in the US have historically focused on the study and prevention of communicable disease transmission (Sleet *et al.*, 2004). Only in the latter half of the 20th century were unintentional injuries recognised as threats to health that could

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be controlled and prevented through epidemiological study, improvements to the social environment and health promotion campaigns. More recently, child maltreatment has also begun to be recognised as a social problem that also lends itself to a public health framework of study and subsequent prevention activities (O'Donnell *et al.*, 2008; Zimmerman and Mercy, 2010).

'A social problem that also lends itself to a public health framework of study and subsequent prevention activities'

A key feature of a 'public health approach' is the ability to utilise surveillance data both as a tool for the identification and tracking of the health threat at the population level and as a means of determining risk and protective factors among subgroups, information that can then be used to develop targeted prevention and intervention programmes. Unfortunately, administrative child protective services data, often used to study victims of child maltreatment, are both incomplete and serve as a poor source of surveillance information (Sedlak and Broadhurst, 2010). Beyond the fact that this administrative data source captures only those children who are officially reported for maltreatment, these data suffer from other notable limitations. Because child protection databases were designed for administrative reporting purposes, the variables they typically contain are limited to those associated with billing and other management tasks (Brady *et al.*, 2001). Absent are more descriptive measures of case characteristics, such as family-level variables, that may confound apparent associations (e.g. race often emerges as a risk factor for maltreatment only when socioeconomic data are not available) (Putnam-Hornstein and Needell, 2011). Also missing is information on aetiological risk factors that predate a first report of maltreatment, or outcomes following contact with child protective services, both of which could be used to inform and improve decision-making.

This article presents findings arising from an ongoing child welfare record linkage project in California, US. These linkages were pursued with the simple goal of compiling data and generating new knowledge concerning children and families reported to the state's child protective services system. Yet linkages with vital records also provide a method for population-level surveillance of reported maltreatment, a key feature of public health campaigns. In the sections that follow, we discuss the rationale for including child maltreatment among public health problems, provide a general overview of a public health framework, describe the process of linking records and present examples of information generated.

'Linkages with vital records also provide a method for population-level surveillance of reported maltreatment, a key feature of public health campaigns'

Child Maltreatment within a Public Health Framework

In the US, child welfare systems were developed in a manner largely consistent with a traditional medical model of case identification, assessment and treatment (Waldfogel, 1998). While child welfare agencies continue to play a critical role in efforts to

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ensure the wellbeing of children, it has become increasingly clear that the child welfare system is poorly suited to addressing the broader social and economic causes of child maltreatment and is not easily adapted to prevention-focused efforts (Berrick, 2009). Certainly, a number of compelling arguments exist as to why child maltreatment should be included under a broader public health umbrella (Zimmerman and Mercy, 2010).

First, even after maltreatment ends, the consequences of abuse or neglect are often far-reaching, with adverse effects associated with a child's physical, cognitive, social and emotional development commonly observed among victims of maltreatment (Felitti *et al.*, 1998; Glaser, 2000; Springer *et al.*, 2007; Wulczyn *et al.*, 2005). While on the one hand disheartening, this growing body of scientific evidence suggests that preventing child maltreatment may be an effective strategy for promoting health and reducing disease burdens later in life − objectives of most public health agendas (Thacker, 2006).

'Preventing child maltreatment may be an effective strategy for promoting health and reducing disease burdens later in life'

Second, while child protective service agencies have been shown to have contact with only a fraction of children affected by maltreatment in the US (Sedlak and Broadhurst, 1996, 2010), public health agencies fall within a large health infrastructure with ready access to a broad population of young children and their families. Maternal and child health programmes offer opportunities to reach children who may be at risk of maltreatment, but are unknown to child protective services agencies, and to do so under less stigmatised and adversarial circumstances (Zimmerman and Mercy, 2010).

Third, public health approaches rely on epidemiologic methods for studying the incidence of social problems over time, across places and populations (Thacker *et al.*, 1989). These methods lend themselves well to the resource-constrained environments within which child protection agencies must function, potentially informing the allocation of limited services to those populations at greatest risk (Wulczyn, 2009).

'Integrated child safety campaigns may be a more successful and efficient means of improving child safety'

Finally, overlapping risk factors for unintentional (or accidental) injuries and intentional (or maltreatment related) childhood injuries suggest that integrated child safety campaigns may be a more successful and efficient means of improving child safety (Peterson and Brown, 1994; Putnam-Hornstein, 2011). Although public health has been most effective in promoting health through passive campaigns targeting environmental changes (e.g. child safety tops on toxic substances), it also has an established track record in the reduction of harm to children through the employment of education, policy and intervention programmes focused on behaviour modifications (e.g. the use of bicycle helmets). Lessons learned from successful public health efforts may translate well to maltreatment prevention.

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A Public Health Framework

Although definitions of public health differ, constant is a focus on the protection and promotion of health and wellbeing at a population level, with prevention figuring prominently into strategies (Dunn and Hayes, 1999; Thacker, 2006; Wilson, 1920). As reflected in Figure 1, the study of child abuse and neglect within a public health framework can be conceptualised as a four-step process, the objectives of which are to: (1) define the problem through data collection and surveillance efforts; (2) uncover possible causes through the identification of risk and protective factors; (3) develop and test interventions in order to discover the most efficacious means of addressing the problem; and (4) implement and monitor prevention and control strategies (Peden *et al.*, 2008; Sleet *et al.*, 2003).

'The study of child abuse and neglect within a public health framework can be conceptualised as a four-step process'

Step One: Surveillance

Surveillance serves as the first step towards the control and prevention of an identified health threat. Surveillance is defined as the ongoing collection, analysis and interpretation of outcome data for use in the planning, implementation and interpretation of population health (Thacker *et al.*, 1989). Described not as 'an end unto itself, but rather a tool', public health surveillance efforts are typically initiated for the purposes of detecting and describing a problem that can then be monitored for geographic and temporal trends in its occurrence (Thacker and Berkelman, 1988, p. 185).

'Surveillance serves as the first step towards the control and prevention of an identified health threat'

Step Two: Identification of Risk and Protective Factors

Surveillance provides ongoing information as to the scope and magnitude of the health threat. The next step in a public heath framework involves identifying both those factors that place individuals at risk, as well as those that serve to protect them. Public health tends to rely on ecological models, allowing risk and protective factors to be considered at both the individual and contextual levels (Diez-Roux, 2000).

'Surveillance provides ongoing information as to the scope and magnitude of the health threat'

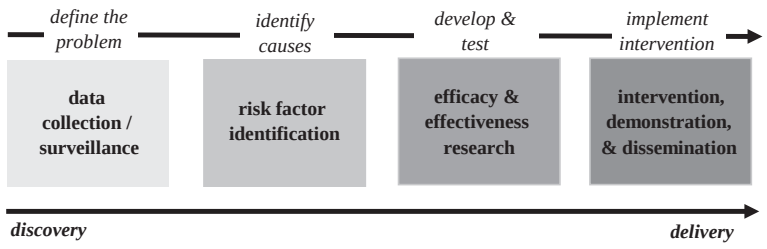

Figure 1. Public health framework (adapted from Sleet *et al.*, 2003).

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Step Three: Development and Testing of Interventions

'The third step in a public health framework involves the development and testing of prevention strategies'

After surveillance efforts have been used to define and parameterise the scope of the problem, with risk and protective factors identified, the third step in a public health framework involves the development and testing of prevention strategies. Although public health is focused on the health of the entire population, prevention programmes are targeted at different segments of the population. Primary prevention programmes are directed at the general population in a universal fashion. Secondary prevention programmes are more narrowly targeted towards populations identified as having one or more risk factors associated with the problem. Tertiary prevention efforts focus on individuals for whom the problem has already occurred, with the goal of minimising negative effects and preventing its recurrence.

Step Four: Implementation of Effective Prevention and Control Strategies

'The final step involves the implementation of effective programmes at the community level'

Steps one to three contribute to the development of comprehensive evidence-based prevention programmes. The final step involves the implementation of effective programmes at the community level. Dissemination is a key feature of this step and continued surveillance is required over time. Within this framework, the cycle returns to surveillance upon the widespread adoption of a prevention programme in order to assess its efficacy across the full population.

Study Objectives: Improved Surveillance

'A serious limitation in lodging an effective public health response'

The lack of reliable information as to the number of children affected by child abuse and neglect has been identified as a serious limitation in lodging an effective public health response (Leeb *et al.*, 2008). Incomplete data: (1) prevent the threat of child maltreatment from being considered in the context of other, more easily measured, public health problems; (2) limit the identification of those groups that are at greatest risk and stand to benefit the most from targeted services; and (3) restrict our ability to track changes in the incidence and prevalence of maltreatment over time, which in turn complicates efforts to then monitor the effectiveness of child maltreatment prevention and intervention activities.

The record linkages described in this article are conceptualised within the earlier described four-step public health framework: linked records serve to generate new information contributing to the surveillance of children reported for possible maltreatment by identifying risk and protective factors present at birth. Through

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record linkages between vital birth and child protective services data this study provides a population-level view of children reported for maltreatment during the first five years of life in California. It should be noted that although there exists a limited body of research based on linked child protection and birth records arising from US and European studies (Murphy *et al.*, 1981; Needell and Barth, 1998; Sidebotham and Heron, 2006; Spencer *et al.*, 2006; Wu *et al.*, 2003), to the best of our knowledge, this is the first US-based study to extend this method of population-based data linkage and inquiry to all children reported to child protective services up to the age of five, and to include all children reported, regardless of whether the allegation of maltreatment was substantiated.

'This study provides a population-level view of children reported for maltreatment during the first five years of life in California'

Methodology

All analyses are based on child-level linkages established between administrative child protective services data from California and statewide vital birth records. In total, this study captures over two million children, 293 441 of whom were reported for possible abuse or neglect before the age of five.

'This study captures over two million children'

Data Sources

Birth Data

Single-year birth cohort datasets (1999 to 2002) were created from encrypted files received from the California Department of Health. In total, 2 112 277 children were born in the state during these four years and are reflected in the analysis that follows.

'In total, 2 112 277 children were born in the state during these four years and are reflected in the analysis'

Child Protective Services Data

A dataset consisting of all unique children referred to California's child welfare system who were both born between 1999 and 2002 and reported for maltreatment before the age of five was created by downloading a child-level file from California's statewide administrative child welfare data collection system. While some unknown fraction of reported children was born outside of California and therefore did not meet the study criteria, the field capturing the state or country of birth contained data in only one per cent of all cases. For those children for whom it was explicitly coded that the child was born outside of California, that information was treated as reliable and those records were dropped. In addition, for those records with a child Social Security number (SSN) recorded (54% of all records), the first three digits of the SSN were examined and the record was dropped if the numbers indicated it was a non-California birth according to published state digit assignments.

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'Based entirely on the secondary analysis of data collected during the normal course of agency operations'

Ethical Approval

This study did not involve any direct contact with human subjects: it was based entirely on the secondary analysis of data collected during the normal course of agency operations, as required by state and federal laws pertaining to registering births and child maltreatment reports. Because personal identifiers were used to link child records across multiple data sources, however, approvals from two separate Committees for the Protection of Human Subjects were requested and granted: California's Health and Human Services and the University of California at Berkeley.

Record Linkages

Linkage Methodology

Record linkage entails 'the bringing together of information from two records that are believed to relate to the same entity' (Herzog *et al.*, 2007, p. 81). In this project, probabilistic linkage strategies (with clerical review) were employed. In probabilistic linkage, two records do not need to agree exactly on a set of linkage variables to be deemed a match. Rather, a statistical model is utilised to compute a numerical value that captures the similarity of two records based on the probabilities of agreement and disagreement for the specified match variables. This strategy has become increasingly sophisticated over the last decade and has been verified as a superior method for linking files that do not have a common unique identifier, as was true of these data (Campbell *et al.*, 2008).

'All record linkages were completed using Link Plus'

Linkage Software

All record linkages were completed using Link Plus, an 'open source' (i.e. free and in the public domain) linkage software developed by the US Centers for Disease Control and Prevention (2010).

Blocking Variables

Blocking variables serve to 'partition the database into a large number of small segments so that the number of pairs being compared is of a reasonable size' (Herzog *et al.*, 2007, p. 125). Link Plus utilises an 'or' blocking methodology in which record comparisons are made between two files only if they contain identical values on at least one of the specified blocking variables. In performing these linkages, the child's first name, the child's last name, the child's date of birth, maternal SSN and paternal SSN were used.

'Several non-unique matching variables were used to identify individual children common to the two files being linked'

Matching Variables

Several non-unique matching variables were used to identify individual children common to the two files being linked. In

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addition to the blocking variables (also utilised as matching variables), the child's middle name, gender and ethnicity were used, as were maternal and paternal names and dates of birth. Link Plus provides several options for using partial, value-specific and 'fuzzy' matching methodologies. More technical details of completed linkages are available upon request.

Data Preparation

Prior to performing any linkages, all blocking and matching variables were systematically reviewed, cleaned and standardised. Data reviews were conducted by running frequency distributions to identify clearly errant values in both numeric and string variables. All variables were coded and formatted according to the same conventions.

'All blocking and matching variables were systematically reviewed, cleaned and standardised'

Match Rates

Record linkage amounts to 'messy-data analysis' (Winkler, 2001, p. 8) and notwithstanding the increasingly sophisticated probabilistic algorithms for automated record linkages, a determination of whether two records truly match often requires the judgement of a human reviewer (Clark, 2004). Based on a prior analysis of vital record birth files, including a close manual examination of a one per cent random sample of comparison pairs falling within each ten-point weight strata, an upper-bound score was established above which all paired records were deemed a match and a lower-bound score was utilised to reject all paired records falling below a given threshold. A clerical review was conducted to determine the match status of those record pairs falling in the designated 'grey area'. Among pairs falling towards the upper end of this grey area, the clerical review was relatively cursory. As the scores dropped, the reviews became increasingly thorough and included manual searches of the full birth file to rule out alternative matches. The count and percentage of child welfare records that were successfully matched to a birth record are reported in Table 1.

'A clerical review was conducted to determine the match status of those record pairs falling in the designated grey area'

Overall, 85 per cent of child welfare records meeting the earlier described criteria were matched to a birth record. Among those child welfare records for which no birth record match was identified, missing data were much more common. In addition,

'Overall, 85 per cent of child welfare records meeting the earlier described criteria were matched to a birth record'

Table 1. Counts and percentages of child protective service (CPS) records successfully linked to a birth record

Birth year	Birth records	Successful linkages	CPS records
1999	519 596	72 630 (84.6%)	85 823
2000	532 964	73 880 (85.2%)	86 777
2001	529 089	73 721 (85.1%)	86 693
2002	531 035	74 374 (85.3%)	87 232

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'Successfully matched children were more likely to have had an allegation of maltreatment substantiated'

successfully matched children were more likely to have had an allegation of maltreatment substantiated (38% vs 16%) and less likely to have been evaluated out over the telephone (9% vs 26%), reflecting the greater information present in the child protective service record (and therefore the greater likelihood of establishing a match) when the child's involvement with the child welfare system was more extensive. No differences in unmatched and matched children were observed by the type of child maltreatment allegation (e.g. neglect, physical abuse, sexual abuse, emotional abuse, at-risk of abuse/other abuse).

Analysis

Based on the linked dataset, the cumulative percentage of children born in California between 1999 and 2002 and reported to child protective services before the age of five was computed and stratified by child and maternal characteristics gleaned from the birth record. The nature and disposition of the abuse or neglect allegation as reflected in the child welfare record were also examined.

'Eight child and maternal variables from the birth record were used to identify group-level differences in the rates of contact with child protective services'

Birth Record Variables

Eight child and maternal variables from the birth record were used to identify group-level differences in the rates of contact with child protective services.

1. Sex: A child's sex was derived directly from the birth record (male, female).
2. Health: Child health was coded as a binary variable indicating a health risk present at birth based on either a birth weight of <2500 grams or the presence of one or more birth abnormalities (risk present, none).
3. Birth payment method: The expected source of payment for the birth was used to create a rough proxy for family socioeconomic status based on a dichotomous coding of Medi-Cal coverage, California's means-tested public health insurance programme that provides healthcare services for low-income individuals (Medi-Cal, other).
4. Maternal race/ethnicity: Race/ethnicity was coded into five categories based on the first identified race and a Hispanic identifier variable (non-Hispanic White, non-Hispanic Black, Hispanic, non-Hispanic Asian/Pacific Islander). Since Native American children were less than one per cent of all births, these children were re-coded as race 'missing'.
5. Maternal age: A mother's age at the time of birth was coded into a variable with four levels (<20 years, 20–24 years, 25–29 years, 30+ years).
6. Maternal education: A four-level variable for maternal education was constructed based on years of school completed: < high school, high school degree, some college, college+.
7. Paternity establishment: California Health and Safety Code Section 102425 (2011) prohibits the release of marital status by the California Department of Public Health, yet also states

'A four-level variable for maternal education was constructed based on years of school completed'

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that 'If the parents are not married to each other, the father's name shall not be listed on the birth certificate unless the father and the mother sign a voluntary declaration of paternity at the hospital before the birth certificate is prepared.' Thus, the absence of established paternity in the record was used as a lower-bound estimate of non-marital births and an indicator of an apparent lack of substantial paternal involvement (missing, established).

8. Birth order: The child's position in a maternally defined birth order was stratified based on whether or not the child was first born (first born, second or higher in birth order).

'If the parents are not married to each other, the father's name shall not be listed on the birth certificate'

Results

Cumulative Percentage of Children Reported for Maltreatment by Characteristics at Birth and Disposition Type

Table 2 reports the cumulative percentage of children reported to child protective services by the age of five, with these children then further stratified by maltreatment disposition. In California, allegations of abuse or neglect are either evaluated out or assigned one of three dispositions: unfounded, inconclusive, or substantiated. Children coded as evaluated out were included in an allegation of maltreatment that was not investigated by CPS. Children with an allegation classified as unfounded received an investigation, but the evidence gathered in the investigation was insufficient to conclude that the child had been maltreated. Similarly, a classification of inconclusive is used when there is evidence suggesting the child may have been maltreated, or is at risk of maltreatment, but the evidence is still insufficient to declare the child maltreated. In both of these situations, formal child welfare services are unlikely to have been provided, although there may have been a referral for community-based services. Finally, a substantiated disposition is the classification used when there is sufficient evidence under state law to make a finding of maltreatment (or risk of maltreatment). There is the greatest range of services provided after an allegation is substantiated. At one extreme a child and family may receive no follow-up services. At the other extreme a child may be placed in out-of-home foster care. For those children who were reported more than once, the most severe disposition was used.

Between 1999 and 2002, over two million children were born in California and 293 441 (13.9%) were referred for possible maltreatment before the age of five. By their fifth birthday, the same fraction of male and female children had been reported at least once (13.9%). Nearly 18 per cent of children with a health risk present at birth had been identified as possible victims of

'Nearly 18 per cent of children with a health risk present at birth had been identified as possible victims of maltreatment'

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Table 2. Cumulative percentage of children born in California between 1999 and 2002 and reported to child protective services before the age of five by characteristics at birth and allegation disposition

	Children reported	Allegation disposition[2]			
	all children	evaluated out	unfounded	inconclusive	substantiated
	n = 293 441	n = 25 344	n = 86 507	n = 71 252	n = 110 338
	%	%	%	%	%
Full population[1]	13.9	1.2	4.1	3.4	5.2
Sex					
male	13.9	1.2	4.1	3.4	5.2
female	13.9	1.2	4.1	3.4	5.2
Health					
risk present	17.9	1.4	4.4	3.8	8.3
none	13.4	1.1	4.1	3.3	4.9
Birth payment method					
Medi-Cal	21.6	1.6	6.0	5.1	8.8
other	8.5	0.9	2.7	2.1	2.7
Maternal race/ ethnicity[3]					
Black	29.7	2.3	7.8	7.6	12.1
White	13.4	1.4	3.5	3.1	5.4
Hispanic	14.1	1.1	4.6	3.5	5.0
Asian/Pacific Islander	5.8	0.6	1.7	1.4	2.0
Maternal age at birth					
<20 yrs	25.4	2.3	6.8	6.8	9.5
20–24 yrs	18.3	1.6	5.2	4.6	7.0
25–29 yrs	12.2	1.0	3.8	2.9	4.5
30+ yrs	9.5	0.8	3.0	2.1	3.6
Maternal education					
<high school	19.9	1.4	4.7	5.7	8.0
high school degree	17.5	1.6	4.3	5.0	6.6
some college	11.1	1.2	2.8	3.5	3.6
college+	3.3	0.4	0.8	1.2	0.8
Paternity					
missing	33.7	2.2	7.7	7.5	16.3
established	11.8	1.1	3.7	2.9	4.0
Birth order					
second or higher	16.0	1.2	4.8	3.8	6.3
first born	10.6	1.2	3.1	2.7	3.5

[1]Differences across variable levels are statistically significant ($p < 0.001$) for all variables except sex.
[2]Allegation disposition coded as the most severe disposition received by the age of five.
[3]Missing and other race/ethnicity were 1.6 per cent of the total.

maltreatment. Over 21 per cent of children whose birth payment method was Medi-Cal had been reported to child protective services compared with less than nine per cent of children who had some other form of insurance coverage.

Almost one (29.7%) out of every three children born to Black mothers in California had been reported to child protective services during the first five years of life. The proportions were notably lower for other ethnic groups, with 13.4 per cent of children born to White mothers, 14.1 per cent of children born to Hispanic mothers and only 5.8 per cent of children born to Asian/ Pacific Islander mothers reported for maltreatment by the age of

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five. One out of every four children born to a teenage mother was reported for possible maltreatment during the first five years of life. This was true of less than one in ten children whose mother was 30 or older at the time of birth. Over 19 per cent of children born to mothers whose education concluded before the completion of high school had been reported for maltreatment compared with 11.1 per cent of children born to mothers with at least some college education and three per cent of children born to mothers with a college degree. One out of every three children born without established paternity was reported to child protective services for maltreatment. Roughly 11 per cent of first-born children had been reported for maltreatment by the age of five versus 16 per cent of children falling higher in the birth order.

'One out of every three children born without established paternity was reported to child protective services for maltreatment'

Table 2 also reports the cumulative percentages of children with a substantiated, inconclusive, unfounded or evaluated out allegation of maltreatment. By the age of five, 5.2 per cent of all children born in California had been identified as substantiated victims of abuse or neglect. Another 3.4 per cent had received an investigation in which the evidence surrounding the allegation of maltreatment was deemed 'inconclusive'. Just over four per cent were reported and received an investigation, but the allegation was unfounded; and 1.2 per cent of children were reported, but the allegation of maltreatment was 'evaluated out' without a formal in-person investigation.

'By the age of five, 5.2 per cent of all children born in California had been identified as substantiated victims of abuse or neglect'

Over eight per cent of children with a health risk present at birth and 8.8 per cent of children whose births were covered by Medi-Cal were identified as substantiated victims of maltreatment. Just over twelve per cent of all Black children born in California were identified as maltreated before their fifth birthday, with the allegation deemed inconclusive for another 7.6 per cent. Just under ten per cent of all children born to teenage mothers were identified as maltreatment victims; 16 per cent of children without an identified father were substantiated as victims of abuse or neglect before the age of five.

'Just under ten per cent of all children born to teenage mothers were identified as maltreatment victims'

The overall substantiation rate and the rates by ethnic group were similar to those observed in an earlier study of the 1999 California birth cohort in which the authors found that 5.2 per cent of all children experienced a substantiated allegation of maltreatment before their fifth birthday (Magruder and Shaw, 2008). The rates reported in that study varied from 1.7 per cent for children of Asian/Pacific Islander mothers, 4.4 per cent among children born to Hispanic mothers, 5.5 per cent for children born to White mothers to 12.3 per cent for children of Black mothers.

Cumulative Percentage of Children Reported for Maltreatment by Characteristics at Birth and Allegation Type

Table 3 reports the cumulative percentage of children reported to child protective services by the age of five, stratified by

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Table 3. Cumulative percentage of children born in California between 1999 and 2002 and reported to child protective services before the age of five by characteristics at birth and allegation type

	Children reported	Allegation type[2]				
	all children	risk/other	emotional	neglect	physical	sexual
	n = 293 441	n = 53 627	n = 32 457	n=154 883	n=37 926	n = 14 548
	%	%	%	%	%	%
Full population[1]	13.9	2.5	1.5	7.4	1.8	0.7
Sex						
male	13.9	2.5	1.5	7.5	2.0	0.4
female	13.9	2.6	1.5	7.3	1.6	0.9
Health						
risk present	17.9	2.6	1.5	11.0	2.1	0.7
none	13.4	2.5	1.5	6.9	1.7	0.7
Birth coverage						
Medi-Cal	21.6	3.8	2.1	12.2	2.6	0.9
other	8.5	1.7	1.1	3.9	1.2	0.6
Maternal race/ethnicity[3]						
Black	29.7	4.8	2.4	17.3	3.8	1.4
White	13.4	1.8	1.2	7.9	1.6	0.8
Hispanic	14.1	3.0	1.8	6.8	1.8	0.7
Asian/Pacific Islander	5.8	1.2	0.9	2.5	0.9	0.2
Maternal age at birth						
<20 yrs	25.4	3.0	2.9	14.7	3.6	1.2
20–24 yrs	18.3	3.1	2.1	9.9	2.5	0.9
25–29 yrs	12.2	2.6	1.4	6.1	1.5	0.6
30+ yrs	9.5	2.1	1.0	4.8	1.1	0.5
Maternal education						
<high school	19.9	3.7	2.1	10.9	2.4	0.8
high school degree	17.5	3.0	1.9	9.4	2.3	0.9
some college	11.1	2.1	1.4	5.2	1.6	0.8
college+	3.3	0.7	0.5	1.3	0.5	0.3
Paternity						
missing	33.7	4.3	2.2	22.2	3.8	1.2
established	11.8	2.2	1.5	5.8	1.6	0.6
Birth order						
second or higher	16.0	3.4	1.6	8.5	1.9	0.7
first born	10.6	1.2	1.4	5.6	1.7	0.7

[1]Differences across variable levels are statistically significant ($p < 0.001$) for all variables except sex.
[2]Allegation type coded as the most severe allegation received by the age of five according to California's maltreatment severity hierarchy.
[3]Missing and other race/ethnicity were 1.6 per cent of the total.

'Neglect was the most prevalent form of maltreatment among children reported to child protective services before the age of five'

maltreatment allegation type. For those children who had more than one maltreatment allegation, California's allegation hierarchy was used and the most severe allegation was examined. This hierarchy is reflected in the table reading from left to right, with risk/other abuse considered the least extreme, and sexual abuse the most extreme, forms of maltreatment, respectively. Neglect was the most prevalent form of maltreatment among children reported to child protective services before the age of five (7.4%), followed by risk of maltreatment (2.5%), physical abuse (1.8%), emotional abuse (1.5%) and sexual abuse (0.7%). As reported in Table 2, there were notable variations in the

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distribution of children reported across the variable levels for all maltreatment types. Falling at one extreme were children without an identified father at birth, 22.2 per cent of whom were reported for neglect before the age of five. At the other end of the neglect spectrum were children born to a mother with a college degree or higher, only 1.3 per cent of whom were reported. Across all maltreatment types, higher levels of maternal education were consistently protective against maltreatment, as was increasing maternal age. The cumulative percentage of Black children reported was greater than other racial groups for all forms of maltreatment – from risk of abuse or neglect to sexual abuse.

Discussion

Recent calls originating from all corners of the globe have been made for child maltreatment to be studied in the context of a public health framework. In 1998, the World Health Organization's Regional Office for Europe concluded 'it is essential to consider child abuse and neglect from a comprehensive public health perspective' and argued that 'child protection strategies need to be incorporated into main stream health and health-related services at all levels' (p. 9). Less than a year later, the World Health Organization issued a press release in which they stated, 'abused children suffer a wide variety of physical, emotional and developmental problems which can hamper their ability to live healthy and productive lives…it is a public health issue of vital importance for [the World Health Organization], and it represents a challenge for the next millennium' (The World Health Organization, 1999). Researchers from Australia (O'Donnell *et al.*, 2008) recently posed the question: 'Is it time to consider a public health approach, using population-based measures of child abuse and neglect to accurately describe the epidemiology of population risk and protective factors?' (p. 325). Further, the US Centers for Disease Control and Prevention (2010) have identified child maltreatment as a 'critical' and 'significant' public health problem that warrants a comprehensive prevention strategy. If the history of public health reads as a continuous redefining of what is deemed unacceptable (Open Systems Group, 1984), the fact that child maltreatment is finally being incorporated in its folds is an unambiguously positive sign. In this article, we describe and advance a public health approach to the study of child maltreatment by providing critical surveillance information in the form of child protective service records linked to population-based vital birth records. Linkages with universally collected data at birth serve to aid in the identification of those groups that are at greatest risk and stand to benefit the most from targeted services.

'It is essential to consider child abuse and neglect from a comprehensive public health perspective'

'It is a public health issue of vital importance for [the World Health Organization], and it represents a challenge for the next millennium'

'Linkages with universally collected data at birth serve to aid in the identification of those groups that are at greatest risk and stand to benefit the most'

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Although a number of studies have documented that children residing in single-parent families face a heightened risk of maltreatment, information concerning a child's family configuration is not available in California's administrative child protective service records. Through birth record linkages, we were able to determine that although only nine per cent of the more than 2.1 million children born in California were missing paternity information, 33.7 per cent of these children were reported for maltreatment before the age of five. The information gleaned from these record linkages not only provides important (and otherwise unavailable) information about the characteristics of children reported to child protective services, but because these data originate in the birth record, it also serves to identify a very high risk group of children who could be readily targeted for services from the day of birth.

'A very high risk group of children who could be readily targeted for services from the day of birth'

Another surveillance shortcoming common to administrative child welfare data surrounds the ability to place the threat of child maltreatment in the context of other, more easily measured, public health problems. The record linkages reported in this article allow for child maltreatment to be considered in terms of the full population of children born in the state − serving to frame the problem in magnitude and scope. All told, 14 per cent of children born in California between 1999 and 2002 were identified as possible victims of maltreatment before reaching their fifth birthday and over five per cent of all children were substantiated as victims of abuse or neglect. Notable variations based on easily measured sociodemographic characteristics such as poverty (22% of children covered by Medi-Cal were reported), maternal education (one out of every five children born to a mother with less than a high school degree was reported), and paternity establishment (over one third of children without established paternity were reported) allow a more nuanced picture to emerge. What is clear is that the burden of child abuse and neglect is a far from uncommon threat to the health and well-being of children.

Finally, even if the ability to track changes in the 'true' incidence and prevalence of maltreatment over time remains limited in the context of administrative child welfare data, linkages across successive birth cohorts allow for the examination of population-level trends in the presence of risk factors associated with child abuse and neglect. In light of the multitude of parental risk factors associated with child maltreatment, it certainly stands to reason that various health promotion strategies might lead to reductions in the incidence and prevalence of child maltreatment. For example, effective teen pregnancy prevention programmes could shift the population of children born to mothers who are at high risk of contact with child protective services. In California, 25.4 per cent of children born to teenage

'Linkages across successive birth cohorts allow for the examination of population-level trends'

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mothers were subsequently identified as possible victims of maltreatment compared with only 9.5 per cent of children born to mothers over the age of 30. Although residual efforts to provide services to young mothers of newborns have been shown to prevent some child maltreatment and improve child wellbeing (Olds *et al.*, 1999), it is unknown whether even modest declines in teen birth rates may prove more impactful as a method for lowering the prevalence of child maltreatment. Linkages with population-based data offer an opportunity to monitor population-level trends with corresponding shifts in the rates of contact with child protective service agencies.

'To monitor population-level trends with corresponding shifts in the rates of contact with child protective service agencies'

Conclusion

In this article, we discuss the limitations of administrative data collected for children reported for possible abuse or neglect and provide an example of record linkages as a means of generating information useful for the surveillance of child maltreatment within a public health framework. In California, recent efforts to extend our understanding of child maltreatment have included the record linkages with vital statistics birth data reported here, as well as linkages with vital death records (Putnam-Hornstein, 2011). Birth record linkages allow the sociodemographic characteristics of children reported for maltreatment to be considered within the context of the full population of children born in California, while also contributing basic variables (e.g. the child's birth weight, paternity information) missing from child protective service records. Death record linkages offer an opportunity to examine premature child death as a possible outcome following a report to child protective services. Future efforts to introduce additional linkages with other administrative social services data are likely to yield still more information that might be fruitfully applied to the surveillance and prevention of child abuse and neglect.

'Future efforts to introduce additional linkages with other administrative social services data are likely to yield still more information'

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References

Berrick JD. 2009. *Take Me Home: Protecting America's Vulnerable Children and Families*. Oxford University Press: New York, NY.

Brady HE, Grand SA, Powell MA, Schink W. 2001. Access and confidentiality issues with administrative data. In *Studies of Welfare Populations: Data Collection and Research Issues*, Moffitt RA, Citro CF, Ploeg MV (eds). National Academy Press: Washington, DC; 220–274.

California Health and Safety Code Section 102425. 2011. Available: http://law.onecle.com/california/health/102425.html.

Campbell KM, Deck D, Krupski A. 2008. Record linkage software in the public domain: A comparison of Link Plus, The Link King, and a 'basic' deterministic algorithm. *Health Informatics Journal* **14**: 5–15.

Centers for Disease Control and Prevention. 2010. Prevent Child Maltreatment. Retrieved: www.cdc.gov/features/healthychildren [5 May 2010]

Centers for Disease Control and Prevention. 2010. Registry Plus, a suite of publicly available software programs for collecting and processing cancer registry data. Available at: http://www.cdc.gov/cancer/npcr/.

Clark DE. 2004. Practical introduction to record linkage for injury research. *Injury Prevention* **10**: 186–191.

Diez-Roux AV. 2000. Multilevel analysis in public health research. *Annual Public Health Reviews* **21**: 171–192.

Dunn J, Hayes M. 1999. Toward a lexicon of population health. *Canadian Journal of Public Health* **90**: S7–S10.

Felitti VJ, Anda RF, Nordenberg D, WIlliamson DF, Spitz AM, Edwards V, Koss M, Marks J. 1998. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine* **14**: 245–258.

Glaser D. 2000. Child abuse and neglect and the brain: a review. *Journal of Child Psychology and Psychiatry* **41**: 97–116.

Herzog TN, Scheuren FJ, Winkler WE. 2007. *Data Quality and Record Linkage Techniques*. Springer: New York, NY.

Leeb R, Paulozzi L, Melanson C, Simon T, Arias I. 2008. *Child Maltreatment Surveillance: Uniform Definitions for Public Health and Recommended Data Elements*. Centers for Disease Control and Prevention, National Center for Injury Control and Prevention: Atlanta, GA.

Magruder J, Shaw TV. 2008. Children ever in care: an examination of cumulative disproportionality. *Child Welfare* **87**: 169–188.

Murphy JF, Jenkins J, Newcombe RG, Sibert JR. 1981. Objective birth data and the prediction of child abuse. *Archives of Diseases in Childhood* **56**: 295–297.

Needell B, Barth RP. 1998. Infants entering foster care compared to other infants using birth status indicators. *Child Abuse & Neglect* **22**: 1179–1187.

O'Donnell M, Scott D, Stanley F. 2008. Child abuse and neglect - is it time for a public health approach? *Australian and New Zealand Journal of Public Health* **32**: 325–330.

Olds DL, Henderson CR, Kitzman HJ, Eckenrode JJ, Cole RE, Tatelbaum RC. 1999. Prenatal and infancy home visitation by nurses: Recent findings. *The Future of Children* **9**: 44–65.

Open Systems Group. 1984. *The Vickers Papers*. Harper and Row Publishers: London.

Peden M, Oyebite K, Ozanne-Smith J, Hyder A, Branche C, Rahman A, Rivara F, Bartolomeos K (eds). 2008. *World Report on Child Injury Prevention*. World Health Organization: Switzerland.

Peterson L, Brown D. 1994. Integrating child injury and abuse-neglect research: Common histories, etiologies, and solutions. *The American Psychological Association* **116**: 293–315.

Putnam-Hornstein E. 2011. Report of maltreatment as a risk factor for injury death. *Child Maltreatment* **16**(3).

Putnam-Hornstein E, Needell B. 2011. Predictors of child protective service contact between birth and age five: An examination of California's 2002 birth cohort. *Children and Youth Services Review* **33**: 1337–1344.

Sedlak A, Broadhurst D. 1996. *The Third National Incidence Study of Child Abuse and Neglect*. US Government Printing Office: Washington, DC.

Sedlak A, Broadhurst D. 2010. *The Fourth National Incidence Study of Child Abuse and Neglect (NIS-4): Report to Congress*. US Government Printing Office: Washington, DC.

Sidebotham P, Heron J. 2006. Child maltreatment in the "children of the nineties": A cohort study of risk factors. *Child Abuse & Neglect* **30**: 497–522.

Sleet DA, Hopkins KN, Olson SJ. 2003. From discovery to delivery: Injury prevention at CDC. *Health Promotion Practice* **4**: 98–102.

Sleet DA, Liller KD, White DD, Hopkins K. 2004. Injuries, injury prevention and public health. *American Journal of Health Behaviors* **28**: S6–S12.

Spencer N, Wallace A, Sundrum R, Bacchus C, Logan S. 2006. Child abuse registration, fetal growth, and preterm birth: A population based study. *Journal of Epidemiology and Community Health* **60**: 337–340.

Springer KW, Sheridan J, Kuo D, Carnes M. 2007. Long-term physical and mental health consequences of childhood physical abuse: results from a large population-based sample of men and women. *Child Abuse & Neglect* **31**: 517–538.

Thacker S. 2006. Epidemiology and public health at CDC. *Morbidity and Mortality Weekly Report*, CDC. Available: http://www.cdc.gov/mmwr/preview/mmwrhtml/su5502a2.htm [3 February 2009].

Thacker S, Berkelman RL. 1988. Public health surveillance in the United States. *Epidemiologic Reviews* **10**: 164–190.

Thacker S, Berkelman R, Stroup D. 1989. The science of public health surveillance. *Journal of Public Health Policy* **10**: 187–203.

Waldfogel J. 1998. *The future of child protection: How to break the cycle of abuse and neglect*. Harvard University Press: Cambridge, MA.

Wilson C. 1920. The untilled fields of public health. *Science* **51**: 23–33.

Winkler WE. 2001. Record Linkage Software and Methods for Merging Administrative Lists (No. RR2001/03) Statistical Research Report Series. Bureau of the Census, Statistical Research Division.

World Health Organization. 1999. WHO Recognizes Child Abuse as a Major Public Health Problem. Press release, WHO/20: 8 April.

World Health Organization. 1998. *First Meeting on Strategies for Child Protection: Report on a WHO Meeting*. Regional Office for Europe. Copenhagen, Denmark.

Wu SS, Ma C, Carter RL, Ariet M, Feaver EA, Roth MB. 2003. Risk factors for infant maltreatment: A population-based study. *Child Abuse & Neglect* **28**: 1253–1264.

Wulczyn F. 2009. Epidemiological perspectives on maltreament prevention. *The Future of Children* **39**: 39–66.

Wulczyn F, Barth R, Yuan Y, Harden BJ, Landsverk J. 2005. *Beyond Common Sense: Child Welfare, Child Well-being, and the Evidence for Policy Reform*. AldineTransaction: New Brunswick, NJ.

Zimmerman F, Mercy JA. 2010. A better start: child maltreatment as a public health priority. Available: http://www.zerotothree.org/maltreatment/child-abuse-neglect [17 September 2010].

Strategies to Prevent Child Maltreatment and Integration Into Practice

By Vincent J. Palusci, MD, MS, and Michael L. Haney, PhD, NCC, LMHC

Introduction

Preventing child abuse and neglect spares children physical and psychological pain and improves their long-term health outcomes. Dubowitz (2002) noted that prevention "is intuitively and morally preferable to intervening after the fact." Therefore, the potential for harm to adults from child maltreatment calls us to action. Early intervention may be more effective in preventing abuse and neglect, may save money for society, and may improve peoples' overall health and well-being, perhaps the most important goals a society can accomplish.

There is increasing evidence to demonstrate the elements of successful interventions, the populations and programs of most benefit, and the best implementation research to demonstrate that we have met our goals. This article reviews current strategies in child abuse prevention and guides professionals in the integration of prevention activities into their daily work.

The Case for Prevention

Recent research has identified the physical and mental conditions increasingly being associated with adverse childhood experiences, such as physical abuse, sexual abuse, and neglect. Neurologic imaging and traumatology studies have delineated the chronic physiologic and structural changes that occur after chronic stress and abuse (De Bellis, 2005; Eluvathingal et al., 2006). Chronic stress and abuse are also associated with specific disease processes and poor mental health outcomes in adults. These adverse childhood experiences (ACES) have been associated with increased rates of teen pregnancy, promiscuity, depression, hallucinations, substance abuse, liver disease, chronic obstructive pulmonary disease, coronary artery disease, and identifiable permanent changes in brain structure and stress hormone function (Anda et al., 2002; Dube, Anda, Felitti, Chapman, & Giles, 2003; Felitti et al., 1998; Middlebrooks & Audage, 2008). Although treatment after the fact can improve mental and physical health and prolong life and productivity, the direct and indirect costs of child maltreatment for both children and adults in lost health, pain, and suffering themselves warrant our taking action to prevent child abuse and neglect.

There is increasing evidence supporting the effectiveness of several universal and selective prevention interventions (Mikton & Butchart, 2009). However, a comprehensive assessment of prevention strategies should also include an analysis of cost and of potential financial benefit (Plotnick & Deppman, 1999). Robert Caldwell (1992) estimated that the costs of a home visitor program in Michigan would be 3.5% of the $823 million estimated cost of child abuse, and small reductions in the rate of child maltreatment were thought to make prevention cost-effective. Also in Michigan in 2002, the estimated yearly loss of tax revenue and productivity due to child maltreatment rose to $1.8 billion (Noor & Caldwell, 2005).

The National Research Council (1993) and others studied clinical conditions associated with abuse and neglect, including depression, posttraumatic stress disorder, and conduct disorders, all of which compound any direct physical injuries inflicted on individual children. Associated trauma and increased risk of low academic achievement, drug use, teen pregnancy, juvenile delinquency, and adult criminology were also noted. Deborah Daro (1988) estimated a national and direct juvenile delinquency cost of $14.9 million based on incidence and the delinquency rate among adolescent victims. She concluded that 1% of severely abused children suffer permanent disability. Daro's cost analysis projected that the national cost and future productivity loss of severely abused and neglected children is between $658 million and $1.3 billion each year, as of 1988, assuming that their impairments would reduce their future earnings by as little as from 5% to 10%.

However, drawing from Maxfield and Widom's work (1996), Fight Crime: Invest in Kids (Alexander, Baca, Fox, Frantz, Huffman et al., 2003) noted that child abuse and neglect costs Americans at least $80 billion annually and affects taxpayers as well as those being directly affected. Prevent Child Abuse America (Wang & Holton, 2008) used "conservative" estimates to calculate direct and indirect costs as $103.8 billion in 2007. Potential benefits of prevention include mitigating the direct costs of child maltreatment as well as improving all of our lives through increased productivity and decreased crime and need for social services (Alexander et al., 2003).

Definitions

Child maltreatment prevention is endorsed by all those who are familiar with the problems associated with child maltreatment, and efforts aimed at preventing abuse are promoted by agencies, governmental officials, and individual practitioners. Unfortunately, beyond a blanket endorsement of the concept, there are many different ideas about what prevention actually means and what activities are considered effective. Definitions vary, yet three categories of prevention are generally described:

1. Primary: Efforts aimed at the general population for the purpose of keeping abuse from happening.
2. Secondary: Efforts aimed at a particular group with increased risk to keep abuse from happening.
3. Tertiary: Efforts aimed at preventing abuse from happening again to those who have already been victimized. This level of prevention may include treatment for the original abuse.

The Centers for Disease Control and Prevention (CDC, 2007) have emphasized that abuse operates in a societal context and requires an entire spectrum of necessary prevention strategies over time, thinking of prevention in terms of WHEN does it occur (before or after abuse), WHO is the focus of prevention (everyone, those at greatest risk, and those who have already experienced abuse), and WHAT is the level of influence and points for intervention (individual, relationship, community, society). These efforts are based on Bronfenbrenner's ecological model, which promotes intervening at the individual, relationship, community, and societal levels (Bronfenbrenner, 1977; Zielinski & Bradshaw, 2006). Approaches implied from these new labels emphasize a shift away from risk reduction as the predominant prevention approach and toward promotion of positive social change. Some argue that prior definitions limited prevention strategies by focusing primarily on potential individual targets of abuse and how to intervene, rather than the environmental and societal context that supports and even condones abusive acts.

Definitions of prevention based on timing can also be considered:

1. Primary: This is taking action *before* abuse has occurred to prevent it from happening.
2. Secondary: This level of prevention is intervening *right after* abuse has occurred.
3. Tertiary: Tertiary prevention is seen as that which takes the long view and works *over time to change conditions* in the environment that promote or support abusiveness.

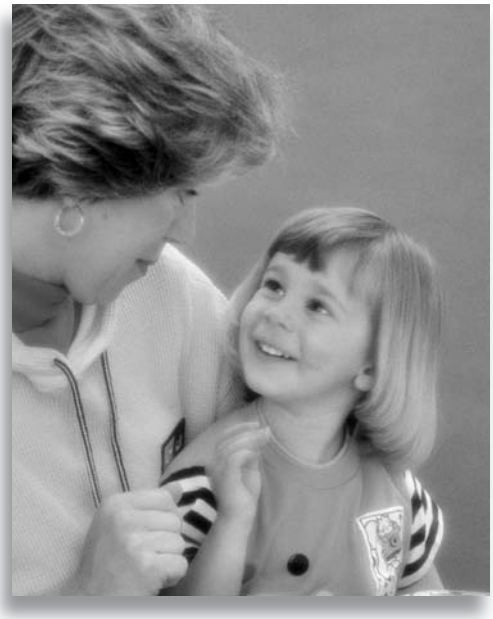
Physicians and other medical professionals have been invited to become more active in prevention as part of this definitional shift. For example, the National Sexual Violence Resource Center (2006) has recently published information about how to involve a broader constituency in prevention through using the "Spectrum of Prevention." Prevention is explicitly not the responsibility of any one agency, profession, or program but is framed as the responsibility of all to create a society less conducive to child maltreatment. In this paradigm, individual skill development, community and provider education, coalition building, organizational change, and policy innovations are all part of the prevention solution.

Successful and Promising Child Maltreatment Prevention Strategies

Although several strategies are reported to prevent child maltreatment, the effectiveness of most programs is still not known (MacMillan, Watlen, Fergesson, Leventhal, & Taussig, 2009). Home visiting programs are not uniformly effective; parenting programs appear to improve parenting but not necessarily reduce child maltreatment; some family programs are successful in reducing physical abuse but not neglect; and sexual abuse educational programs have created controversy despite some promising results. One suggested strategy is to tailor programs to one or more levels of intervention, given our understanding that child maltreatment occurs because of many factors simultaneously on the parental, child, family/relationship, community, and societal levels (World Health Organization & the International Society to Prevent Child Abuse and Neglect, 2006). We will now review successful and promising prevention strategies to assist professionals in sorting through myriad intervention models and potential outcomes.

Home Visiting Home visiting programs aim to prevent child abuse and neglect by influencing parenting factors linked to maltreatment: (1) inadequate knowledge of child development, (2) belief in abusive parenting, (3) empathy, (4) sensitive, responsive parenting, (5) parent stress and social support, and (6) the ability to provide a safe and stimulating home environment. By changing these factors, home visiting programs also seek to

improve child development and health outcomes associated with abuse and neglect. They have noted reductions of 40% of child maltreatment in certain models (Sweet & Appelbaum, 2004; Olds, 2006; Gomby, 2007). In a comprehensive review, Gomby (2005) examined the findings from 12 recent meta-analyses and other studies that used rigorous research methods, including randomized trials and quasi-experimental designs. Home visitation programs were most effective when they targeted families with many risk factors and used highly trained professionals who carefully followed a research-based model of intervention. Long-term follow-up with low-income single mothers who received home visitation services suggested that these programs are also effective in reducing child abuse and neglect in families where domestic violence is *not* present, decreasing the number of subsequent pregnancies, arrest rates, and the amount of time on welfare (Olds, Eckenrode, Henderson, Kitzman, Powers, & Cole, 1997; Eckenrode et al., 2000). Home visiting by nurses has been consistently effective at reducing preterm and low-weight births, increasing well child care medical visits and reducing deaths and hospitalizations for injuries and ingestions (Olds, Henderson, Tatelbaum, & Chamberlin, 1986; Schuster, Wood, Duan, Mazel, Sherbourne, & Halfon, 1998; Barlow, Davis, McIntosh, Jarret, Mockford, & Stewart-Brown, 2007; Caldera, Burrell, Rodriguez, Crowne, Rohde, & Duggan, 2007; Olds et al., 2002; King et al., 2001; Donovan et al., 2007; MacMillan, Thomas, Walsh, Boyle, Shannon, & Gafni, 2005). The findings have been replicated in a population of medically at-risk infants, where home visiting using paraprofessionals was associated with lower use of corporal punishment, greater safety maintenance in the home, and fewer reported child injuries (Bugental & Schwartz, 2009).



Some programs such as Healthy Families America (HFA) have used paraprofessionals to provide services (Duggan et al., 2004). In a more recent randomized trial of HFA in New York, mothers in the program committed only one-quarter as many acts of serious abuse and neglect as did control mothers in the first 2 years (Dumont et al., 2008). An evaluation of Healthy Families Florida found that the program using paraprofessionals has had a positive impact on preventing child maltreatment, showing that children in families who completed treatment or had long-term, intensive intervention experienced significantly less child maltreatment than did comparison groups who had received little or no service. This effect was accomplished in spite of the fact that, in general, participants were at significantly higher risk for child maltreatment than the overall population. According to Williams, Stern & Associates (2005), Healthy Families Florida participants had 20% less child maltreatment than all families in their target service areas. In addition, families who completed the program fared much better than their comparison group counterparts and were more likely to read to their children at early ages. Also, Healthy Families positively affected self-sufficiency, defined as *employment*. The program met or exceeded its goals for preventing maltreatment after program completion, provision of immunizations and well-baby checkups, increasing time between pregnancies, and participant satisfaction with services (Williams, Stern & Associates, 2005).

The Nurse-Family Partnership (NFP) is an evidence-based nurse home visitation program that improves the health, well-being, and self-sufficiency of low-income, first-time parents and their children. NFP models have been evaluated longitudinally across three sites using randomized trials (Olds, 2006) and have been replicated in 250 counties. One analysis showed that for every $1 spent on the NFP, there were $4 in savings for taxpayers (Alexander et al., 2003). Other specific programs have been reviewed, but overall, it is difficult to show improvements in key outcomes such as child abuse and neglect (Rigney & Brown, 2009). Perhaps results aren't forthcoming because the programs have wide variability in the job description of the home visitor, program implementation, and costs, which makes comparison difficult.

Family Wellness Programs Family wellness programs, including a variety of parent and family interventions, have been demonstrated to have some positive effects. These programs range from short-term counseling to parenting classes, sometimes with home visiting and sometimes with intensive "wrap-around" services for families at high risk for maltreatment. Many of these have been grouped together, making assessment problematic, but early meta-analyses show promising reductions in child maltreatment (MacLeod & Nelson, 2000). Intensive family preservation programs with high levels of participant involvement, an empowerment/strengths-based approach, and social support were more effective. In one study, programs designed to meet families' basic concrete needs and to provide mentoring were more effective than parenting and child development programming, and center–based services were more effective than home-based ones (Chaffin, Bonner, & Hill, 2001). In one series of 1,601 inner-city clients with moderate risk, programs that helped families meet basic needs and provided mentoring were found to be more effective than parenting or child development programming (Chaffin et al., 2001). At-risk

parents who do not receive parent coaching or education have higher rates of child maltreatment, parent arrest, and child hospitalization for violence (Alexander et al., 2003).

Family-Based Parenting Interventions Parenting programs, delivered by health visitors, have been found to improve child mental health and behavior, and reduce social dysfunction among parents in one randomized controlled trial (Patterson, Barlow, Mockford, Klimes, Pyper, & Stewart-Brown, 2002). A meta-analysis of parent training, a subset of parent interventions, has concluded that training can change childrearing strategies as well as modify parents' attitudes and perceptions (Lundahl & Harris, 2006). However, parent training models often differ, which precludes direct comparisons. Parent training can include reviewing child development, teaching and practicing specific skills, identifying and addressing maladaptive behaviors, and supporting parents in managing their own emotions and responding to stress. Effect sizes overall were thought to be moderate, with outcomes affected by how training was delivered and under what conditions. Finally, family socioeconomic status, relationship with the trainer, inclusion of fathers, the need for additional child therapy, inclusion of a home visitor, proper length, delivery mode, and delivery setting must also be addressed to maximize potential outcomes.

A more recent CDC meta-analysis of parent training programs (2009) looked at program components and delivery methods that had the greatest effect on child behavior and parent skills. It concluded that teaching parents emotional communication skills and positive child interaction skills, while requiring practice with their children during each session, was the most effective in helping them to acquire effective parenting skills and behaviors. Teaching parents about the correct use of time out, to respond consistently to their child, to interact positively with their child, and to require practice were all associated with decreases in children's externalizing behaviors (CDC, 2009).

In another model, Palusci, Crum, Bliss, and Bavolek (2008) found that parents with a variety of problems, including incarceration, substance abuse, and stress, had improved empathy, understanding of child development, and other skills after an 8-week program of interactive classes using a family nurturing program. The "Triple P" system was designed as a comprehensive, population-level system of parent and family support with five intervention levels of increasing intensity and narrowing population reach. The system combines various targeted interventions to ensure a safe environment, including promoting learning, using assertive discipline, maintaining reasonable expectations, and taking care of oneself as a parent. These principles then translate into 35 specific strategies and parenting skills. A recent large-scale randomized trial of the system noted lesser increases in substantiated child maltreatment, child out-of-home placements, and child maltreatment injuries in the intervention counties (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009).

Health-Based Services Health services during the prenatal period and early childhood have generally not been shown universally to result in reduced child abuse and neglect, but a recent randomized trial in an inner-city clinic with high-risk families was able to show lower rates of maltreatment, CPS reports, harsh punishment, and improved health services after an intervention of pediatric resident education in a primary care medical setting (Dubowitz, Feigelman, Lane, & Kim, 2009). It is often not possible during the prenatal and immediate postnatal periods to reliably identify families who will go on to maltreat their children, suggesting that anticipatory guidance for all families offers a better chance of reducing child maltreatment and violence (Brayden et al., 1993; Peters & Barlow, 2004). There are several barriers (time, training, culture, sensitive issues) to widespread implementation that can be addressed by identifying potential strategies, such as the use of handouts and local news stories, to begin a dialogue during routine pediatric visits (Sege, Hatmaker-Flanigan, De Vos, Lenn-Goodman, & Spivak, 2006). There remain several high-risk groups that will need special, focused attention by the health care system. Addicted mothers, for example, need access to drug and alcohol treatment programs that can prevent neurologic damage to fetuses (such as fetal alcohol syndrome), and neurologic damage at birth interacts with deficient parenting to multiply the risk of criminality and maltreatment (Alexander et al., 2003). Mental health services need to be available for depressed or mentally ill parents who have greatly increased risk for physically abusing or killing their children (McCurdy & Daro, 1994).

Community Strategies A large body of theory and empirical research suggests

that intervention at the neighborhood level is likely to prevent child maltreatment within families. This represents a "fourth wave" in prevention activities, with emphasis on altering communities on par with those aimed at the individual parenting level (Daro & Dodge, 2009). The two components of intervention that appear to be most promising are social capital development and community coordination of individualized services. Social disorganization theory suggests that child abuse can be reduced by building social capital within communities—by creating an environment of mutual reciprocity in which residents are collectively engaged in supporting each other and in protecting children. Research regarding the capacity and quality of service delivery systems in communities with high rates of maltreatment underscores the importance of strengthening a community's service infrastructure by expanding capacity, improving coordination, and streamlining service delivery (Daro & Dodge, 2009). Community strategies to prevent child abuse and promote child protection have focused on creating supportive residential communities whose residents share a belief in collective responsibility to protect children from harm, and on expanding the range of services and instrumental supports directly available to parents. Both elements—individual responsibility and a strong formal service infrastructure—are important. The challenge, however, is to develop a community strategy that strikes the appropriate balance between individual responsibility and public investment.

Daro and Dodge (2009) have also noted that, in the short run, the case for community prevention is promising on both theoretical and empirical grounds. Community prevention efforts are well grounded in a strong theory of change and, in some cases, have strong outcomes. At least some of the models have reduced reported rates of child abuse and injury to young children, altered parent-child interactions at the community level, and reduced parental stress and improved parental efficacy. When focusing on community building, the models can mobilize volunteers and engage diverse sectors within the community such as first responders, the faith community, local businesses, and civic groups in preventing child abuse. This mobilization can exert synergistic impact on other desired community outcomes, such as economic development and better health care.

Societal Policies Factors in society that can contribute to child maltreatment include the social, economic, health and education policies that lead to poor living standards, socioeconomic instability, or hardship as well as social or cultural norms that promote or glorify violence, demand rigid gender roles, or diminish the status of the child with regard to the parent (WHO, 2006). On the global scale, the United Nations Convention on the Rights of the Child offers a framework as a legal instrument for integrating the principles of children's rights with professional ethics and for the policy changes needed to enhance public health responses to prevent maltreatment (Reading et al., 2009). Each of these rights has specific implications for practice, advocacy, and research that can assist in defining, measuring, legislating, monitoring, and preventing child maltreatment. Achieving appropriate investments in community child abuse prevention programs will require a research and policy agenda that recognizes the importance of linking learning with practice. It is not enough for scholars and program evaluators to learn how maltreatment develops and what interventions are effective, and for practitioners, separately, to implement innovative interventions in their work. Instead, initiatives must be implemented and assessed in a manner that maximizes both the ability of researchers to determine the effort's efficacy and the ability of program managers and policy makers to draw on these data to shape their practice and policy decisions, which can affect society as well as families and communities (WHO, 2006; Daro & Dodge, 2009).

Elements of Effective Approaches

The Prenatal and Perinatal Periods Ray Helfer (1987) noted the "window of opportunity" that is present in the perinatal period to enhance parent-child interactions and prevent physical abuse. This period, which he defined as from one year before birth to 18–24 months of life, was determined to be a critical time to teach new parents skills of interaction with their newborns. Several program models have shown promise based upon key periods within this time frame, including prepregnancy planning, early conception, late pregnancy, prelabor and labor, immediately following delivery, and at home with the child. Opportunities for prevention in the early months of life include teaching parents and caregivers to cope with infant crying and how to provide a safe sleep environment for their infant. A recent meta-analysis of several early childhood interventions concluded that the evidence for their preventing child maltreatment in the first year of life is weak, but longer-term studies may show reductions in child maltreatment similar to other programs such as home visiting, when longer follow-up can be achieved (Reynolds, Mathieson, & Topitzes, 2009).

Public Health Approach The public health model follows a common pattern of intervention and evaluation when addressing a variety of conditions. The problem is defined, risk and protective factors are identified, prevention strategies are developed and tested, and if successful, they are widely adopted (CDC, 2009). A key operating assumption in such efforts is that change initiated in one sector will also have measurable spillover effects into other sectors and that the individuals who receive information or direct assistance will change in ways that begin to alter normative behavioral assumptions across the population. This gradual and evolutionary view of change is reflected in many public health initiatives that, over time, have produced dramatic improvement in such areas as smoking cessation, reduction in drunk driving, increased use of seat belts, and increased conservation efforts. CDC and the Maternal Child Health Bureau, for example, have

strengthened the public health role and funding for child maltreatment and violence prevention (Children's Safety Network, 2007; CDC, 2007). A caution is that the public health model of reducing adverse outcomes through normative change may not be directly applicable to the problem of child maltreatment. In contrast to the "stop smoking," "don't drink and drive," and "use seat-belts" campaigns, child abuse prevention often lacks specific behavioral directions that the general public can embrace and feel empowered to impose on others in their community. Exceptions may exist for specific forms of maltreatment, such as shaken baby syndrome, but much maltreatment is neglect, which is less amenable to identification and public health intervention (Schnitzer, Covington, Wirtz, Verhoek-Oftedahl, & Palusci, 2008). In these situations, the public health approach can still affect child maltreatment by applying what we know about various types of abuse to create more effective social action for prevention.

Evidence-Based Programs
Although evaluating child maltreatment prevention programs has been discussed for some time (Helfer, 1982), it is only recently that the practice field has begun to develop the necessary capacity to understand and use evidence in decision making. National organizations—such as the U.S. Centers for Disease Control and Prevention, Prevent Child Abuse America, Parents Anonymous, and the National Alliance of Children's Trust and Prevention Funds—have begun to assess and disseminate information about the effectiveness of programs (Prevent Child Abuse America, 2008). The World Health Organization (2006) has also assembled a guide to assist policy makers and program planners in using and developing evidence-based programs. The CDC has promoted evidence in the creation and implementation of family programs, for example, which integrate evidence and evaluation into the program model. Programs should ideally monitor their impact, create and enhance new approaches to prevention based on those results, apply and adapt effective practices, and build community readiness for additional activities (CDC, 2008).

Targeting Specific Types of Child Maltreatment Several parent education programs have been evaluated for their association with decreases in physical abuse and neglect. Family Connections, a multifaceted, home visiting community-based child neglect prevention program, showed "cost effective" improvements in risk and protective factors and behavioral outcomes (DePanfilis, Dubowitz, & Kunz, 2008). To address a specific form of physical abuse, Mark Dias and colleagues devised a hospital-based parent education program implemented immediately after birth that has been shown to decrease the incidence of shaken baby syndrome (Dias, Smith, deGuehery, Mazur, Li, & Shaffer, 2005). After a similar program delivered to over 15,000 new parents in West Michigan, the number of SBS cases admitted to the hospital dropped from 7 per year to 5.3, a 24% reduction (Palusci, Zeemering, Bliss, Combs, & Stoiko, 2006).

Barr and colleagues (2009) have devised a program of parent education in late pregnancy, delivery, and early infancy phases to change maternal knowledge and behaviors relevant to infant shaking (Barr et al., 2009). Using a randomized controlled trial, they were able to demonstrate how "The Period of Purple Crying" was able to increase maternal knowledge scores, knowledge about the dangers of shaking, and sharing that information with other caretakers. No significant differences were noted in maternal behavioral responses to crying.

Two risk factors, poverty and substance abuse, have been singled out as particularly important in terms of the strength of their association with physical abuse and neglect (Ondersma & Chase, 2003). Ondersma and Chase review the pathways in which substance abuse potentiates the effects of poverty and increases the risk of neglect, and they suggest a number of ways professionals can reduce substance abuse and maltreatment. Increased recognition and integration of substance abuse treatment in child welfare is a first step. A motivationally based public health approach for potentially at-risk parents would be proactive, brief, and repetitive and would incorporate substance abuse prevention messages into routine public health approaches spread over the parenting years. There is growing evidence that such programs, when implemented in multiple settings without stigmatizing parents, can appreciably reduce substance abuse and its associated maltreatment (Ondersma & Chase, 2003).

The biggest questions of how best to prevent sexual abuse, how to reduce rates over time, and eventually, eliminate sexual abuse remain unanswered. There are numerous signs that prior efforts

have been useful, but new methods need to be further explored and researched. In tests that show learning and skill acquisition for children and adults as a result of policy change, education, or media campaigns, study after study shows benefits of past prevention efforts (Davis & Gidycz, 2000; Rispens, Aleman, & Goudena, 1997). However, until recently, no study actually showed that participation in a prevention program resulted in reduced rates of sexual abuse for participants, with only anecdotal reports on successes and actions taken to stay safe as evidence (Plummer, 2001). A recent study, however, showed that college women (n=825) who had participated in a child sexual abuse prevention program as children were significantly less likely to experience subsequent sexual abuse than those who had not had such a program (Gibson & Leitenberg, 2000). Additionally, although some argue that sexual abuse has not decreased as a result of sexual abuse prevention efforts (Bolen, 2003), actual rates of sexual abuse do seem to be decreasing, and one proposed explanation is that sexual abuse prevention efforts may be at least part of the reason (Finkelhor & Jones, 2004). Finkelhor (2007) has concluded that these decreased rates and other available evidence support providing high-quality sexual abuse prevention education programs because children are able to acquire the concepts, the programs promote disclosure, there are lower rates of victimization, and children have less self-blame after attending these programs. There is additional evidence that movements to build adult and community responsibility for child sexual abuse prevention, such as the "STOP It Now" program, are also an important component.

Despite the prevalence and demonstrated long-term effects of psychological maltreatment, there is little evidence detailing specific programs and practices designed specifically for its primary prevention. Several interventions for prevention of physical abuse and neglect do promote attachment and enhanced parent-child interactions, which by their very nature should decrease psychological maltreatment. However, given the varying definitions of psychological maltreatment from study to study and our difficulty in its accurate identification and reporting, it will be inherently problematic to show its reduction after prevention activities.

Integrating Prevention Into Professional Practice

Professionals have several potential roles in violence prevention, including advocating for resources for effective programs, screening, recognizing and referring at-risk families for services, and promoting nurturing parenting and child-raising styles (AAP, 1999). Johnson (1998), Dubowitz (2002), and Plummer and Palusci (in press) have suggested several opportunities for professionals to take a leadership role in preventing child maltreatment:

Parent Education Professionals need to give parents effective strategies for discipline and nurturing by providing materials, consultation and referral. They should promote issues of Internet safety, supervision, selecting safe babysitters, and choosing quality day care programs. Posters in waiting rooms, take-home brochures, and lists of Web addresses should be readily available for referrals for parents' use. Additional resources on child abuse prevention programs that exist in and around the community and referrals of parents to area agencies for additional information or assistance are also vital prevention interventions.

Community Awareness Professionals need to offer to provide radio or TV public service announcements to build awareness of child abuse as a societal and public health issue and an issue related to physical and mental health. Health care professionals have the credibility to promote awareness of the links between childhood trauma and future health problems.

Bystander Involvement In personal or professional capacities, professionals need to be become involved when they are concerned about a child's safety and to seek supervision or consultation when necessary. Despite great demands on their time, professionals must be willing to make referrals to Child Protective Services based on reasonable suspicion rather than waiting until they are certain to report child maltreatment.

Early Behavior Problem Identification Caregivers often consult with authorities about behavior problems with their children, who may be exhibiting reactive symptoms of being abused or of stress after trauma exposure. Behavioral problems are often nonspecific, but professionals can guide parents to seek additional assistance, while guarding against parental overreaction to self-exploration or developmentally-appropriate behavior.

Policy and Organizational Prevention Efforts Professionals should be willing to make changes in policy, hiring, supervision, and training in their own office or organization to put proven risk-reduction procedures in place. This can include establishing clinical practice guidelines to address these issues in the office and clinic.

Improved Clinical Care and Education Professionals need to recognize risk factors for violence when providing clinic care and be able to identify, treat, and refer violence-related problems at all stages of child development. There are several tools available, such as from the American Academy of Pediatrics (AAP, 2005). Professionals need to identify, for example, issues with mental illness, substance abuse, stress, inappropriate supervision, family violence and exposure to media violence, access to firearms, gang involvement and signs of poor self-esteem, school failure, and depression (AAP, 2005). Professionals need to support early bonding and attachment, educate parents on normal age-appropriate behaviors for children of all ages, and educate parents

about parenting skills, limit setting, and protective factors to be nurtured in children to help prevent a variety of injuries. Consistent discipline practices and body safety techniques should be emphasized.

Treatment and Referral Professionals need to know what they can handle through office counseling and when they need to refer families for help. They must also be cognizant of the resources available in their community to address these risks. This will require knowledge of the child welfare, emergency shelter, and substance abuse treatment systems and how to make referrals to appropriate therapists and mental health professionals.

Advocacy Professionals should use their given status in the community to advocate for the needs of individual families and for the broader needs of children in society. This includes working on public policy which can be best achieved by working with organizations that address the needs of children in different arenas. Professionals can endorse and support quality, comprehensive child-focused education and can serve on advisory boards for a local child abuse prevention agency or home visiting program, thereby assisting in networking alliances between prevention programs and the treatment field (AAP, 2009). Professionals can also be role models and leaders in their communities by offering support for family and neighbors who might need encouragement, help, or referrals and being advocates to assure that their communities have resources and services for parents.

Keeping Up to Date With the Field Professionals can be more effective advocates if they are knowledgeable about the current prevention field and evidence-based strategies for prevention. In the CPS practice field, professionals can identify prevention opportunities within the population of families and children who come to their system, but who are unsubstantiated or do not require that the children be taken into protective custody. Professionals in the "more traditional" fields of practice can help prevention professionals and volunteers by recognizing the importance of their prevention work, participating in multidisciplinary training, and helping to bridge the gap between research and practice.

References

Alexander, R., Baca, L., & Fox, J. A., Frantz, M., Huffman, L. et al. (2003). *New hope for preventing child abuse and neglect: Proven solutions to save lives and prevent future crime.* Washington, DC: Fight Crime: Invest in Kids. Retrieved September 26, 2008, from: http://www.fightcrime.org/reportlist.php

American Academy of Pediatrics (AAP). (2005). *Connected Kids: Safe Strong Secure, A new violence prevention program from the American Academy of Pediatrics.* Elk Grove Village, IL: AAP.

American Academy of Pediatrics, Council on Community Pediatrics (AAP). (2009). The role of preschool home-visiting programs in improving children's developmental and health outcomes. *Pediatrics*, *123*(2), 598–603.

American Acadmy of Pediatrics, Task Force on Violence (AAP). (1999). The role of the pediatrician in youth violence prevention in clinical practice and at the community level. *Pediatrics, 103*(1), 173–181.

Anda, R. F., Whitfield, C. L., Felitti, V. J., Chapman, D., Edwards, V. J., Dube, S. R., & Williamson, D. F. (2002). Alcohol-impaired parents and adverse childhood experiences: The risk of depression and alcoholism during adulthood. *Psychiatric Services*, *53,* 1001–1009.

Barlow, J., Davis, H., McIntosh, E., Jarrett, P., Mockford, C., & Stewart-Brown, S. (2007). Role of home visiting in improving parenting and health in families at risk of abuse and neglect: Results of a multicentre randomised controlled trial and economic evaluation. *Archives of Diseases in Children*, *92*, 229–233.

Barr, R. G., Rivara, F. P., Barr, M., Cummings, P., Taylor, J., Lengua, L. J., & Meredith-Benitez, E. (2009). Effectiveness of educational materials designed to change knowledge and behaviors regarding crying and shaken baby syndrome in mothers of newborns: A randomized, controlled trial. *Pediatrics*, *123*(6), 972–980.

Bolen, R. M. (2003). Child sexual abuse: Prevention or promotion? *Social Work, 48*, 174–185.

Brayden, R. M., Altemeier, W. A., Dietrich, M. S., Tucker, D. D., Christensen, M. J., McLaughlin, J., & Sherrod, K. B. (1993). A prospective study of secondary prevention of child maltreatment. *Journal of Pediatrics*, *122*(4), 511–516.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist, 32*, 513–530.

Bugental, D. B., & Schwartz, A. (2009). A cognitive approach to child maltreatment prevention among medically at-risk infants. *Developmental Psychology, 45*(1), 284–288.

Caldera, D., Burrell, L., Rodriguez, K., Crowne, S. S., Rohde, C., & Duggan, A. (2007). Impact of a statewide homevisiting program on parenting and on child health and development. *Child Abuse & Neglect*, *31*(10), 829–852.

Caldwell, R. A. (1992). The costs of child abuse vs. child abuse prevention: Michigan's experience. Accessed September 26, 2008, at: https://www.msu.edu/~bob/cost1992.pdf

Centers for Disease Control and Prevention (CDC). (2007). *Preventing maltreatment: Program activities guide.* Atlanta, GA: Author. Retrieved July 8, 2009, from: http://www.cdc.gov/ncipc/dvp/pcmguide.htm

Centers for Disease Control and Prevention (CDC). (2008). *Strategic direction for maltreatment prevention: Preventing child maltreatment through the promotion of safe, stable, and nurturing relationships between children and caregivers.* Atlanta, GA: Authors.

Centers for Disease Control and Prevention (CDC). (2009). *Parent training programs: Insight for practitioners.* Atlanta, GA: Author.

Chaffin, M., Bonner, B. L., & Hill, R. F. (2001). Family preservation and family support programs: Child maltreatment outcomes across client risk levels and program types. *Child Abuse & Neglect*, *25*(11), 1269–1289.

Children's Safety Network. (2007). *An MCH approach to preventing child maltreatment.* Newton, MA: Author.

Daro, D. (1988). *Confronting child abuse: Research for effective program design.* Washington, DC: National Academy of Press.

Daro, D., & Dodge, D. A. (2009). Creating community responsibility for child protection: Expanding partnerships, changing context. *The Future of Children*, *19*(2), 67–93.

Davis, K., & Gidycz, C. (2000). Child sexual abuse prevention programs: A meta-analysis. *Journal of Clinical & Child Psychology*, *29*, 257–265.

De Bellis, M. D. (2005). The psychobiology of neglect. *Child Maltreatment, 10*(2), 150–172.

DePanfilis D., Dubowitz, H., & Kunz, J. (2008). Assessing the cost-effectiveness of Family Connections. *Child Abuse & Neglect*, *32*(3), 335–351.

Dias, M. S., Smith, K., deGuehery, K., Mazur, P., Li, V., & Shaffer, M. L. (2005). Preventing abusive head trauma among infant and young children: A hospital-based, parent education program. *Pediatrics, 115*(4), 470–477.

Donovan, E. F., Ammerman, R. T., Besl, J., Atherton, H., Khoury, J. C., Altaye, M., Putnam, F. W., & Van Ginkel, J. B. (2007). Intensive home visiting is associated with decreased risk of infant death. *Pediatrics, 119*, 1145–1152.

Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D. P., & Giles, W. H. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: The adverse childhood experiences study. *Pediatrics, 111*, 564–572.

Dubowitz, H. (2002). Preventing child neglect and physical abuse: A role for pediatricians. *Pediatrics in Review*, *23*(6), 191–196.

Dubowitz, H., Feigelman, S., Lane, W., & Kim, J. (2009). Pediatric primary care to help prevent child maltreatment: The Safe Environment for Every Kid (SEEK) model. *Pediatrics*, *123*(3), 858–864.

Duggan, A., McFarlane, E., Fuddy, L., Burrell, L., Higman, S. M., Windham, A., & Sia, C. (2004). Randomized trial of a statewide home visiting program: impact in preventing child abuse and neglect. *Child Abuse & Neglect, 28*(6), 589–595.

Dumont, K., Mitchell-Herzfeld, S., Greene, R., Lee, E., Lowenfels, A., Rodriguez, M., & Dorabawila, V. (2008). Healthy Families New York (HFNY) randomized trial: Effects on early child abuse and neglect. *Child Abuse & Neglect, 32*(2), 295–315.

Eckenrode, J., Ganzel, B., Henderson, C. R., Smith, E., Olds, D. L., Powers, J., Cole, R., Kitzman, H., & Sidora, K. (2000). Preventing child abuse and neglect with a program of nurse home visitation: The limiting effects of domestic violence. *Journal of the American Medical Association, 284*(11), 1385–1391.

Eluvathingal, T. J., Chugani, H. T., Behen, M. E., Juhasz, C., Muzik, O., Maqbool, M., Chugani, D. C., & Makki, M. (2006). Abnormal brain connectivity in children after early severe socioemotional deprivation: A diffusion tensor imaging study. *Pediatrics, 117*, 2093–2100.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). The relationship of adult health status to childhood abuse and household dysfunction. *American Journal of Preventive Medicine, 14*, 245–258.

Finkelhor, D. (2007). Prevention of sexual abuse through educational programs directed toward children. *Pediatrics, 120*(3), 640–645.

Finklehor, D., & Jones, L. M. (2004). Explanations for the decline in child sexual abuse cases. *OJJDP: Juvenile Justice Bulletin*. Retrieved August 6, 2006, from: http://www.ojjdp.ncjrs.gov

Gibson, L., & Leitenberg, H. (2000). Child sexual abuse prevention programs: Do they decrease the occurrence of child sexual abuse? *Child Abuse and Neglect, 24*(9), 1115–1125.

Gomby, D. S. (2005). *Home visitation in 2005: Outcomes for children and parents.*[Invest In Kids working paper no. 7]. Washington, DC: Committee for Economic Development.

Gomby, D. S. (2007). The promise and limitations of home visiting: Implementing effective programs. *Child Abuse & Neglect, 31*(6), 793–799.

Helfer, R. E. (1982). A review of the literature on the prevention of child abuse and neglect. *Child Abuse & Neglect, 6*(2), 251–261.

Helfer, R. E. (1987). The perinatal period, a window of opportunity for enhancing parent-infant communication: An approach to prevention. *Child Abuse & Neglect, 11*(4), 565–579.

Johnson, C. F. (1998). *Actions pediatricians can take to prevent child maltreatment: A checklist* [unpublished manuscript].

King, W. J., Klassen, T. P., LeBlanc, J., Bernard-Bonnin, A., Robitaillle, Y., Pham, B., Coyle, D., Tenenbein, M., & Pless, I. B. (2001). The effectiveness of a home visit to prevent childhood injury. *Pediatrics, 108*(2), 382–388.

Lundahl, B., & Harris, N. (2006). Delivering parent training to families at risk to abuse: Lessons from three meta-analyses. *APSAC Advisor*, *18*(3), 7–11.

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.

MacMillan, H. L., Thomas, B. H., Walsh, C. A., Boyle, M. H., Shannon, H. S., & Gafni, A. (2005). Effectiveness of home visitation by public health nurses in the prevention of the recurrence of child physical abuse and neglect: A randomised controlled trial. *Lancet, 365*, 1786–1793.

MacMillan, H. L., Wathen, C. N., Fergusson, D. M., Leventhal, J. M., & Taussig, H. N. (2009). Interventions to prevent child maltreatment and associated impairment. *Lancet, 373*, 250–266.

Maxfield, M. G., & Widom, C. S. (1996). The cycle of violence: Revisited six year's later. *Archives of Pediatric and Adolescent Medicine, 150*(4), 390–395.

McCurdy, K., & Daro, D. (1994). Child maltreatment: A national survey of reports and fatalities. *Journal of Interpersonal Violence*, 9(1), 75–94.

Middlebrooks, S., & Audage, N. C. (2008). *The effects of childhood stress on health across the lifespan*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Mikton, C., & Butchart, A. (2009). Child maltreatment prevention: A systematic review of reviews. *Bulletin of the World Health Organization, 87*, 353–361.

National Research Council. (1993). *Understanding child abuse and neglect.* NY: Free Press, Macmillan.

National Sexual Violence Resource Center. (2006). *National Resource Directory and Handbook Preventing Child Sexual Abuse.* Retrieved August 18, 2006, from:
http://www.nsvrc.org/publications/directories/csa_directory/index.html

Noor, I., & Caldwell, R. A. (2005). *The costs of child abuse vs. child abuse prevention: A multi-year follow-up in Michigan*. Retrieved September 26, 2008, from: https://www.msu.edu/~bob/cost2005.pdf

Olds, D. L. (2006). The nurse-family partnership: An evidence-based preventative intervention. *Infant Mental Health Journal, 27*(1), 5–25.

Olds, D. L., Eckenrode, J., Henderson, C. R., Kitzman, H., Powers, J., Cole, R., et al. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect: 15-year follow-up of a randomized trial. *Journal of the American Medical Association, 278*, 637–643.

Olds, D. L., Henderson, C. R., Kitzman, H. J., Tatlebaum, R., & Chamberlin, R. (1986). Improving the delivery of prenatal care and outcomes of pregnancy: A randomized trial of nurse home visitation. *Pediatrics, 77*(1), 16–28.

Olds, D. L., Robinson, J., O'Brien, R., Luckey, D. W., Pettitt, L. M., Henderson, C. R., Ng, R. K., Sheff, K. L., Korfmacher, J., Hiatt, S., & Talmi, A. (2002). Home visiting by paraprofessionals and nurses: A randomized, controlled trial. *Pediatrics, 110*(3), 486–496.

Ondersma, S. J., & Chase, S. K. (2003). Substance abuse and child maltreatment prevention. *The APSAC Advisor*, *15*(3), 8–11.

Palusci, V. J., Crum, P., Bliss, R., & Bavolek, S. J. (2008). Changes in parenting attitudes and knowledge among inmates and other at-risk populations after a family nurturing program. *Children and Youth Services Review, 30*(1), 79–89.

Palusci, V. J., Zeemering, W., Bliss, R. C., Combs, A., & Stoiko, M. A. (2006, April 29). *Preventing abusive head trauma using a directed parent education program.* Presented at the Pediatric Academic Societies Meeting. Atlanta, GA.

Patterson, J., Barlow, J., Mockford, C., Klimes, I., Pyper, C., & Stewart-Brown, S. (2002). Improving mental health through parenting programmes: Block randomized controlled trial. *Archives of Diseases in Children, 87*, 472–477.

Peters, R., & Barlow, J. (2004). Systematic review of instruments designed to predict child maltreatment during the antenatal and postnatal periods. *Child Abuse Review*, *12*, 416–439.

Plotnick, R.D., & Deppman, L. (1999). Using benefit-cost analysis to assess child abuse prevention and intervention programs. *Child Welfare*, *78(*3), 381–407.

Plummer, C.A. (2001). Prevention of child sexual abuse: A survey of 87 programs. *Violence and Victims, 16*(5), 575–588.

Plummer, C.A., & Palusci, V. J. (In press). Sexual Abuse Prevention, In R. Kaplan (Ed.), *Sexual assault medical care for the victim: A guide for clinicians. Vol. 1: Children and Adolescents.* St Louis, MO: GW Medical Publishing.

Prevent Child Abuse America. (2008). *BECAUSE Kids Count! Building and Enhancing Community Alliances United for Safety and Empowerment.* Retrieved September 26, 2008, from: http://member.preventchildabuse.org/site/PageServer?pagename=research_because_kids_count.

Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009, January 22). Population-based prevention of child maltreatment: The U.S. Triple-P System Population Trial. *Prevention Science* [online]. DOI: 10.1007/s11121-009-0123-3.

Reading R., Bissell, S., Harvin, J., Masson, J., Moynihan, S., Pais, M. S., Thoburn, J., & Webb, E. (2009). Promotion of children's rights and prevention of child maltreatment. *Lancet, 373*, 332–343.

Reynolds, A. J., Mathieson, L. C., & Topitzes, J. W. (2009). Do early childhood interventions prevent child maltreatment? *Child Maltreatment*, *14*(5), 182–206.

Rigney, L., & Brown, E. J. (2009, Winter). The use of paraprofessionals in a prevention program for child maltreatment: History, practice, and the need for better research. *The APSAC Advisor*, *21*, 13–20.

Rispens, J., Aleman, A., & Goudena, P. (1997). Prevention of child sexual victimization: A meta-analysis of school programs. *Child Abuse & Neglect, 21*, 975–987.

Schnitzer, P. G., Covington, T. M., Wirtz, S. J., Verhoek-Oftedahl, W., & Palusci, V.J. (2008). Public health surveillance of fatal child maltreatment: Analysis of three state programs. *American Journal of Public Health, 98*(2), 296–303.

Schuster, M. A., Wood, D. L., Duan, N., Mazel, R. M., Sherbourne, C. D., & Halfon, N. (1998). Utilization of well-child care services for African American infants in a low-income community: Results of a randomized, controlled case management/home visitation intervention. *Pediatrics, 101*, 999–1005.

Sege, R. D., Hatmaker-Flanigan, E., De Vos, E., Levin-Goodman, R., & Spivak, H. (2006). Anticipatory guidance and violence prevention: Results from family and pediatrician focus groups. *Pediatrics, 117*, 455–463.

Sweet, M. A., & Appelbaum, M. I. (2004). Is home visiting an effective strategy? A meta-analytic review of home visiting programs for families with young children. *Child Development 75*(5), 1435–1456.

Wang, C. T., & Holton, J. (2008). *Total estimated cost of child abuse and neglect in the United States.* Chicago: Prevent Child Abuse America**.**

Williams, Stern & Associates (2005). *Health Families Florida evaluation report: January1, 1999–December 31, 2003.* Miami, FL: Author.

World Health Organization (WHO), & the International Society for the Prevention of Child Abuse and Neglect (IPSCAN). (2006). *Preventing child maltreatment: A guide to taking action and generating evidence.* Geneva, Switzerland: WHO.

Zielinski. D., & Bradshaw, C. (2006). Ecological influences on the sequelae of child maltreatment: A review of the literature, *Child Maltreatment, 11*, 49–62.

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STRENGTHENING HOME-VISITING INTERVENTION POLICY: EXPANDING REACH, BUILDING KNOWLEDGE

Deborah Daro and Kenneth A. Dodge

Many argue that the expansion of home visitation should be built solely around programs that have been proven through carefully structured clinical trials that engage a well-specified target population. We believe this approach is valuable but insufficient to achieve the type of population-level change that such reforms generally promise. We propose a home-visitation policy framework that embeds high-quality targeted interventions within a universal system of support that begins with an assessment of all new parents. This assessment process would carry the triadic mission of assessing parental capacity, linking families with services commensurate with their needs, and learning to do better.

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A common vehicle for reaching families as early as possible is offering pregnant women home-visitation services. No other service model has garnered comparable levels of political support nor generated more controversy.[1] Today, home visitation is viewed by some as a critical linchpin for a much-needed coordinated early intervention system and by others as yet another example of a prevention strategy promising way more than it can deliver.[2]

Several national models (for example, Parents as Teachers, Healthy Families America, Early Head Start, Head Start, Parent Child Home Program, SafeCare, HIPPY, and the Nurse-Family Partnership) are now widely available across the country.[3] These programs compete for access to the same population based on age and socio-demographics. In other ways, however, they are complementary and components of a potential comprehensive array of services across early childhood. In addition, more than forty states have invested in home visitation and the infrastructure necessary to ensure that these services are of high quality and are integrated into broader systems of early intervention and support.[4]

Effective public policy requires a solid idea which links actions to desired impacts, an implementation plan that extends support to the full population in need, and a research agenda that supports the learning necessary to guide innovation and efficient investment. The field of home visiting still has a long way to go to meet these conditions. One strategy is to build the policy using the traditional scientific framework, beginning with carefully crafted clinical trials of clearly defined service models which focus on a well-specified target population. Once proven, these models are then broadly adopted with the expectation that impacts will expand accordingly. This approach was reflected in President Obama's initial FY 2010 budget in which he advocated for the broad expansion of early home visitation by nurses. Although the proposal did not explicitly limit support to a single model, the program elements and evidence base proposed in that request mirrored the core characteristics and research agenda of the Nurse-Family Partnership (NFP).[5]

In response to this proposal, we and others argued that such an approach would not achieve maximum impacts and benefits for the next generation of young children for four principal reasons:

—Building a national initiative solely on the basis of a single model's limited target population (that is, low-income primiparous women who voluntarily commit to home visits for twenty-seven months) will leave most high-risk infants unserved and will limit the likelihood of community-level change in available services and supports for parenting.

—Building a national initiative solely on the basis of evidence generated by small randomized clinical trials with volunteer subject groups at limited sites provides little guidance on how to bring the model to sufficient scale to serve the national interest.

—Building a national initiative based solely on past evaluations of impact on a select group of women who consented to a research study fails to hold the initiative accountable for impact on the current population, particularly on previously untested subgroups.

—Building a national initiative that fails to understand that all parents face challenges in raising their children undermines collective responsibility and will

not ignite the political support necessary to create a robust early intervention culture that can sustain public investment in this area and foster behavioral change.[6]

As the policy agenda for home visitation moves forward and the impacts of this strategy are evaluated in terms of secular change in a broad set of population-level indicators such as child maltreatment and child development, we fear that population-level indicators will not change and the movement may become at risk. Therefore, we believe a distinctively different practice and research framework is needed. Specifically, our home-visitation policy framework would embed high-quality targeted interventions within a universal system of support that begins with an assessment of all newborns and their families. This assessment process would carry the triadic mission of assessing parental capacity to provide for a child's safety and healthy development, linking families with services commensurate with their needs, and building new evidence-based services to address identified unmet needs. Further, the research base promoted and valued under this system would not simply be one that presumes impacts that had been achieved in past trials but also places equal value on learning what is needed to do better.

Limits of the Targeted Approach

Many argue that the most efficient and prudent policy path, particularly in tough economic times, is to focus on expanding services to the most vulnerable populations. The logic underlying this approach is that because these groups are in greatest need, the opportunity for achieving measureable reduction in costly child and family outcomes is greatest through targeted interventions. The strategy also represents a more just policy in that public dollars are being directed to those least able to secure resources on their own. Investments in replicating Head Start and more recently Early Head Start (EHS) to increase access to high-quality early learning opportunities for the disadvantaged reflect this policy approach.

Targeted interventions, by definition, leave many families not eligible for service.

Although the exclusive replication of any intensive and well-researched home-visiting intervention that targets only one segment of the at-risk population may well achieve substantial change for many of its program participants, we believe that this approach, as public policy, will not generate impacts of the magnitude that are necessary to achieve and sustain substantial population-level change. The limit of this approach goes well beyond the financing that would be necessary to bring a program to full scale. The problem is that, even at full scale, there would be little impact on the population rate of maltreatment.

Targeted interventions, by definition, leave many families not eligible for service. In the case of NFP, services are limited to first-time low-income mothers who can be identified before the end of the second trimester of pregnancy and who voluntarily consent to participate in home visiting for twenty-seven months.[7] Based on the 2006 birth data available from the Centers for Disease Control, a unique focus on first-time parents would leave about 62 percent of newborns ineligible for service (about 2.7 million births annually). Further, infants in the foster care system, certainly a population at high risk for multiple negative outcomes, are eight times more likely than other infants

to have mothers who received no prenatal care—a reality that would have precluded these women from accessing NFP or other models offered only during pregnancy.[8]

Demonstrating through a clinical trial that a program model is efficacious with its targeted volunteer population is no guarantee that if widely disseminated the program would achieve these same impacts with the larger population. Even within the context of a clearly specified target population and transparent eligibility criteria, full penetration is difficult to achieve. Populations demonstrating the greatest risk for maltreatment such as substance-abusing mothers and those involved in child welfare services are known to have relatively low rates of enrollment in voluntary programs.[9] These parents often find it difficult to focus on their children's needs and therefore are often less motivated to seek out and use supportive services.[10]

Achieving efficiency is best done through a comprehensive assessment that identifies the specific needs of participants and refers them to the most appropriate service.

Once enrolled, families often do not remain enrolled long enough to achieve maximum impacts. Wide variation in retention rates exist across voluntary home-visitation programs, and many model home-visitation programs struggle to deliver supportive services to their target populations.[11] One study of a multi-year home-visitation program found the average study participant remained enrolled in services for a little over a year. Of the families in the study sample who had the opportunity to enroll for at least two years, only one-third achieved this service threshold.[12] Even a highly effective program is unlikely to alter population-level rates on core outcomes when it leaves many in need of assistance ineligible for enrollment or unwilling to enroll, and fails to retain the majority of those they do engage.

Although targeted services offer assistance to populations known to be at higher risk for specific negative outcomes, the strategy provides no support for segments of the population who rise in risk after the enrollment period due to life circumstances or are at risk based on criteria other than income. For example, maltreatment and poor parenting skills are not limited to low-income families or single-parent families and can surface in families across the income spectrum.[13] Risk varies across subgroups and may be more or less elevated as family circumstances change or a child's developmental needs vary. Many high-risk groups can be identified outside of the bounds of eligibility for prenatal home visiting with primiparous low-income mothers. Later-born infants in these same families, infants born at low birth weight, infants born to mothers who had experienced maltreatment as children, infants born to mothers who initiate prenatal care in the last trimester or not at all, and infants whose mothers display parenting deficits are all at elevated risk. Similarly, no risk assessment tool has perfect predictability and most fail to identify a significant proportion of families in need of assistance and inappropriately label others.[14] Sorting out eligibility and establishing selective recruitment strategies are costly and may, in the end, again fail to yield the type of coverage and enrollment levels

needed to achieve population-level reductions in key outcomes.

Beyond these implementation challenges, targeted programs, which require that families be identified as having certain economic or personal deficits can be stigmatizing. The very families one hopes to engage in such efforts may refuse participation for fear of being labeled as being inadequate parents. Also, the possible self-identification of a mother as being singled out because she is at risk might inadvertently enhance risk in a perverse self-fulfilling prophecy.

Finally, an assumption of targeted programs such as NFP is that the community context and community service capacity are sufficient to support the program. As David Olds of the University of Colorado, Denver, and his colleagues note, the NFP nurse refers mothers to community services such as substance abuse and mental health treatment to accomplish core outcomes.[15] The nurse relies on these services to be available and of high quality. When programs such as NFP are relatively few in number, providers make limited demands on fragile local service systems. As these targeted models are taken to scale, however, the demands for specialized clinical services dramatically increase, with providers competing with each other to secure the slots that are available for their specific clients. Providers focusing on serving an individual family cannot contemplate system or policy change. Programs operating in isolation play no role in enhancing community service systems, levels, and culture. This political reality may further limit service availability for the most isolated families who are unlikely to seek out and enroll in voluntary programs or who fall outside eligibility boundaries.

Creating A Universal System of Support

Starting in the mid-nineteenth century, our nation made a commitment to public education for all children. The nation persisted in this goal based on the compelling public interest in having an informed electorate and a literate workforce. We did not create a public education system for poor children; we created the standard for all children. At the time that universal public education was debated, it was argued that it should be mandated only for low-income families because wealthier families would meet their educational needs anyway by private sources. That argument lost in favor of the overall public good. By mandating public education to be universal, all children were equally valued and their education was deemed society's collective responsibility. Today, this commitment and collective responsibility is being gradually extended to children between birth and age 3.

Promoting this extension by simply implementing one or even several targeted home-visitation models will not shape the robust prevention system of care required to foster early learning opportunities capable of reducing the performance gap. Extension of model EHS programs has not dramatically improved the kindergarten readiness of the nation's population; expansion of charter schools has not altered the average performance in the nation's urban education programs; and expansion of targeted violence prevention programs has not reduced the nation's violence rate. This is not to say that individuals enrolled in these programs have not benefitted. Unfortunately, these gains, from a population perspective, have been modest and far from transformative.

At present, states are making substantial investments in supporting individual home-visitation models, as well

as developing early intervention systems that support a continuum of services for new parents. Based on reporting from thirty-one states, the National Center for Children in Poverty found the aggregate annual level of support for home-visiting programs in these states exceeded $250 million.[16] A similar survey of twenty-six states conducted by the National Conference of State Legislatures pegged investment levels at $281 million in FY 2008.[17] Although no comprehensive figure is available with respect to the number of families these investments reach, the Congressional Research Service estimates that no more than 3 percent of families with children under the age of six, or 7 percent of those same families with income below 200 percent of the poverty line, are being served.[18]

Realizing population-level change will require communities to develop a preventive system of care that expands access to a range of evidence-based programs.

Even if federal investments in home-visitation services reach the most optimistic levels being proposed in Congress, these resources would allow for doubling the number of families reached, to a total of 6 percent of all families with young children and 14 percent of those living in poverty. Given all the challenges inherent in accurately targeting those at highest risk, in enticing them to enroll and remain in voluntary programs, and in achieving core outcomes, it remains unlikely that even this level of investment will produce population-level change.

The relatively high costs of these interventions underscore the importance of identifying an efficient way to match families with appropriate levels of support. Achieving this level of efficiency is best done, not through an eligibility system based on demographically-based risk, but rather through a comprehensive assessment that identifies the specific needs of participants and refers them to the most appropriate service. Although the cost of such a system has not been well specified, the per participant cost for these assessments is substantially less than providing intensive home-based interventions. For example, Cuyahoga County, Ohio (Cleveland) implemented a two-tiered home-visitation program in 1999 which included a single nurse visit to all first-time and teen parents, followed by more intensive services for those at high risk. Over a five-year period, the universal program screened 34,279 newborns at a cost of $6.3 million ($184 per participant). The county also invested almost $28 million dollars in its intensive home-visitation option which served 9,585 families during the same period at an average cost of $2,921 per participant.[19] In Hawaii, a universal screening program assessed roughly 13,500 newborns annually in FY 2007 and 2008, at a per participant cost of $147.[20] A new universal program in Durham County, North Carolina is devoted to having nurses visit every newborn family one to three times and then matching families in need with community-based services. The universal nurse portion of the program costs approximately $350 per family.[21]

Communities which provide a limited number of home visits to all or most new parents, such as the efforts undertaken in Cuyahoga County and Durham County,

offer opportunities to understand better the needs of new parents and the extent to which resources exist to address these needs adequately.[22] The eventual impacts of this type of embedded system on child development outcomes and parental behaviors are not yet known because studies are now in progress. In part, impacts will be a function of implementation quality, the screening system's ability to identify accurately those in need, and the capacity of local formal and informal resources to meet identified demands. Realizing population-level change will require communities to develop a preventive system of care[23] that expands family access to a range of evidence-based programs.

Sensible Evidence-Based Practice

Defining the evidentiary base necessary for estimating the potential impacts of a given intervention is complex and particularly challenging when the reform involves multiple strategies. Randomized control trials are often the best and most reliable method for determining whether changes observed in program participants over time are due to the intervention rather than to other factors. Maximizing the utility of program evaluation efforts, however, requires more than just randomized clinical trials. As noted by the American Evaluation Association in a February 2009 memo to Peter Orszag, the Director of the Office of Management and Budget:

> "There are no simple answers to questions about how well programs work, and there is no single analytic approach or method that can decipher the complexities that are inherent within the program environment and assess the ultimate value of public programs."[24]

Echoing a similar sentiment, a recent report by the Government Accountability Office concluded that requiring evidence from randomized studies as the sole proof of effectiveness would "likely exclude many potentially effective and worthwhile practices."[25] Although randomized trials offer the most rigorous method for establishing that assignment to a program results in positive outcomes, other research designs and statistical controls may be necessary in some contexts, and they may still allow program evaluators to make reliable and valid estimates of program effects.

Beyond determining program impacts on participants, research is needed to assess how program models or practice innovations address implementation challenges such as staff retention, participant enrollment and retention rates, collaboration with other service providers, and securing diverse and stable funding. Such information is needed not only during the initial stages of implementation but also over time. This type of documentation is essential for determining an intervention's continued viability in light of the inevitable changes that occur within the social fabric and public policy arena.

Conclusion

Empirical evidence supports the efficacy of home-visiting programs and their growing capacity to achieve their stated objectives with an increasing proportion of new parents. Maintaining this upward trend requires more than the dissemination of evidence-based models. Equally important is the task of assessing parental capacity to provide for a child's safety and linking families with services commensurate with their needs. For some families, the matching will be enrollment in intensive home-based interventions. For most families, this process

will serve as a way to raise awareness of local resources that are available in a community to help parents effectively meet the needs of their children and find assistance in times of stress. For the entire community, these assessments will grow service capacity where it is needed most. We believe that approaches that couple universal screening with targeted program delivery are most likely to achieve population-level improvement in child outcomes.

Endnotes

[1] Ron Haskins, Christina Paxson, and Jeanne Brooks-Gunn, *Social Science Rising: A Tale of Evidence Shaping Public Policy,* Future of Children Policy Brief (Princeton, NJ: Princeton-Brookings, Fall 2009).

[2] Deborah Daro, "The History of Science and Child Abuse Prevention—A Reciprocal Relationship," in *Community-Based Prevention of Child Maltreatment*, eds. Kenneth Dodge and Doriane Coleman (New York: Guilford Press, 2009); Mark Chaffin, "Is It Time to Rethink Healthy Start/Healthy Families?" *Child Abuse and Neglect* 28, no. 6 (2004): 589-595.

[3] Emilie Stoltzfus and Karen E. Lynch, *Home Visitation for Families with Young Children*, report prepared for Members and Comittees of Congress (Washington, DC: Congressional Research Service, July 2009).

[4] Kay Johnson, *State-Based Home Visiting: Strengthening Programs Through State Leadership* (New York: Columbia University, Mailman School of Public Health, National Center for Children in Poverty, 2009).

[5] David L. Olds, Lois Sadler, and Harriet Kitzman, "Programs for Parents of Infants and Toddlers: Recent Evidence from Randomized Trials," *Journal of Child Psychology and Psychiatry* 48, no. 3-4 (2007): 355-391.

[6] Deborah Daro and others, "Open Letter to President Obama Regarding His Proposed FY 2010 Budget and its Investment in Home Visitation," (letter, April 21, 2009). Available at http://www.maine-eccs.org/Daro%20Dodge%20Weiss%20Zigler%20Comments%20on%20Home%20Visiting%20Proposal.pdf.

[7] David L. Olds and others, "Preventing Child Abuse and Neglect with Home Visiting by Nurses," in *Community-Based Prevention of Child Maltreatment*, eds. Kenneth Dodge and Doriane Coleman (New York: Guilford Press, 2009).

[8] Barbara Needell and Richard P. Barth, "Infants Entering Foster Care Compared to Other Infants Using Birth Status Indicators," *Child Abuse and Neglect* 22, no. 12 (1998): 1179-1187.

[9] Deborah Daro and others, "Sustaining New Parents in Home Visitation Services: Key Participant and Program Factors," *Child Abuse and Neglect* 27, no. 10 (2003): 1101-1125.

[10] Neil B. Guterman, *Stopping Child Maltreatment before it Starts: Emerging Horizons in Early Home Visitation Services* (Thousand Oaks, CA: Sage, 2001); Maryam Navaie-Waliser and others, "Factors Predicting Completion of a Home Visitation Program by High-Risk Pregnant Women: The North Carolina Maternal Outreach Worker Program," *American Journal of Public Health* 90, no. 1 (2000): 121-124.

[11] Ann Duggan and others, "Hawaii's Healthy Start Program of Home Visiting for At-Risk Families: Evaluation of Family Identification, Family Engagement, and Service Delivery," *Pediatrics 105*, no. 1 (2000): 250-260; Karen McCurdy and Deborah Daro, "Parent Involvement in Family Support Programs: An Integrated Theory," *Family Relations* 50, no. 2 (2001): 113-121.

[12] Deborah Daro and others, "Sustaining New Parents in Home Visitation Services: Key Participant and Program Factors," *Child Abuse and Neglect* 27 (2003): 1101-1125.

[13] Adrea D. Theodore and others, "Epidemiologic Features of the Physical and Sexual Maltreatment of Children in the Carolinas," *Pediatrics* 115, no. 3 (2005): 331-337.

[14] John E. Lochman and The Conduct Problems Prevention Research Group, "Screening of Child Behavior Problems for Prevention Programs at School Entry," *Journal of Consulting and Clinical Psychology* 63, no. 4 (1995): 549-559.

[15] David L. Olds, Lois Sadler, and Harriet Kitzman, "Programs for Parents of Infants and Toddlers: Recent Evidence from Randomized Trials," *Journal of Child Psychology and Psychiatry* 48, no. 3-4 (2007): 355-391.

[16] Johnson, *State-Based Home Visiting.*

[17] Steffanie Clothier and Julie Poppe, *Early Care and Education State Budget Actions FY 2007 and FY 2008* (Washington, DC: National Conference of State Legislatures, April 2008).

[18] Stoltzfus and Lynch, *Home Visitation for Families with Young Children.*

[19] Robert L. Fischer, Nina Lalich, and Claudia Coulton, "Taking it to Scale: Evaluating the Scope and Reach of a Community-Wide Initiative on Early Childhood," *Evaluation and Program Planning* 31 (2008): 199-208.

[20] Personal communication with Cindy Hirai, State of Hawaii Department of Health, Healthy Start Program Head, Maternal, and Child Health Branch, Family Violence Prevention Program Coordinator (2009).

[21] Kenneth A. Dodge, *Unpublished Report* (Durham, NC, 2010).

[22] Deborah Daro and others, *Welcome Home and Early Start: An Assessment of Program Quality and Outcomes* (Chicago, IL: Chapin Hall at the University of Chicago, 2005); Deborah Daro and Kenneth A. Dodge, "Creating Community Responsibility for Child Protection: Possibilities and Challenges," *The Future of Children* 19, no. 2 (2009): 67-97; Kenneth A. Dodge and others, "Community-Level Prevention of Child Maltreatment: The Durham

Family Initiative," in *Community-based Prevention of Child Maltreatment*, eds. Kenneth Dodge and Doriane Coleman (New York: Guilford Press, 2009).

[23] Patrick H. Tolan and Kenneth A. Dodge, "Children's Mental Health as a Primary Care and Concern: A System for Comprehensive Support and Service," *American Psychologist* 60, no. 6 (2005): 601-614.

[24] American Evaluation Association Evaluation Policy Task Force, *An Evaluation Roadmap for a More Effective Government* (Fairhaven, MA: American Evaluation Association, February 2009).

[25] U.S. Government Accountability Office, *Program Evaluation: A Variety of Rigorous Methods Can Help Identify Effective Interventions*, GAO-10-30GOA (Washington, DC: U.S. Government Accountability Office, November 2009).

Durham Connects

OVERVIEW

Durham Connects launched in 2008 as a universal home visiting service. The county health department nurses delivered the program.

The program provided in-home health assessments of mothers and newborns. The nurses followed a standardized protocol, developed through research and intensive piloting. Visits started when the babies were 2 to 12 weeks old. Up to two follow-up visits were part of the protocol. Assessments covered four areas:

- Health care arrangements
- Caring for an infant
- Safe homes—household material needs and safety
- Parental support (well-being and social support)

The assessments were starting points for further conversations. If nurses identified a need and families wanted support, parents were connected with community resources.

Ten nurses provided the service and each one averaged about 200 families per year, or about four new families a week.

Durham Connects underwent a rigorous evaluation. Implementation was monitored to ensure fidelity and to document that families followed up on referrals.

STRATEGY (July 1, 2009 through December 31, 2010)

- Enrollment in the Durham Connects (DC) randomized control trial ended December 31, 2010.
    - Eligible subjects included all live births occurring at either Duke Hospital or Durham Regional Hospital to a family residing in Durham County between July 1, 2009 and December 31, 2010. The births were randomly assigned (even-numbered birth dates to the intervention group and odd-numbered birth dates to the control group).

PROCESS INDICATORS

DC was successful in enrolling eligible families and referring those with needs to services. The following tables capture relevant enrollment and referral data.

Category	Number	Percent of Total
Eligible families for intervention (born on even date)	2,327	100%
Families receiving brief intervention session in the hospital	1,862	80%
Families completing one or more home visits (classified as having completed the program)	1,596	68.6%

Of those families who received the initial hospital session, 85.7% went on to complete the program. Among those families, completion rates were highest for families receiving Medicaid (89.4% versus 79.9% for non-Medicaid families) and Hispanic families (92.2%). The completion rate for white families was 86.4%, and 80.5% for African-American families.

Data on the **1,596 families** completing a home visit are provided below:

Category	Number	Percent of Total
Received only one home visit (indicating low risk)	508	31.8%
Received one to two follow up home visits (indicating higher risk)	1,088	68.2%

In total, home visits resulted in **1,546 referrals** to community providers. Below are data on successful referrals:

Category	Number	Percent of Total
Families reported a successful contact	946	61.2%
Families reporting that services were received within four weeks	600	38.8%

Quality assurance data indicate that adherence or fidelity to the home visit protocol was achieved 85.1% of the time, which is generally accepted to be high.

Final Data Analysis of the Randomized Trial

In summary, random assignment to DC is associated with:

- more family connections to community resources;
- higher quality of childcare placements;
- more positive mother parenting behavior;
- more positive father-infant relationships; and,
- safer home environments.

Further, DC families had fewer visits to the emergency room, overnight hospital stays, and unplanned visits to pediatric offices.

Specific findings for DC families six months after the intervention (when compared to control families) are listed below: [Note: all findings are statistically significant unless noted otherwise.]

<u>Service utilization</u>:

- DC families were 18% more likely to access community resources.
- Children of DC families were 15% more likely to be placed in a high quality child care settings.
- Non-Medicaid DC families were 17% more likely to have back up child care plans.

- DC families were 3% more likely to have recently seen a pediatrician. (This finding, however, is not statistically significant).
- No differences were found between the treatment and control groups on measures of accessing family resources and social provisions. Similarly, no difference was found regarding the use of respite child care.

Parenting and family well being

- DC parents were 18% more likely to report positive parenting practices such as hugging, offering encouragement and providing warmth to their infant.
- DC parents were 50% more likely to report talking to their infant.
- On three separate measures, DC fathers were 10% more likely to be involved with the infant.
- Medicaid-eligible DC parents were 24% more likely to demonstrate knowledge about infant crying.
- In-home interviewers (unaware of whether the family was in the treatment or control group) were 8% more likely to rate DC homes as safe.
- Though there was no difference between the treatment and control groups when measuring the mother's overall mental health, DC mothers were 33% less likely to report clinical depression and 32% less likely to report clinical anxiety. As with the overall mental health measure, there was no reported difference in substance abuse.
- No differences were found on measures of domestic violence in the home.

Healthcare utilization

- DC families experienced 17% fewer emergency medical visits.
- DC families experienced 60% fewer overnight hospital stays.
- On all measures of emergency care, DC families were 30% less likely to use emergent care (either with a physician or in the hospital emergency dept.) and Medicaid-eligible DC families were 39% less likely to do so.

On two measures, the control group outperformed DC families:

- Medicaid-eligible control families were 8% more likely to still be using community services after 6 months; and,
- All control families were 3% more likely to report knowledge of infant development. (This difference, however, is not statistically significant).

SCALING AND SUSTAINING

Obviously, despite the positive findings, Durham Connects will not be considered a complete success unless it is sustained and even replicated. Toward both ends, progress is evident.

Efficiencies in the model are being implemented (mainly by slightly increasing in the RN's caseload), which will bring the costs for implementation at scale - meaning all newborns in

Durham - to roughly $1.6 million annually (or about $500 dollars per family, down from the original cost of $700 per family).

Leaders in the Durham community are actively making the case to support Durham Connects countywide.

The model was written into North Carolina's "Race to the Top for Early Childhood" federal grant application. The grant will provide $70 million (across four years) to enhance North Carolina's early childhood system. Funds are earmarked to expand Durham Connects into as many as six rural counties. Conversations are underway about the expansion.

The National Institute of Health is funding a longitudinal evaluation of the model (approximately $800,000 a year for five years).

Finally, both Wisconsin and Massachusetts have approached Dr. Dodge about replicating the program in their states.

RAND LABOR AND POPULATION

RESEARCH BRIEF

Proven Benefits of Early Childhood Interventions

RAND RESEARCH AREAS
THE ARTS
CHILD POLICY
CIVIL JUSTICE
EDUCATION
ENERGY AND ENVIRONMENT
HEALTH AND HEALTH CARE
INTERNATIONAL AFFAIRS
NATIONAL SECURITY
POPULATION AND AGING
PUBLIC SAFETY
SCIENCE AND TECHNOLOGY
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There is increasing recognition that the first few years of a child's life are a particularly sensitive period in the process of development, laying a foundation in childhood and beyond for cognitive functioning; behavioral, social, and self-regulatory capacities; and physical health. Yet many children face various stressors during these years that can impair their healthy development. Early childhood intervention programs are designed to mitigate the factors that place children at risk of poor outcomes. Such programs provide supports for the parents, the children, or the family as a whole. These supports may be in the form of learning activities or other structured experiences that affect a child directly or that have indirect effects through training parents or otherwise enhancing the caregiving environment.

As part of a recent study, RAND researchers synthesized what is known from the scientifically sound research literature about the short- and long-term benefits from early intervention programs, the features that are associated with more-effective programs, and the economic gains that accrue from investing additional resources in early childhood. We summarize those findings here. A companion research brief focuses on the characteristics and number of children who may need help to overcome threats to healthy development, such as resource disparities in early childhood. It also addresses the consequences of those threats for educational outcomes and beyond.

Key findings:

- **Early childhood intervention programs have been shown to yield benefits in academic achievement, behavior, educational progression and attainment, delinquency and crime, and labor market success, among other domains.**
- **Interventions with better-trained caregivers and smaller child-to-staff ratios appear to offer more favorable results.**
- **Well-designed early childhood interventions have been found to generate a return to society ranging from $1.80 to $17.07 for each dollar spent on the program.**

A Range of Benefits

The study focused on programs that provide child development services from the prenatal period until kindergarten entry and that had scientifically sound evaluations. A literature review identified twenty such programs, nineteen of which demonstrated favorable effects on child outcomes. Fifteen of the effective programs were judged to have a "strong" evidence base because they measured outcomes at the time of kindergarten entry or beyond. The remaining four were not judged to have a strong evidence base because, as of the last follow-up, the participants had not yet reached kindergarten age. Many or all of the children in those programs were as young as age 2 or 3, so there is less information as to the lasting effects of the program on outcomes of interest. The evidence base for these programs was designated "promising."

Although these programs represent varied approaches to early intervention, they fall into one of three broad approaches (see the accompanying table). Programs in the first group concentrate primarily on providing parent education and other family supports through home visiting or services provided in other settings (e.g., medical provider offices, classrooms in child-care centers). A second approach focuses on providing early childhood education, typically in a center-based setting, for one or two years prior to school entry. A third strategy combines the two approaches, with early childhood education services provided in centers

supplemented by parental education delivered in the same setting or through home visits.

These nineteen early intervention programs demonstrated significant and often sizable benefits in at least one of the following domains: cognition and academic achievement, behavioral and emotional competencies, educational progression and attainment, child maltreatment, health, delinquency and crime, social welfare program use, and labor market success. In some cases, the improved outcomes in these domains were demonstrated soon after the program ended; in other cases, the favorable impacts were observed through adolescence and in the transition to adulthood. In the case of the Perry Preschool Program, lasting benefits in multiple domains have been measured thirty-five years after the intervention ended.

Even though findings suggest that early benefits in terms of cognition or school achievement may eventually fade, the evidence indicates that there can be longer-lasting and substantial gains in outcomes such as special education placement and grade retention, high school graduation rates, labor market outcomes, social welfare program use, and crime. A few studies indicate that the parents of participating children can also benefit from early intervention programs, particularly when they are specifically targeted by the intervention.

Effective Early Childhood Intervention Programs Included in Study

Home Visiting or Parent Education
DARE to be You
Developmentally Supportive Care: Newborn Individualized Developmental Care and Assessment Program*
HIPPY (Home Instruction Program for Preschool Youngsters) USA
Incredible Years
Nurse-Family Partnership Program
Parents as Teachers*
Project CARE (Carolina Approach to Responsive Education)—without early childhood education
Reach Out and Read*
Home Visiting or Parent Education Combined with Early Childhood Education
Carolina Abecedarian Project
Chicago Child-Parent Centers
Early Head Start*
Early Training Project
Head Start
High/Scope Perry Preschool Project
Houston Parent-Child Development Center
Infant Health and Development Program
Project CARE—with early childhood education
Syracuse Family Development Research Program
Early Childhood Education Only
Oklahoma Pre-K
NOTES: All listed programs are judged to have a strong evidence base, except those marked with an asterisk. For the latter, a substantial number of children were as young as age 2 or 3 at the time of the most recent follow-up, so their evidence base is judged to be promising.

Features of Effective Programs

Policymakers and providers considering early childhood intervention programs may choose to adopt one of the proven program models shown in the table, several of which already operate on a large scale or are being replicated on a larger scale. Beyond these proven models, the literature offers some guidance about those features that are associated with better outcomes for children. Based on experimental and quasi-experimental evaluations of program design features, as well as comparisons of effects across model programs, three features appear to be associated with more effective interventions:

- Programs with better-trained caregivers appear to be more effective. In the context of center-based programs, this may take the form of a lead teacher with a college degree as opposed to no degree. In the context of home visiting programs, researchers have found stronger impacts when services are provided by nurse home visitors as opposed to a paraprofessional or lay professional home visitor.
- In the context of center-based programs, there is evidence to suggest that programs are more successful when they have smaller child-to-staff ratios.
- There is some evidence that more intensive programs are associated with better outcomes, but not enough to indicate the optimal number of program hours or how they might vary with child risk characteristics.

Ideally, we would like to know more about intervention features that generate better outcomes for children so that policymakers and practitioners can achieve optimal program designs for the children and families they serve. Thus, continued evaluation of model programs and effective program features is essential.

Economic Returns from Effective Early Intervention Programs

It is noteworthy that the features associated with more successful programs tend to be costly. This suggests that more money may need to be spent to obtain greater benefits—at least up to a point. It is therefore reasonable to ask whether devoting resources to achieve benefits associated with successful but more costly programs is worth the investment.

Notably, many of the benefits from early childhood interventions listed above can be translated into dollar figures and compared with program costs. For example, if school outcomes improve, fewer resources may be spent on grade repetition or special education classes. If improvements in school performance lead to higher educational attainment and subsequent economic success in adulthood, the government may benefit from higher tax revenues and reduced outlays for social welfare programs and the criminal justice system. As a result of improved economic outcomes, participants themselves benefit from higher lifetime incomes, and other

members of society gain from reduced levels of delinquency and crime.

Researchers have conducted benefit-cost analyses, using accepted methodologies, for a subset of the programs we identified as having favorable effects. For those programs with benefits that could readily be expressed in dollar terms and those that served more-disadvantaged children and families, the estimates of benefits per child served, net of program costs, range from about $1,400 per child to nearly $240,000 per child. Viewed another way, the returns to society for each dollar invested extend from $1.80 to $17.07. Some of the largest estimates of net benefits were found for programs with the longest follow-up, because those studies measured the impact for outcomes that most readily translate into dollar benefits (e.g., employment benefits, crime reduction). Large economic returns were found for programs that required a large investment (over $40,000 per child), but returns were also positive for programs that cost considerably less (under $2,000 per child). Programs with per-child costs in between these two figures also generated positive net benefits. The economic returns were favorable for programs that focused on home visiting or parent education as well as for programs that combined those services with early childhood education.

Because not all benefits can be translated into dollar values, these benefit-cost estimates for effective programs are likely to be conservative. Moreover, such analyses do not incorporate some of the other potential benefits that were not measured in the studies. These might include improved labor market performance for the parents of participating children, as well as stronger national economic competitiveness as a result of improvements in educational attainment of the future workforce. It is important to note that these findings represent the potential effects of well-designed and well-implemented interventions. They do not necessarily imply that all such early childhood interventions, delivered for any given amount of time, would generate benefits that offset costs.

For decisionmakers considering investments in early childhood interventions, these findings indicate that a body of sound research exists that can guide resource allocation decisions. This evidence base sheds light on the types of programs that have been demonstrated to be effective, the features associated with effective programs, and the potential for returns to society that exceed the resources invested in program delivery. These proven results signal the future promise of investing early in the lives of disadvantaged children. ■

This research brief describes work for RAND Labor and Population documented in *Early Childhood Interventions: Proven Results, Future Promise* by Lynn A. Karoly, M. Rebecca Kilburn, and Jill S. Cannon, MG-341-PNC (available at www.rand.org/publications/MG/MG341), 2005, 200 pages, $24, ISBN: 0-8330-3836-2. MG-341 is also available from RAND Distribution Services (phone: 310-451-7002; toll free 877-584-8642; or email: order@rand.org). The RAND Corporation is a nonprofit research organization providing objective analysis and effective solutions that address the challenges facing the public and private sectors around the world. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors. **RAND**® is a registered trademark.

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PPN Issue Briefs

Promising Practices for Preventing Child Abuse and Neglect

This summary provides a concise overview of research-based information related to preventing child abuse and neglect. As defined by the Federal Child Abuse Prevention and Treatment Act (CAPTA), child abuse and neglect is:

> "any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or is an act or failure to act which presents an imminent risk of serious harm"

For more information about this topic, see additional resources from PPN shown at the right, or consult the references at the end of the Issue Brief.

What is the scope of the problem?

Incidence of Maltreatment

Every year in the United States, more than one out of every hundred children are victims of substantiated child abuse and neglect. For instance, in 2006, 3.6 million cases of child maltreatment were investigated, which is a rate of 47.8 per 1,000 children. In that year, nearly 1 million maltreatment claims were substantiated meaning that the investigation confirmed that the alleged child maltreatment had occurred; a rate of 12.1 per 1,000 children. The rates have held relatively steady during the preceding five years with some minor increases in investigation, but there has been essentially no change in the rate of cases that were substantiated. *[1]*

Type of Maltreatment

There is a range of maltreatment types, and they are tracked within these broad categories: neglect, physical abuse, sexual abuse, psychological maltreatment and medical neglect. Neglect is by far the most common type of maltreatment experienced by children, with nearly two-thirds of maltreatment cases being neglect (see Figure 1). Examples of neglect include failing to provide food to a child when a caregiver is able, or being incapacitated at times when a child needs supervision. In 2006, an estimated 1,530 children died as a result of abuse or neglect, and forty-one percent of these deaths were attributable to neglect. *[1]*

Figure 1. Types of Maltreatment Reported — Neglect Most Common

More on this Topic

To read more on the topic of child abuse and neglect prevention, please see related content from PPN:

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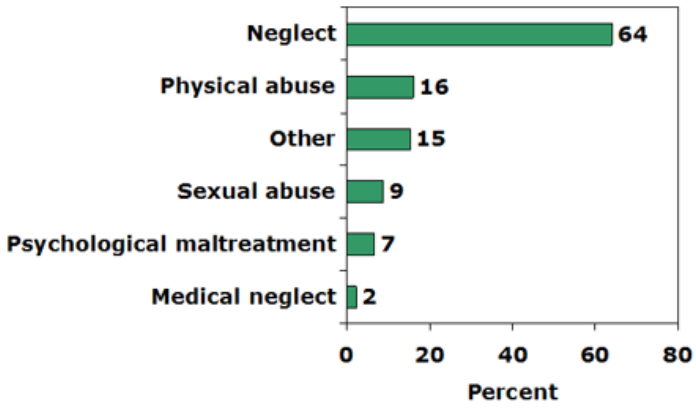


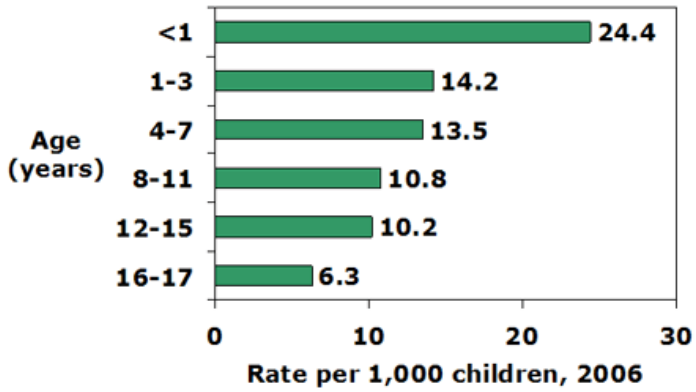
Source: *Child Maltreatment 2006*, Administration on Children, Youth and Families, 2008

Victims and Perpetrators of Maltreatment

Children under one year of age are the most common victims of abuse and neglect, with about 24 out of 1,000 being victims of maltreatment (Figure 2). Infants are not exclusively the victims of child maltreatment, and the chart below reports maltreatment by age. Boys and girls suffer from maltreatment in roughly equivalent numbers; 48% of victims in FY2006 were boys while 52% were girls. Additionally, children of different races and ethnicities are maltreated. In 2006, 49% of victims were White, 23% were African-American, and 18% were Hispanic. *[1]*

Parents are by far the most common perpetrators—83 percent of perpetrators are parents. There is limited data available about the characteristics of these parents due to differences in the way that states collect and report data on maltreatment. However, from the data available on 60% of cases, it is known that 27% of all maltreatment victims in 2006 lived with a single mother, 22% lived with both parents (whose marital status was unknown), and 20% lived with married parents. Taken together, these statistics support the argument for providing prevention and early intervention to families with new babies, and for directing the primary focus of prevention and intervention efforts towards parents rather than other caregivers. *[1]*

Figure 2. Youngest Children Are at Greatest Risk



Source: *Child Maltreatment 2006*, Administration on Children, Youth and Families, 2008

Risk and Protective Factors

Research has identified factors that are associated with either greater or lower risk of being maltreated. These factors include characteristics of the individual, family, community, and greater society. Below are several examples of risk and protective factors.

Risk factors:

- Disabilities or mental retardation in children
- Social isolation of families
- Parents' lack of understanding of children's needs and child development

- Poverty and other socioeconomic disadvantage, such as unemployment
- Family disorganization, dissolution, and violence, including intimate partner violence
- Lack of family cohesion
- Substance abuse in family
- Parental stress and distress, including depression or other mental health conditions
- Community violence

Protective factors:

- Supportive family environment
- Nurturing parenting skills
- Stable family relationships
- Having household rules and parental monitoring of the child
- Parental employment and high parental education
- Adequate housing
- Access to health care and social services
- Communities that support parents and take responsibility for preventing abuse [2]

What are the costs to individuals and society?

Child maltreatment burdens individuals and society in a number of different ways. First and foremost it harms the victim, and not just when maltreatment happens—it also has long-term consequences. Additionally, there are financial and other non-monetary costs at the societal level.

Consequences for Individuals

Children who are victims of abuse or neglect are at higher risk for a number of negative outcomes throughout their lifespan. They are at risk for having negative outcomes in the areas of physical and mental health, cognitive development, academic achievement, and the development of healthy social behavior and relationships. For example, childhood victims of abuse and neglect have higher rates of depression, hopelessness and low self-esteem [3]. Victims of maltreatment are also at greater risk of having developmental delays than their peers [4], and have lower academic achievement (e.g., lower grades and standardized test scores, and higher rates of grade retention) [3]. Antisocial behavior, physical aggression, fear and anger are consistently observed outcomes in victims of childhood physical abuse [3]. These traits can also hinder children's and adults' abilities to form healthy social relationships. Studies have also found that adults who experienced abuse and neglect as children have higher rates of physical and sexual assault/abuse (perpetrators or victims), kidnapping or stalking, and having a family friend who is murdered or commits suicide compared to adults who did not experience maltreatment during childhood. [5]

Consequences for Society

The impact of child abuse and neglect is also felt by the greater society in the form of monetary and non-monetary costs. Wang and Holton (2007) drew from a number of data sources in an attempt to estimate the annual cost of child abuse and neglect. They estimate that the total costs to society, both direct and indirect, of child abuse and neglect is around $100 billion annually in the United States. About one-third of the total amount is spent on direct costs of maltreatment including hospitalization for injuries, mental health services, child welfare system costs, and law enforcement. Indirect costs include expenses for providing special education services, costs to the juvenile delinquency system for operating things such as residential facilities (maltreatment is a risk factor for delinquent behavior), long-term mental health and health care costs for adults who are victims as children, costs to the adult criminal justice system due to the link between earlier child maltreatment and violent crimes. Lost productivity to society makes up the greatest share of the roughly $70 billion of indirect costs, estimated by Wang and Holton to be over $30 billion. [6]

What are promising strategies for preventing abuse and neglect?

Many approaches have been developed to attempt to prevent child abuse and neglect. They may seek to prevent the risk factors listed above from developing. They may also seek to put protective factors in place for children and families, or strengthen protective factors that are already present in children's lives. Some strategies are universal approaches (primary prevention) meant to reach all corners of society while others are individual approaches that target at-risk groups (secondary prevention) or families where abuse has previously occurred (tertiary prevention). Examples of promising practices include:

- public awareness and education,
- skill-based curricula or life skills training for children and youth,
- parent education programs,
- home visitation programs
- family support services including respite or crisis care,

Below, we describe some of these practices in more detail and review evidence of their effectiveness.

Primary Prevention

With the broadest reach, ***public awareness activities*** are one of the more common approaches to preventing child abuse and neglect. Through various methods including public service announcements, information kits and brochures, and TV/other media content, sponsors of public awareness campaigns can reach a broad audience to promote healthy parenting practices and inform the public about what can and should be done when maltreatment is suspected. *[2]*

Few rigorous evaluations have attempted to measure the effect of public awareness campaigns on preventing child abuse and neglect per se. Instead, impact is most commonly measured by methods designed to measure exposure to the campaign or activity (e.g., telephone surveys asking community members if they remembered seeing campaign materials) and through increased contacts made to the campaign sponsor or designated prevention organization (e.g., increased calls made to prevention and reporting hotlines). For example, an evaluation of a multimedia campaign to promote awareness and understanding of the link between addiction and child abuse was found to be responsible for 62% increase in the average monthly number of calls made to telephone hotline for child abuse and neglect, though the actual impact on abuse and neglect prevention was not assessed. *[7]*

Perhaps the most widely studied use of public education and awareness campaigns related to child abuse and neglect have been those focused on preventing shaken baby syndrome. Public awareness campaigns first started appearing in the 1980's with a more organized, national effort starting in 1992 and funded by the National Center on Child Abuse and Neglect (NCCAN), which spread the message "Never Shake a Baby." An evaluation of NCCAN's three year project to educate the public about the dangers of shaking a baby found that one-third of people who gave feedback on the educational materials reported that this was the first time they been informed on this topic *[8]*. In other words, there is some research on whether this strategy reaches audiences and whether audiences gain information, but we know little about whether it actually prevents child maltreatment.

Skill-based curricula for children and parent education programs and support groups can be provided universally or can be targeted for at-risk children and parents. ***Skill-based curricula for children*** seek to teach children skills they can employ to keep themselves safe, such as being able to distinguish if they have been touched appropriately or inappropriately and what they should do if they experience the latter. The Safe Child Program is one example of a skill-based curriculum for children with the goal of preventing sexual, emotional, and physical abuse of children. Evaluations of the program have found it to be successful in teaching children skills to help them avoid being victims of abuse including how to speak up for themselves, how to recognize dangerous situations or inappropriate behavior by other people, and knowing where and how to get help (read the Safe Child Program PPN program summary).

Parent education programs seek to help parents develop appropriate discipline techniques and to gain knowledge and understanding about age-appropriate behavior and expected developmental milestones. These programs also tend to have a component that helps parents learn the skills of identifying community resources that provide support to families, such as economic resources.

Numerous programs and curricula have been developed for these purposes. *[2]* One example of a program that provides parent education is the Chicago Child-Parent Centers (read the Chicago Child-Parent Centers PPN program summary), which combines enriched preschool, home visiting, and referrals of families to social services. In a 15-year follow-up study of the program, a significantly fewer number of children who had participated in

the program in preschool were the subjects of child maltreatment reports compared to preschoolers who had not participated. [9] Another promising parent education program focused on preventing shaken baby syndrome is the *Period of PURPLE Crying*, which attempts to help parents understand and cope with the stresses of normal infant crying. A randomized control trial of the program found that it succeeded in enhancing mothers' knowledge about infant crying and women who participated in the program were more likely to walk away in situations where an infant was crying inconsolably compared to control group mothers. [10] A recent meta-analysis conducted by the Centers for Disease Control and Prevention on training programs for parents with children ages zero to seven, identified components within parent training programs found to have a positive impact on acquiring parenting skills and behaviors and decreasing children's externalizing behaviors. The components that were found to positively impact the two program outcomes studied by the meta-analysis are displayed below:

Content and Program Delivery Components Found to Have a Positive Effect on Parent Training Program Outcomes	
Outcome 1: Acquiring Parenting Skills and Behaviors	Teaching parents emotional communication skills *(content component)*
	Teaching parents positive parent-child interaction skills *(content component)*
	Requiring parents to practice with their child during program sessions *(program delivery component)*
Outcome 2: Decreases in Children's Externalizing Behaviors	Teaching parents the correct use of time out *(content component)*
	Teaching parents to respond consistently to their child *(content component)*
	Teaching parents to interact positively with their child *(content component)*
	Requiring parents to practice with their child during program sessions *(program delivery component)*

Practitioners can use the study's findings when considering programs to implement or modifying programs they currently offer to emphasize the more effective components. [11]

Secondary Prevention

Several approaches that are more typically used with children and families who have known risk factors for abuse include home visitation programs, respite and crisis care programs, and family resource centers.

Home visitation programs are typically provided to pregnant women and families with new or young children. Through home visits and other personal contact, home visitation programs provide information about child development, positive parenting practices, and establishing social supports. Two prominent examples of home visiting programs are Nurse Family Partnership and Healthy Families New York. Both programs have an established evidence base showing that they are effective in reducing child abuse by parents. Evaluations of Nurse Family Partnership show that the program's impacts are sustainable many years after participants complete the program. In a nine year follow-up study, Olds et al. (2007) found that children who participated with their mothers in the program were less likely to die of preventable causes. [12] A recent evaluation of Healthy Families New York, which incorporates the Healthy Families America critical elements, found that mothers who participated in the program, including "psychologically vulnerable" mothers, reported committing one-quarter as many acts of serious abuse at age 2 compared to mothers in the study's control group. Also, compared to the control group mothers, young first-time mothers in the HFNY group who were randomly assigned at 30 weeks of pregnancy or less were less likely at the time their children were two years olds to engage in minor physical aggression in the past year (51% versus 70%) and harsh parenting in the past week (41% versus 62%). [13] (Read the Nurse Family Partnership and Healthy Families New York PPN program summaries).

Another common approach to child maltreatment prevention is ***respite and crisis care***. Respite and crisis care services provide short-term urgent services to families in crisis due to family illness or other emergency, or when a caregiver overwhelmed with stress needs a temporary place where the child can be cared for. Respite care is also used by caregivers of children already involved in the child welfare system, such as adult kinship caregivers, adoptive, and foster caregivers. While there have not been rigorous studies demonstrating that respite and crisis care prevent child maltreatment, there is some

research that shows these services reduce the risk factors and enhance the protective factors that are linked to child maltreatment. For instance, when a group of this type of caregiver who cared for children in the child welfare system with special needs was surveyed, respondents reported that using respite care reduced their feelings of stress, increased their feelings of being supported, and improved positive attitude toward children. *[14]* Overall, however, little evidence is available demonstrating the strategies' ability to prevent child abuse and neglect.

Respite care is often provided in the context of ***family resource centers***. Family resource centers can provide a wide range of formal and informal services to families in need, such as parent skill training, job training, substance abuse prevention, mental health or family counseling, and financial support services (e.g., meeting basic needs, housing, etc.). The services offered by the centers are tailored to the needs of the families it serves and the surrounding community. *[2]* Despite the popularity of centers like these, the literature does not contain rigorous evaluations of the effectiveness of family resource centers in preventing child maltreatment.

Evidence for Promoting Prevention

Several studies have synthesized existing studies of child maltreatment prevention programs. A meta-analysis conducted by the Washington State Institute for Public Policy (Lee, 2008) found evidence of the effectiveness of several prevention programs. Their analyses also found that for several of the effective programs, the costs of the programs were significantly lower than the achieved benefits. *[15]* An older meta-analysis from Abt Associates, Inc., which included a range of family support approaches, found that as a whole the effect of the programs on child abuse and neglect outcomes was relatively small. *[16]*

The Promising Practices Network provides summaries of several programs that have been rigorously evaluated and found to have a positive impact on preventing child abuse and neglect. (Read the PPN program summaries of Child Abuse and Neglect Prevention and Treatment programs.) PPN has also reviewed several compendia that provide evidence-based information about programs that have been found to prevent child abuse and neglect, or mitigate its consequences. Two of the reviewed compendia used similar criteria for evaluating a program's evidence. These are Child Trends' LINKS and the Department of Health and Human Services' *Emerging Practices in the Prevention of Child Abuse and Neglect*. Read more about these compendia in the Child Abuse and Neglect Resources and Tools section of the site.

References

1. U.S. Department of Health and Human Services, Administration on Children, Youth and Families. *Child Maltreatment 2006* (Washington, DC: U.S. Government Printing Office, 2008). [As of March 2009, available at: http://www.acf.hhs.gov/programs/cb/pubs/cm06/cm06.pdf]

2. U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. *Emerging Practices in the Prevention of Child Abuse and Neglect.* (Washington, DC: U.S. Government Printing Office; 2003. [As of March 2009, available at: http://www.childwelfare.gov/preventing/programs/whatworks/report/]

3. Child Trends, *The Multiple Dimensions of Child Abuse and Neglect: New Insights into an Old Problem*, May 2002. [As of March 2009, available at: http://www.ddcf.org/doris_duke_files/download_files/ChildAbuseRB.pdf]

4. FPG Child Development Institute at UNC-Chapel Hill, *After Abuse: Early Intervention Services for Infants and Toddlers*, August 2008. [As of March 2009, available at: http://www.fpg.unc.edu/~snapshots/Snap54.pdf]

5. Widom, C., Czaja, S., and Dutton, MA (2008). "Childhood Victimization and Lifetime Revictimization," *Child Abuse and Neglect*, v32, n8, p785-796.

6. Wang, C-T and Holton, J. "Total Estimated Cost of Child Abuse and Neglect in the United States," *Prevent Child Abuse America*, Chicago, IL. September 2007. [As of March 2009, available at: http://www.preventchildabuse.org/about_us/media_releases/pcaa_pew_economic_impact_study_final.pdf]

7. Andrews, A.B., McLeese, D.G., Curran, S. (1995). "The Impact of a Media Campaign on Public Action to Help Maltreated Children in Addictive Families," *Child Abuse & Neglect*, v19, n8, p921-932.

8. Showers, J. (2001). Chapter Seventeen: Preventing Shaken Baby Syndrome, *Journal of Aggression, Maltreatment & Trauma*, v5, n1, p349-365.

9. Reynolds, A.J., Temple, J.A., Robertson, D., and Mann, E. (2001). "Long-Term Effects of an Early Childhood Intervention on Educational Attainment and Juvenile Arrest," *Journal of the American Medical Association*, v285, n18, p2339-2346.

10. Barr, R.G., Barr, M., Fujiwara, T., Conway, J., Catherine, N., Brant, R. (2009) "Do Educational Materials Change Knowledge and Behaviour about Crying and Shaken Baby Syndrome? A Randomized Controlled Trial," *Canadian Medical Association Journal*, v180, n7, p 727-733.

11. Centers for Disease Control and Prevention. *Parent Training Programs: Insight for Practitioners*. Atlanta (GA): Centers for Disease Control; 2009. [As of June 2009, available at: http://www.cdc.gov/ViolencePrevention/pdf/Parent_Training_Brief-a.pdf]

12. Olds, D., Kitzman, H., Hanks, C., Cole, R., Anson, E. Sidora-Arcoleo, K., Luckey, D.W., Henderson, C.R., Holmberg, J., Tutt, R.A., Stevenson, A.J., and Bondy, J. (2007). "Effects of Nurse Home Visiting on Maternal Life Course and Child Development: Age 9 Follow-up Results of a Randomized Trial," *Pediatrics*, Vol. 120, n4, p e832-e845.

13. DuMont, K., Mitchell-Herzfeld, S., Greene, R., Lee, E., Lowenfels, A., Rodriguez, M., & Dorabawila, V. (2008). "Healthy Families New York (HFNY) Randomized Trial: Effects on Early Child Abuse and Neglect," *Child Abuse & Neglect*, v32, p 295-315.

14. Owens-Kane, Sandra (2007). "Respite Care: Outcomes for Kinship and Non-Kinship Caregivers." *Journal of Health & Social Policy*, Vol. 22, No. 3/4, 2007, pp. 85-99.

15. Lee, S., Aos, S., Miller, M. (2008), *Evidence-Based Programs to Prevent Children from Entering and Remaining in the Child Welfare System: Benefits and Costs for Washington,* Olympia: Washington State Institute for Public Policy, Document No. 08-07-3901. [As of March 2009, available at: http://www.wsipp.wa.gov/rptfiles/08-07-3901.pdf]

16. Abt Associates, Inc., *National Evaluation of Family Support Programs; Volume A: The Meta-Analysis: Final Report*, April 2001. [As of June 2009, available at: http://www.abtassociates.com/reports/NEFSP-VolA.pdf]

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Kidsdata Overview by Barbara Needell

Kidsdata.org, a program of the Lucile Packard Foundation for Children's Health, is a public service that promotes the health and well being of children by making a wide range of trustworthy information easily accessible to policymakers, service providers, grantseekers, media, parents, educators, and others who influence kids' lives.

The kidsdata website allows users to find, customize, download, and share data on more than 400 measures related to child health and well being. Data are available for every county, city, school district, and legislative district in California. User-friendly displays make it easy to incorporate data from more than 35 trusted public sources into reports, presentations, grant proposals, policy decisions, media stories, and advocacy work. In addition, kidsdata.org summarizes the significance of each topic, offers policy implications, and assembles key links to related websites and research.

The Lucile Packard Foundation for Children's Health operates kidsdata.org to raise the visibility of key issues affecting California's children, and to make it easy for leaders to use data in their work, whether that's assessing community needs, setting priorities, tracking progress, making program/policy decisions, or identifying new areas of concern.

Visit kidsdata.org, and sign up to receive custom e-mail notices when data of interest to you are updated.

kidsdata.org

We've got your numbers.

Things to Know About Kidsdata.org

- Kidsdata.org is a comprehensive website that tracks hundreds of indicators on the health and well being of children in California from numerous recognized data sources.
- Data on the site are continually updated, and can be customized by year, locale, ethnicity, age, and more. The results can be viewed as tables, maps, or bar, trend, and pie graphs then downloaded into Word, PowerPoint, or Excel.
- The site's charts, graphs, and maps can help tell your story in grant proposals, research reports, presentations, public education, advocacy campaigns, and other work on behalf of children.
- The site provides descriptions detailing why each issue is important and what the data mean, as well as policy implications and links to key websites and research.
- Kidsdata.org raises the visibility of key issues affecting California's children, and provides data that help communities make decisions on issues that affect children by enabling policymakers to set priorities, track progress, and identify new areas of concern.
- The site promotes the well being of children by making pertinent, trustworthy information easily accessible to parents, policymakers, service providers, grantseekers, media, educators, and others who influence the lives of children.

A Sample of Data on Kidsdata.org

Kidsdata.org offers access to data for cities, school districts, and counties statewide, so you can assess how children in your area are faring compared to neighboring communities and to similar locales across California.

***A sample of our topics**:*

- **Alcohol, Tobacco & Other Drug Use**
- **Asthma**
- **Bullying & Harassment**
- **Child Abuse & Neglect**
- **Child Care**
- **Demographics**
- **Emotional Health**
- **Environmental Health**
- **Foster Care**
- **Gang Involvement**
- **Health & Dental Care**
- **High School Dropouts**
- **Immigration**
- **Juvenile Arrests**
- **Nutrition & Weight**
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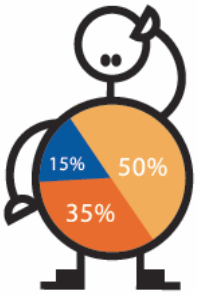
- **Poverty**
- **Reading & Math Proficiency**
- **School Safety**
- **Special Health Care Needs**
- **Teen Sexual Health**



For additional information, contact us at kidsdata@lpfch.org. Kidsdata.org is a project of the Lucile Packard Foundation for Children's Health.

Visit kidsdata.org

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Lucile Packard FOUNDATION for Children's Health

Session III

Selected Programs Furthering Prevention and Protection

Pregnancy and parenting among youth in foster care: A review
Deborah v. Svoboda, Terry V. Shaw, Richard P. Barth, Charlotte Lyn Bright
Children and Youth Services Review 34 (2012) 876-875

For those interested in reading more on this topic, see Shaw, Barth, Svoboda and Shaikh, *Fostering Safe Choices Final Report*, U Maryland School of Social Work, 12/31/2010, http://www.thenationalcampaign.org/fostercare/PDF/Fostering_Safe_Choices.pdf

Children and Youth Services Review 34 (2012) 867–875

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Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth

Pregnancy and parenting among youth in foster care: A review☆

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ABSTRACT

Parenting during adolescence is often followed by a range of untoward outcomes of young parents and their children. The birth rate and experience of pregnancy and parenting for youth in foster care are, however, little studied. Emerging research suggests greater risk for early pregnancy or parenthood for this population. The research on possible reasons for this elevated risk is considered. This review reports the findings related to prevalence, risk factors, and protective factors for pregnancy and parenting among youth in foster care. Youth report their motivations for parenting and barriers to preventing pregnancy. Child welfare workers and administrators report lack of policy and practice guidance related to pregnancy prevention and reproductive healthcare for youth in foster care.

Contents

1. Introduction

While recent prevalence data suggest a decrease in births from 15 to 19-year-old females in the United States (Hamilton, Martin, & Ventura, 2010), adolescent parenthood remains a concern due to documented poor outcomes. Adolescent mothers are at risk of increased incidence of depression in young adulthood (Barnet, Liu, & DeVoe, 2008; Kalil & Kunz, 2002), have lower educational attainment and less economic success than similar youth (Boden, Fergusson, & Horwood, 2008; Serbin et al., 2004), are more likely than older women to experience problems in pregnancy (Beers & Hollo, 2009), and use harsher parenting methods (Lee, 2009).

The children of adolescent parents have higher risk of infant mortality (Phipps, Sowers, & DeMonner, 2002), may be more likely to experience child maltreatment (Lee & Goerge, 1999), and have a higher risk of death (Overpeck, Brenner, Trumble, Trifiletti, & Berendes, 1998). Children born to adolescent parents are observed to have more reported behavioral problems (Jaffee, Caspi, Moffitt, Belsky, & Silva, 2001) and have higher rates of educational and school related difficulties (Jaffee et al., 2001). Children of adolescent parents report lower overall life satisfaction (Lipman, Georgiades, & Boyle, 2011) and are, themselves, more likely to engage in risky sexual behaviors in adolescence (Jaffee et al., 2001; Levine, Emery, & Pollack, 2007; Phipps et al., 2002).

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While the overall adolescent birth rate appears to be declining, disparate birth rates by race and origin persist, with higher birth rates respectively for American Indian/Alaska Native (55.5 per 1000), African–American (59 per 1000), and Hispanic (70.1 per 1000) young women compared to their Non-Hispanic White peers (25.6 per 1000) (Hamilton et al., 2010). Just as adolescent parenthood is disproportionately dominated by minority youth, so is foster care. Minority youth make up approximately half of all youth in out-of-home care supervised by child welfare services (U. S. Department of Health and Human Services, 2010) but only 24% of youth under 18 in the general population (U. S. Census Bureau, 2011). This suggests that, all else being equal, the foster care population will have higher birth rates than the population in general due to the extant disproportional representation. One study in Maryland found that the birth rate for youth in foster care was almost three times the rate of the general population in Maryland (92.7 births per 1000 girls compared to 32.7 births per 1000 girls overall) (Shaw, Barth, Svoboda, & Shaikh, 2010).

As interest in adolescent pregnancy and parenting in child welfare populations grows, scholars and practitioners in this area have begun to address the gaps in our understanding through prevalence studies (Courtney & Dworsky, 2006; Love, McIntosh, Rosst, & Tertzakian, 2005), prevention campaigns (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2010), and sex education programs focused on foster youth (Becker & Barth, 2000). The dialog related to pregnancy prevention or sexual activity among youth in care predominately assumes heterosexuality of youth, with a consistent oversight of the risks for early pregnancy for youth who identify themselves as lesbian, gay, bisexual, transgendered, or queer (LGBTQ). Youth in foster care are in a unique position of trying to meet the challenging psychosocial and sexual demands of adolescence while engaged with various child welfare staff, providers, and/or foster parents through potentially numerous placements, schools, friends, and neighborhoods (Love et al., 2005; Pryce & Samuels, 2010); they might be considered an especially vulnerable population with a high risk of early parenthood and the least prepared to cope with that parenthood when it occurs.

According to the most recent report from the Adoption and Foster Care Analysis Reporting System (AFCARS), there were 408,425 children living in an out-of-home placement in the foster care system in the United States on September 30, 2010 (U.S. Department of Health and Human Services et al., 2011). Of these children in foster care, approximately 32% were in the reproductive age group of 14 to 20 years of age. Typically the backgrounds of foster youth include a history of neglect or physical, sexual or emotional abuse (Stock, Bell, Boyer, & Connell, 1997). Many are under juvenile court supervision and enter out-of-home care as a result of their behavioral problems in the home (Barth, Wildfire, & Green, 2006). Others develop more intensive behavioral health problems following the experience of multiple years and placements in foster care (Newton, Litrownik, & Landsverk, 2000). Although direct research on the pregnancy risks among foster youth is not available, much of the foster care population has experienced trauma and behavioral health issues associated with higher risk of pregnancy (Barnet et al., 2008; Kirby, 2002; Mollborn & Morningstar, 2009).

In an effort to prevent pregnancies among youth in foster care, child welfare professionals, policy makers, and scholars are faced with deciphering the prevalence, scope, and factors related to adolescent pregnancy. While qualitative studies have revealed that some adolescent women plan a pregnancy or intend to have a child (Dworsky & DeCoursey, 2009; Love et al., 2005; Pryce & Samuels, 2010), this review focuses on what researchers have learned thus far about unplanned early parenthood for youth in foster care. Our understanding of the prevalence and incidence of first and subsequent pregnancies, abortions, and births for young women who are in foster care is limited given the lack of consistent and standardized documentation. Even less is known of the scope of involvement in teen pregnancy and parenting by young men in foster care. To begin to address these gaps in the literature, the following review is a synthesis of findings related to prevalence of, and risk and protective factors related to, adolescent pregnancy and parenting among child welfare-involved youth.

2. Method

The review includes an examination and synthesis of the key findings and recommendations from studies of pregnancy or parenting among youth in foster care. Studies published in peer-reviewed journals from 1989 through 2010 and non-peer reviewed research reports (or white papers) from research institutes and government departments were considered for review. Inclusion criteria for this review required the study to focus on youth in foster care either entirely or as a subset of the sample. While studies from other countries are no doubt informative, this review is limited to samples from the United States because of international contextual differences in child welfare policy and practice. Those studies that duplicated findings from the same data set were not included in the review. Databases searched included Google Scholar, Academic Search Premier, Social Service Abstracts, and Sociological Abstracts. Search terms included “foster care” AND “youth” OR “teen(s)” OR “adolescent(s)” AND “pregnancy” OR “pregnancy prevention” OR “sexual behavior”. A hand search from key studies was also conducted. A final sample of 16 empirical studies was located and met inclusion criteria.

The studies chosen for the review are diverse in their methodology and strengths, although common themes across the studies' findings are enumerated following the results. The profile of the reviewed studies is a combination of research designs, various sample populations, and methods with mixed results (Table 1). The various designs include experimental, observational, and descriptive. The samples range from youth in out-of-home care, youth transitioning from foster care, adults formerly in foster care, child welfare personnel, and foster care parents and providers. The various sources of data were collected from administrative data, survey and structured interviews, on-line surveys, and focus groups.

A summary of the key findings and recommendations relevant to pregnancy among youth in foster care are presented here jointly in an effort to reach a diverse audience and to spur future research. Following the summaries, common themes and nuances of results are presented, closing with a discussion on future research.

3. Results

In an effort to identify risk behaviors including the prevalence of unplanned pregnancy, James, Montgomery, Leslie, and Zhang (2009) conducted an analysis of National Survey of Child and Adolescent Well-Being (NSCAW) data including a subset of 877 youth aged 11 or older, and for which sexual risk behaviors were recorded using the social development model as a theoretical framework. Of the girls who were sexually active, 39.3% had been pregnant at some time in their lives, with over one half of the pregnancies ending in childbirth with an additional quarter of these girls indicating having a second child. Factors such as inconsistent relations with trusted adults, placement changes, mental health problems, and developmental needs were identified as barriers for youth in foster care to building relationships that include conversations and assistance to prevent unplanned pregnancy.

Health risk behaviors were examined by Leslie et al. (2010), who also used a subsample of the NSCAW study to examine the health risk behaviors (including pregnancy) of youth between ages 11 and 15. A total of 993 youth of both genders were included in the study. Of the sample, 0.7% of the eleven year olds, 4.3% of the twelve to fourteen year olds and 18.7% of the fifteen year olds reported being pregnant or causing a pregnancy. Additionally, a higher percentage of girls

Table 1
Summary of reviewed studies.

Study	Population/sample	Summary
Carpenter, S. C., Clyman, R. B., Davidson, A. J., & Steiner, J. F. (2001). The association of foster care or kinship care with adolescent sexual behavior and first pregnancy. *Pediatrics*, *108* (3), e46	Data on women in the 1995 National Survey of Family Growth (NSFG). A total of 89 women reported foster care placement, 513 reported kinship care placement, and 9018 did not report either type of placement.	More females in foster care and kinship care reported unwanted sexual experiences before the age of 18 compared to the comparison group (17.7% for foster care and 12.5% for kinship care compared to 8.1%, respectively). Females in foster care and kinship care were on average younger at first conception (given ages − 11.3 months and 8.6 months respectively); and, being in out-of-home care was a predictor of having higher than the median number of sexual partners (foster care OR: 1.7, 1.0–2.8 and kinship care OR: 1.4, 1.1–1.8).
Collins, M.E., Clay, C. M., & Ward, R. (2007). *Leaving care in Massachusetts: Policy and supports to facilitate transition to adulthood.* Boston, MA: Boston University School of Social Work.	Massachusetts DSS administrative data on 812 youth who turned 18 in 2005. Surveys with 96 youth who aged out of foster care. Interviews with 16 youth who returned to foster care after the age of 18.	Analysis of administrative data from MA Department of Social Services and a survey of former foster youth found 43% had been pregnant or had caused someone to get pregnant.
Constantine, W. L., Jerman, P., & Constantine, N. A. (2009). *Sex education and reproductive health needs of foster and transitioning youth in three California counties.* Public Health Institute, Center for Research on Adolescent Health and development. Retrieved from: http://teenbirths.phi.org/.	Qualitative study consisting of focus groups, interviews and surveys. Respondents included former foster youth (n = 21), caregivers (n = 6), child welfare workers (n = 58), administrators (n = 9) and public health nurses (n = 5).	Findings reflect common themes from prior research related to access to information, services and relationships with caregivers and staff. Responses to the four areas of questioning include: lack of attention to the sexual and reproductive health needs of youth in care, lack of clear guidance; consistent messages, and policy for staff as to their role in addressing these needs; limited knowledge by staff as to current contraception methods and risks of sexually transmitted infections; and lack of comfort by staff and foster parents to address sexual and reproductive health for the youth in their care.
Courtney, M. E., & Dworsky, A. (2006). Early outcomes for young adults transitioning from out-of-home care in the USA. *Child and Family Social Work*, *11*(3), 209–219.	A report from the second round of the Midwest Study, interviewing youth around their 19th birthday, 282 are being supervised by the state and 321 who had left out-of-home care.	Youth who remained under supervision of the state child welfare system appeared to have an increase in positive outcomes in the majority of the domains over those youth who did not choose to remain under the supervision of the state after their 18th birthday including higher incidence of pregnancy and parenting.
Dworsky, A., & DeCoursey, J. (2009). *Pregnant and parenting foster youth: Their needs, their experiences.* Chicago: Chapin Hall Center for Children at the University of Chicago.	Descriptive study of the experiences of 2950 youth of both genders who were pregnant or parenting while in care of the Teen Parenting Service Network (TPSN).	Of the children born to TPSN foster youth, 11% of the mothers' children and 4% of the fathers' children were placed in care due to child abuse or neglect. Interviews revealed difficulties in engaging youth in services available to them, such as the Independent Living Placement Services, prenatal care, contraception, and family planning.
Gotbaum, B. (May, 2005). *Children raising children: City fails to adequately assist pregnant and parenting youth in foster care.* New York: Public Advocate for the City of New York.	An exploratory survey of foster care agencies in New York City (65% response rate) and representing approximately 57% of the children in foster care.	One in six of the foster girls were pregnant or parenting, with 82% of the mothers caring for their child(ren). Over half of the agencies reported no training in place for foster youth related to parenting and care of their children.
Haight, W., Finet, D., Bamba, S., & Helton, J. (2009). The beliefs of resilient African-American adolescent mothers transitioning from foster care to independent living: A case-based analysis. *Children and Youth Services Review*, *31*, 53–62.	Qualitative intensive study of 3 African American women transitioning from foster care.	The interviews, writings, and participant observations revealed themes such as children acting as motivators for success, stability, and maturing; parenting as a challenge financially, and responsibility-wise; teen parenthood eliciting negative responses from caseworkers and others in authority; fear of losing their children to the child welfare system; and identifying individuals, spiritual beliefs, cultural beliefs, and practical programs that were supportive.
James, S., Montgomery, S. B., Leslie, L. K., & Zhang, J. (2009). Sexual risk behaviors among youth in the child welfare system. *Children & Youth Services Review*; *31*: 990–1000.	Data on 877 youth of both genders between ages 11 and 14 at baseline from the National Survey of Child and Adolescent Well-being (NSCAW) were used to examine sexual risk behaviors over a 36 month period.	The authors looked at three groups within the overall sample. The full sample with both genders (n = 877), a sexually active sub-sample of both genders (n = 417), and a female only sample (n = 500). Multivariate analysis suggested that age (OR = 2.17, CI 1.60, 2.94), evidence of delinquency at baseline (OR = 1.08, CI 1.03, 1.14), and having deviant peers at baseline (OR = 3.30, CI 1.45, 7.50) led to higher odds of self-reported consensual sexual intercourse, while the presence of caregiver monitoring (OR = 0.58, CI 0.34, 0.99) decreased the odds. Caregiver connectedness (OR = 0.32, CI 0.14, 0.73) and religiosity (OR = 0.44, CI 0.23, 0.84) were shown to increase the odds of using protection during consensual sex (always/often use protection was the

(continued on next page)

Table 1 (*continued*)

Study	Population/sample	Summary
		reference group in the analysis). Among the female only group older girls (OR = 4.37, CI 2.09, 9.14) and having deviant peers at baseline (OR = 7.43, CI 2.27, 24.30) led to increased odds of pregnancy while caregiver education having a high school diploma or equivalent (OR = 0.15, CI 0.03, 0.84) or some college (OR = 0.12, CI 0.02, 0.87) decreased the odds of pregnancy.
Kerr, D. C. R., Leve, L. D., & Chamberlain, P. (2009). Pregnancy rates among juvenile justice girls in two randomized controlled trials of multidimensional treatment foster care. *Journal of Consulting and Clinical Psychology*, *77* (3), 588–593.	Two randomized controlled trials with girls mandated into group care. The 166 female participants were randomly assigned to either group care (n = 85) or to Multidimensional Treatment Foster Care (MTFC) (n = 81).	By the two-year follow-up, 26.9% of the MTFC sample had a reported pregnancy, compared with 46.9% of the group care sample, a statistically significant difference favoring MTFC. Findings supported the influence of the MTFC on first and subsequent pregnancies by youth in care.
Krebs, B., & de Castro, N. (1995). *Caring for our Children: Improving the foster care system for teen mothers and their children*. New York, NY: Youth Advocacy Center.	Cross sectional survey and focus groups with pregnant and parenting teens in out-of-home care (n = 73). Interviewed social workers and city officials (NYC).	Administrative data was not collected for pregnancies or births among youth in the foster care system. Data was available from the maternity residences and group homes revealing approximately 264 births to young women in foster care in 1994. Survey demographics found female teens residing in maternity group homes or mother/child placements represented diverse educational achievements, placement histories, ethnicities, and ages. These young women faced separation from their infants after birth due to lack of appropriate placements and a complicated placement process within the child welfare system.
Leslie, L. K., James, S., Monn, A., Kauten, M. C., Zhang, J., & Aarons, G. (2010). Health-Risk Behaviors in Young Adolescents in the Child Welfare System. *Journal of Adolescent Health*, *47*(1), 26–34.	Nationally representative sample from NSCAW. Of the 993 youth, half were male, half female.	Findings suggest that factors for both the general population and the high-risk population have similar characteristics that lead to higher rates of health-risk behaviors. Of the 993 youth, 4.3% of the 12 to 14 year olds (31/686) and 18.7% of the youth 15 and older (12/76) were either pregnant or had gotten someone pregnant.
Love, L. T., McIntosh, J., Rosst, M., & Tertzakian, K. (2005). Fostering hope: Preventing teen pregnancy among youth in foster care. Washington, DC: National Campaign to Prevent Teen Pregnancy.	An on-line survey was conducted for child welfare staff in twelve agencies, resulting in 371 respondents. Focus groups with 121 youth of both genders in foster care and 31 foster parents were conducted.	Parenting youth made up 58% of the focus group participants. Themes related to youth in foster care: a) a lack of important relationships for youth in care, b) youth identified that there are benefits to having a baby as a teen even though unplanned, c) there is pressure to be sexually active, d) information on sex and pregnancy is offered too late and too little, e) access to contraception may not result in use, f) youth sexual activity are based on present impulse even in the presence of long term goals, and g) males and females identified distrust between the sexes in relation to contraceptive use.
Max, J., & Paluzzi, P. (2005). Healthy Teen Network Summary Report: Promoting successful transition from foster/group home settings to independent living among pregnant and parenting teens. Washington, DC: Author.	Qualitative study using interviews with twelve key informants from foster care providers from across the country.	Findings from the interviews revealed assets and barriers in five areas of influence on youth, such as individual, family, peer, community and society. Individually, youth in the foster care system who are pregnant and/or parenting lead complex lives, they are in need of healthy relationships with their peers, services that address their multiple needs such as employment, housing, child care, and education, and increased attention to the needs of youth in care who are pregnant or parenting was beneficial to this particular group of youth.
Polit, D., Morton, T., & Morrow White, C. (1989). Sex, contraception and pregnancy among adolescents in foster care. *Family Planning Perspectives*, 21(5), 203–208.	Quantitative analysis of 177 youth currently in child welfare (90 in out of home care and 87 living at home with in-home services). Comparisons on rates of sexual experience were conducted using the National Survey of Young Women.	Youth still living at home were more likely to report being currently sexually active, though they also reported having greater understanding, access, and use of contraceptives. No significant difference in reported pregnancy or births was seen. Comparisons to the NSYW suggested that both groups (in-home and out-of-home) had higher rates of being sexually active (45.6% vs 29.6% for out-of home and 54.7% vs 35.4% for in-home). Additionally, the in-home group had significantly higher percentage of youth reporting they were ever pregnant (21.0% vs 9.3%). Both groups were found to score significantly lower on the birth control knowledge scale (8.2 vs. 11.4 for out-of-home and 9.6 vs. 10.9 for in-home).

Table 1 (*continued*)

Study	Population/sample	Summary
Pryce, J. M., & Samuels, G. M. (2010). Renewal and risk: The dual experience of motherhood and aging out of the child welfare system. *Journal of Adolescent Research*, *25*(*2*), *205–230.*	Qualitative interviews with 15 females who were pregnant or parenting at the time of the interview. Participants drawn from Wave 1 survey of the Midwest Evaluation of Adult Outcomes of Former Foster Youth.	The new mothers in the study struggled with the tension between their past experiences while simultaneously plotting a new course. The reality of the cost of failure came out during the discussions hi-lighting the amount of fore-thought that these young ladies had in place. The authors suggest that motherhood can be a source of healing for young women.
Sakai S., Lin, H., & Flores, G. (2011). Health outcomes and family services in kinship care. *Archives of Pediatrics & Adolescent Medicine*; 165(2): 159–165.	A sample of 1308 children of both genders entering out of home care from the National Survey of Child and Adolescent Well-being.	Children in kinship care have lower risks of behavior (RR = 0.59, CI[0.41,0.80]) and social skills problems (RR = 0.61, CI[0.40,0.87]). Additionally, kinship care was

reported having been pregnant (4.9%) than that of boys having caused a pregnancy (3.9%). Due to the high rate of health risk behaviors for these youth the authors posit the importance of early (before age 12) intervention at multiple levels (individual, peer, school, etc.) to develop protective factors within the youth and therefore lessen risk factors over time.

The rate of pregnancy has been reported in the results of a randomized control trial of an intensive foster care model (Multidimensional Treatment Foster Care: MTFC) of treatment for youth in the juvenile justice system, intended to reduce rates of pregnancy and other problematic behavior in comparison to traditional group care (Kerr, Leve, & Chamberlain, 2009). Although these youth were originally referred by juvenile services, not child welfare services, MTFC has now become a staple of child welfare services. Young women who were court mandated to out-of-home care were randomly assigned to the standard group care or the MTFC treatment model. Sexual activity and pregnancy were measured by self-reports and caregiver reports at a baseline interview and subsequent interviews at 12 and 24 months for Trial 1 participants. Trial 2 participants were interviewed at baseline, 6, 12, 18, and 24 months. By the two-year follow-up, 26.9% of the intervention sample had a reported pregnancy, compared with 46.9% of the group care sample, a statistically significant difference. Findings supported the influence of the intervention on reducing both first and subsequent pregnancies to youth in care.

An early Midwestern study by Polit, Morton, and Morrow White (1989) surveyed youth with child welfare involvement as to their sexual activity, occurrence of pregnancy, and contraceptive knowledge and use. Ninety youth placed in foster care and 87 youth retained in their homes by child welfare between ages 13 and 18 responded to the survey. Youth living at home reported being more sexually active (47% reporting they had ever had sexual intercourse voluntarily compared to 33% of the out-of-home respondents), but there were no significant differences in the percent of respondents reporting pregnancy and/or birth. Youth at home reported having more understanding (64% used contraceptives at most recent intercourse compared to 45% of the out-of-home respondents) and access to contraception (34% ever obtained contraceptives from a family planning clinic compared to 13% of the out-of-home respondents). A match to a demographically similar sample from the 1979 National Survey of Young Women (NSYW) to compare rates of sexual activity and knowledge of contraception, and subsequent comparisons, showed youth with child welfare experience had higher rates of ever having intercourse compared to the NSYW group (45.6% vs. 29.6% for out-of-home care and 54.7% vs. 35.4% for in-home). Youth in the NSYW scored higher on a scale designed to measure birth control knowledge (11.4% vs. 8.2% for out-of-home care and 10.9% vs. 9.6% for in-home), suggesting that youth with child welfare experience have less understanding of birth control while at the same time having higher rates of being sexually active.

Considering the incidence of pregnancy, births, parenting, and subsequent pregnancies for youth in foster care, scholars have incorporated mixed methods to learn the experience of youth in care in relationship to these life experiences. One of the early advocacy based reports that shed light on the experiences of pregnant and parenting girls in foster care was initiated in 1995 by a New York City (NYC) based advocacy group, Youth Advocacy Center (YAC) (Krebs & de Castro, 1995). The authors interviewed and surveyed youth in foster care, social workers, and officials related to the foster care system in NYC. The study was the first to document systematic problems for youth in care who gave birth or fathered a child while in out-of-home care in NYC, finding a lack of appropriate placement opportunities for female foster youth who were pregnant, and following the birth, for the mother and newborn. No records were maintained as to the number of youth in care who were pregnant or parenting in this study.

Advocates and service providers in NYC once again addressed the question of what was happening to young mothers in foster care following a tragic death of an infant whose mother was then in foster care (Gotbaum, 2005). The survey by the Public Advocate's Office for the City of New York reached 57% of the foster care population in New York and revealed that 16% of the females were either pregnant or parenting. The findings recorded insufficient services for girls in foster care who were pregnant or parenting, with 3 out of 4 young mothers not placed in Mother/Baby Foster Care due to lack of space and a continued practice of separation of mother and infant (Gotbaum, 2005).

A mixed methods study sought to broaden understanding of the experiences of youth in foster care with unplanned pregnancies and their prevention. The Uhlich Children's Advantage Network (UCAN) conducted focus groups with 121 parenting and non-parenting youth in foster care and 31 foster parents to learn their views on teenage sex and pregnancy (Love et al., 2005), learning that youth want to have close relationships with caring adults, including talking about sex. Youth identified positive consequences to having an unplanned pregnancy, and their desire to improve on their own parental abilities. The youth reported beliefs that a child should be born within a committed relationship between parents who have financial stability, education, and the ability to care for the child. Surveys from child welfare workers captured the challenges to addressing pregnancy prevention with the youth in their care due to an absence of a defined role, clear policy, and plans to address pregnancy prevention among youth in care.

An in-depth qualitative study by Haight, Finet, Bamba, and Helton (2009) documents the perspectives of three African–American young women, ages 19 and 20, transitioning from foster care. The study was designed to understand the impact of an unplanned pregnancy and birth on young women while in foster care, and findings revealed overwhelming challenges and obligations in addition to discussions of the rewarding outcomes of motherhood. Pregnancy and birth of a child were motivating factors for these young women to succeed, mature, and stabilize their lives. The transitioning foster youth identified their cultural backgrounds, spiritual beliefs, caring adults, and

programs with practical assistance as supportive factors in their feeling successful as a parent. The less positive experiences included financial burdens, negative attitude by some adults toward teen mothers, and fear of losing their children.

Experience in one's family was examined in relationship to parenting in a qualitative study by Pryce and Samuels (2010) with semi-structured interviews of 15 young women who were formerly in foster care. Two of the women were pregnant at the time of the interview and the remaining young women were parenting at least one child. The participants were 20 years old on average and had spent between 3 and 16 years in care. The unique life experiences of young women in foster care were contrasted with their counterparts without out-of-home placement, such as missing relationships with one's own mother and residency with multiple caregivers. Findings revealed that the young women had experienced unplanned pregnancies that resulted in heightened awareness to "get down to business" and "an increased 'drive' to achieve" (Pryce & Samuels, 2010, p. 214) when faced with the birth of their children. Pregnancy and parenting experienced by these young women provided a sense of purpose and value to their lives not experienced previously and an opportunity for reflection on the mothering experienced from biological and foster mothers. Although the young women expressed commitment to care for their own children differently than they were cared for, the authors noted the difficulties in developing identities as emerging adults for the young parents, as well as poverty and histories of trauma that influenced the ability of the young women to parent successfully.

Using multiple sources of information, a three county California study assessed the overall reproductive health service needs for youth in foster care (Constantine, Jerman, & Constantine, 2009). The study consisted of focus groups, interviews and surveys with former foster youth (n = 21), caregivers (n = 6), child welfare workers (n = 58), administrators (n = 9) and public health nurses (n = 5). Findings reported the lack of policies and protocols to guide the child welfare workers, the lack of training on reproductive health needs for youth in foster care, and the limited comfort among child welfare workers to address sexuality and reproductive health matters with the youth under their supervision.

A series of interviews with 12 professionals directs attention to what can be learned from foster care providers about existing or needed supports for parenting or pregnant youth (Max & Paluzzi, 2005). On an individual level, the providers identified pregnant and/or parenting youth in the foster care system as leading complex lives with insights and experiences that can provide valuable input into programming that meets their needs. On a family level, consistent relationships with trusting adults were reported as assisting in healthy development for youth while the presence or absence of biological family members were seen as barriers. On a peer level, healthy relationships with peers and significant others are assets although often youth are seen as connected to unhealthy peer relationships. Youth in foster care who are pregnant or parenting tend to transition better to adulthood when comprehensive services are available given the obstacles they face in that transition for employment, housing, mental and physical health services, and child care needs. Finally, on a social level those care providers reported increased attention on pregnant and parenting youth aids in attending to the needs of foster youth, although the specific population faces additional challenges.

The Midwest Evaluation of the Adult Functioning of Former Foster Youth (The Midwest Study) is a longitudinal study with youth "aging out" of the foster care system in Illinois, Wisconsin, and Iowa (Courtney & Dworsky, 2006). Survey data from the second wave of data collection with young adults who were or formerly were residing in out-of-home placements was compared to data from the 2002 National Longitudinal Study of Adolescent Health (Add Health). Related to pregnancy history, nearly half of the Midwest Study participants had been pregnant prior to their 19th birthday compared to 20% of their peers.

Outcomes for youth who have transitioned from foster care and those who chose to return to care after reaching the age of 18 are documented in a study initiated by the state of Massachusetts Task Force on Youth Aging-Out of Department of Social Services (DSS) Care (Collins, Clay, & Ward, 2007). Data was collected from administrative records, interviews with stakeholders and youth, and a survey of youth who turned 18 years of age while in care. One of the outcomes examined included the reproductive health of the youth. Close to half of the survey respondents (43%) had been pregnant or gotten someone pregnant while in care and 15% reported having their children with them while in care. The study revealed significant needs parenting youth have for appropriate housing for themselves and their children, along with child care options and parenting skills training. Youth were consistent in their desire to have more input into their plans of care as they aged out of foster care; this sentiment was mirrored in the stakeholder interviews. Stakeholders reported the need for additional and age appropriate resources for this population, a youth development approach to service delivery, and independent evaluation of DSS services.

Using administrative data, Dworsky and DeCoursey (2009) described the experiences of youth in foster care who were pregnant or parenting while in care of the Teen Parenting Service Network (TPSN) from 1999 to 2006, a total service population of 2950. The study of the TPSN alumni included interviews with the youth, and representative caseworkers and program directors from each TPSN regional partner. The youth gave birth at an average age of 17.8 years, with one-third of young women giving birth before age 16. Approximately 30% of the TPSN female foster youth would have a second pregnancy. Interviews revealed difficulties in engaging youth in services available to them, such as the Independent Living Placement Services, prenatal care, contraception, and family planning. Pregnancy prevention was found to involve the same information and methods of delivery for all youth, including those with developmental delays, addictions, and mental health concerns.

Examining the outcomes for youth depending on their out-of-home placement was the focus of a secondary analysis of the 1995 National Survey of Family Growth (NSFG), representing approximately 9620 women who were in foster care between 1951 and the early 1990s (Carpenter, Clyman, Davidson, & Steiner, 2001). The authors compared pregnancy in women with three different childhood residential experiences: foster care, kinship care, and no out-of-home placement. They did not find a difference in the reproductive outcomes for women who had resided in foster care in comparison to those who lived in kinship care.

A second study comparing youth in foster care placement and those placed in kinship care examined the mental health and behavioral outcomes and access to health services for youth in care, along with the support services received by the kinship care and foster care providers, using data collected at three years post placement from the National Survey of Child and Adolescent Well-Being (NSCAW) (Sakai, Lin, & Flores, 2011). In stark contrast to the findings by Carpenter et al. (2001), the authors concluded that youth in kinship care had "nearly 7 times the risk of pregnancy (12.6% vs. 1.9%, respectively)" (p. 162) compared to youth in non-kinship foster care. The study revealed that the youth in kinship care were more likely to be living in a lower income household with more children in the house, and a care provider of an older age when compared to foster care. Characteristics of kinship care such as the lack of financial support for kinship care providers and the limited supportive services for kinship care providers were identified as areas in need of reform.

These studies begin to fill in the picture of pregnancy and parenting by youth in foster care in the U. S. While all these studies looked at pregnancy prevention for girls, only a few included male perspectives

(Collins et al., 2007; Dworsky & DeCoursey, 2009; Leslie et al., 2010; Love et al., 2005). Overall, results suggest that youth in foster care are less informed about pregnancy prevention methods (Polit et al., 1989), more sexually active (Carpenter et al., 2001; Polit et al., 1989), more likely than their peers to become pregnant prior to age 18, often more than once (Collins et al., 2007; Courtney & Dworsky, 2006; James et al., 2009; Leslie et al., 2010; Polit et al., 1989), and those who are informed and have access are not necessarily using prevention methods (James et al., 2009; Love et al., 2005). Barriers related to lack of protocol and support for case managers, foster parents, and care providers to address healthy sexual development were documented in focus groups and surveys as reasons for a lack of pregnancy prevention and contraceptive knowledge for youth in foster care (Constantine et al., 2009; Dworsky & DeCoursey, 2009). The reported experiences of youth in care ranged from perceived negligence on the part of the various systems involved in the placement of foster youth with their newborn (Dworsky & DeCoursey, 2009; Krebs & de Castro, 1995), to limited, sporadic, or delayed sex education and reproductive healthcare for youth in care (Constantine et al., 2009; Love et al., 2005).

4. Discussion

4.1. Common themes across studies

The literature demonstrates a consistency in the reports of the barriers and opportunities for youth in care, the diverse mental and physical health needs of youth, the influences of traumatic life experiences on sexual development, the influence of poverty, and the disruption of relationships and living environments for youth in foster care. Studies have revealed the lack of data collection, documentation, or reporting on the prevalence of pregnancy and/or parenting for youth who are in foster care (Gotbaum, 2005; Krebs & de Castro, 1995; Love et al., 2005). A common finding among studies is the lack of consistent documentation across jurisdictions and states to calculate the birth rate among youth in foster care. In addition, the lack of written policies and protocols to address prevention of pregnancy was reported by child welfare workers, former foster youth, and foster parents (Constantine et al., 2009; Love et al., 2005).

A consistent and important theme throughout the literature is the value of connections with a caring adult in the lives of youth in foster care. These adults could be members of the family, workers, or some other meaningful, consistent relationship that a youth has developed. Youth who remained under state supervision after the age of 18 were found to have a lower incidence of pregnancy than those who did not choose to remain in care (Courtney & Dworsky, 2006). Caregiver connectedness was related to increased contraceptive use and decreased odds of pregnancy (James et al., 2009). In focus groups youth cite the lack of a caring relationship with an adult as a barrier to gaining and acting on reproductive health information (Constantine et al., 2009; Haight, et al., 2009; Love et al., 2005; Max & Paluzzi, 2005).

Systematic analysis of administrative data reported the incidence of pregnancy among young women in foster care ranged from 16% in New York City (Gotbaum, 2005) to close to 50% of the recorded pregnancies in the Midwest Study (Courtney & Dworsky, 2006). Those studies with access to several state-wide or country-wide databases reported missing data and limitations in matching cases across databases of several state agencies such as vital statistics, Medicaid, and child welfare (Courtney & Dworsky, 2006; Dworsky &DeCoursey, 2009).

The motivations for youth to continue a pregnancy have been reported through qualitative interviews and focus groups with child welfare workers, foster parents, and youth currently or formerly in foster care. Such motivations have included the desire to have a family, to hold onto relationships with a boy/girlfriend, to parent in a way they did not experience, to be identified as an adult/mother in family of origin, to have “something” that belongs just to them, and to not abandon a baby as they felt abandoned (Constantine et al., 2009; Love et al., 2005; Pryce & Samuels, 2010). Youth reported the difficulties in parenting at a young age while in foster care due to limited housing for themselves and their child(ren), the negative stereotypes of young mothers, the added burdens to complete their education, their limited knowledge of caring for an infant, financial burdens, and the loss of teen experiences (Constantine et al., 2009; Haight et al., 2009; Pryce & Samuels, 2010).

4.2. Recommendations across studies

The literature highlights the uniqueness of the adolescent and emerging adult population placed in foster care. Overall, scholars have noted that youth in child welfare should be considered a high risk population for early unplanned pregnancy given prior research related to protective and risk factors (James et al., 2009; Leslie et al., 2010; Pryce & Samuels, 2010), and the youths' lived experiences and behaviors (Carpenter et al., 2001; Dworsky & DeCoursey, 2009; Pryce & Samuels, 2010). The limited knowledge of the prevalence of pregnancy and parenting among young women and men in foster care is furthered by the lack of consistent record keeping and reporting of pregnancy and its outcomes (Constantine et al., 2009; Krebs & de Castro, 1995). The studies in this review noted areas in need of development and further exploration related to 1) the development and clarification of policies and practices within the child welfare system, 2) the reproductive health and identity needs of youth in foster care, and, 3) considerations in developing pregnancy prevention programs for this population of youth.

4.2.1. Child welfare policy and practice

Researchers have concluded that child welfare professionals, care providers, and foster parents are seeking and would benefit from the establishment of clear, consistent policies and protocol related to their role and practices to promote positive reproductive and sexual health, including pregnancy prevention, among foster youth (Constantine et al., 2009; Love et al., 2005; Max & Paluzzi, 2005). Clear policies are needed to ensure that a full range of services are provided to pregnant youth, including but not limited to counseling on pregnancy options, prevention of subsequent pregnancies, and prenatal care resources (Collins et al., 2007; Constantine et al., 2009; Love et al., 2005). Once policies and protocol are in place, care providers, Independent Living Program caseworkers, child welfare staff, and foster parents need to be equipped with accurate information, training and support to regularly address issues of sexuality, safe sex, relationships, and decisions related to sex, with youth in their care along with the community resources to obtain healthcare services (Constantine et al., 2009; Haight et al., 2009). Policies related to the recruitment and training of foster parents and care providers should include the rights of youth in care to access information and services related to sex education and reproductive healthcare (Constantine et al., 2009; Love et al., 2005).

Policy and practice related to youth transitioning from foster care were addressed in a portion of the literature reviewed. Researchers recommended extension of services to youth up to age 21, including services to support pregnant and parenting youth transitioning out of care (Courtney & Dworsky, 2006; Dworsky & DeCoursey, 2009; Max & Paluzzi, 2005). Generally, in order to support the successful transition of youth out of the foster care system, youth in care need stability in their housing and personal relationships (Constantine et al., 2009; Gotbaum, 2005; Love et al., 2005). This may not be sufficient, however, to reduce unwanted or early pregnancies and births. These youth may also need a specific intervention related to reproductive health services. Former foster youth may also need additional parenting assistance as they are less likely to have families to provide

child care, respite, and helpful consultation about successful parenting practices than other young parents (Max & Paluzzi, 2005).

4.2.2. Prevention of unplanned pregnancy

Pregnancy prevention programs in child welfare need to take into consideration the motivations for youth to become parents and the role of sexual relationships with adolescent and adult men among young women in care (Constantine et al., 2009; Haight et al., 2009; Love et al., 2005; Pryce & Samuels, 2010). Foster parents and child welfare practitioners reported the value of support and mentoring for youth in foster care to build positive relationships, set future goals, and create alternatives to becoming a young parent (Constantine et al., 2009; Love et al., 2005).

Prior to the development of further prevention programs, scholars recommend comprehensive needs assessments be conducted on the available reproductive healthcare education for youth, child welfare practitioners, care providers, and foster parents, along with an assessment of the reproductive healthcare services available for youth in foster care (Constantine et al., 2009). Consequently, future development of age appropriate programs is needed to address prevention of initial and subsequent pregnancy (Dworsky & DeCoursey, 2009) for elementary and middle school age children prior to Independent Living Programs (Constantine et al., 2009; Love et al., 2005). Promising new findings from an intervention with girls in foster care making the transition to middle school shows that cognitive behavioral group work with foster parents and youth can reduce externalizing and internalizing problems which may later contribute to high risk behavior (Smith, Leve, & Chamberlain, 2011).

Expansion of pregnancy prevention programs to address multiple aspects of sexuality, including the characteristics of and capacity to build positive relationships with peers and dating partners as well as sexual identity development, would meet identified needs of foster youth and their foster parents (Constantine et al., 2009; Love et al., 2005; Pryce & Samuels, 2010). Pregnancy prevention programs targeting youth in care also need to undergo rigorous evaluation (Constantine et al., 2009, James et al., 2009; Love et al., 2005). Ideally, these programs should directly address issues related to the unique experiences and history of youth in foster care, as *Power Through Choices* does. It is also possible that programs which have been affirmatively tested with populations consistent with the local demographics of the adolescents in foster care (e.g., Becoming a Responsible Teen [St. Lawrence & Jackson State University Community Health Program, 1994], which was tested among African American youth in Mississippi, and Making Proud Choices [Jemmott, Jemmott, & Fong, 1998], which was tested among African American youth in Pennsylvania) may be as effective. If these programs prove ineffective, further research will be needed on the differences in beliefs and behaviors related to pregnancy by youth in foster care in relationship to their race, ethnicity, sexual orientation, gender, and age to inform the development of next generation prevention efforts, and provision of services for pregnant and parenting youth (Haight et al., 2009; Love et al., 2005).

Finally, the reviewed studies identified gaps in research and revealed common themes across studies. Future research is needed to understand the impact of abuse and neglect on overall reproductive health of youth in foster care. Research is needed to understand the role young men in out-of-home care play in adolescent pregnancy, along with an assessment of their parenting needs (Haight et al., 2009; Love et al., 2005). Interest in positive youth development programs and prior research supports further inquiry into the effectiveness of these programs to preventing pregnancy (Constantine et al., 2009; Max & Paluzzi, 2005).

4.2.3. Implications for future research, practice, and policy

In order to gain a clearer picture of the scope of unplanned pregnancy and its prevention among all youth in the U.S. foster care system, documentation of pregnancy, abortions, adoptions, live births, and parenting among young women and men in foster care is needed. In order to successfully document these factors it is important for state and local child welfare systems to develop inter-agency data sharing agreements with agencies overseeing health, mental health, and vital records. It is only through such collaborations that the true nature of issues surrounding births and pregnancy can be effectively understood, monitored, and acted upon. Future pregnancy prevention efforts directed at foster youth can best be implemented taking into consideration what we have learned from prior research as to the motivations for pregnancies, the barriers to prevention, and the protective factors identified by youth and child welfare professionals coupled with accurate and timely information related to the incidence and prevalence of pregnancy and parenting by the youth in foster care. The range of experiences related to pregnancy prevention for LGBTQ youth in foster care have yet to be documented and examined.

Common themes from qualitative studies have expressed the significance of consistent, engaged, and trustworthy adults in the lives of youth in foster care. These findings are not new. Advocates for youth, child welfare professionals, care providers, and youth themselves have agreed on this matter (Constantine et al., 2009; Love et al., 2005; Pryce & Samuels, 2010). According to the studies reviewed, future research, policy initiatives, and practice efforts are needed to focus on the protective factors for healthy sexual development for youth in foster care, including prevention of pregnancy.

5. Conclusion

The literature tells a consistent story of the specific and unique needs of foster youth related to the prevention of unplanned teen pregnancy. Foster youth have inconsistent relationships with adults, experience less stability in their living arrangements, have a history of trauma, and have on the whole less access to prevention messages than their peers outside of foster care. These barriers place foster youth at increased risk of becoming parents at an early age. The lack of consistent policies and guidance for child welfare workers and the dearth of training exacerbate an already challenging problem. The research evidence as to the increasing needs of youth in foster care, even with the consistency of message, has not led to focused federal or state attention to the issue of pregnancy prevention for youth in foster care. A text search undertaken as part of this analysis of the recorded state Child and Family Service Reviews (CFSR), Program Improvement Plans (PIPS) required of all state child welfare agencies (US DHHS, 2010), showed a complete lack of any discussion of issues related to pregnancy, pregnancy prevention, or family planning. In the years since the introduction of Child and Family Service Reviews (CFSRs), and the focus on the safety, permanency and well-being of children in foster care, child welfare agencies have been required to ensure that children receive necessary services. Although this requirement has arguably boosted the interplay among child welfare agencies, community resources and government programs across disciplines, such as education, mental health, medical care, and social outlets for youth in care, little discussion about family planning has yet resulted.

The difficulty in measuring the number of births to youth in foster care is behind much of the challenge in developing effective programs. Birth records hold the answers to many of the questions about the outcomes for foster youth who become parents. The integration of State Automated Child Welfare Information Systems (SACWIS) and birth records through data sharing agreements and inter-agency collaborative processes is a necessary step in understanding the scope of the problem and developing ways to measure success. State and federal agencies should take a leadership role in this issue and provide the necessary resources and regulatory requirements

related to defining, measuring and addressing issues of teen pregnancy in foster care. Data integration will lead to a rapid and sustainable growth in the knowledge base in this area. Then, inclusion of family planning, and pregnancy prevention in particular, should become a required element of the discussion of efforts to ensure child well-being.

References

Barnet, B., Liu, J., & DeVoe, M. (2008). Double jeopardy: Depressive symptoms and rapid subsequent pregnancy in adolescent mothers. *Archives of Pediatrics & Adolescent Medicine*, *162*(3), 246–252.

Barth, R. P., Wildfire, J., & Green, R. L. (2006). Placement into foster care and the interplay of urbanicity, child behavior problems, and poverty. *The American Journal of Orthopsychiatry*, *26*(3), 358–366, doi:10.1037/0002-9432.76.3.358.

Becker, M. G., & Barth, R. P. (2000). Power through choices: The development of a sexuality education curriculum for youths in out-of-home care. *Child Welfare*, *79*(3), 269–282. Retrieved from http://www.cwla.org/articles/cwjabstracts.htm

Beers, L. A. S., & Hollo, R. E. (2009). Approaching the adolescent-headed family: A review of teen parenting. *Current Problems in Pediatric and Adolescent Health Care*, *39*(9), 216–233, doi:10.1016/j.cppeds.2009.09.001.

Boden, J. M., Fergusson, D. M., & Horwood, L. J. (2008). Early motherhood and subsequent life outcomes. *Journal of Child Psychology and Psychiatry*, *49*(2), 151–160, doi:10.1111/j.1469-7610.2007.01830.x.

Carpenter, S. C., Clyman, R. B., Davidson, A. J., & Steiner, J. F. (2001). The association of foster care or kinship care with adolescent sexual behavior and first pregnancy. *Pediatrics*, *108*(3), 46. Retrieved from http://www.pediatrics.org/cgi/content/full/108/3/e46

Collins, M. E., Clay, C. M., & Ward, R. (2007). *Leaving care in Massachusetts: Policy and supports to facilitate transition to adulthood.* Boston, MA: Boston University School of Social Work. Retrieved from http://www.bu.edu/ssw/files/pdf/20080603-ytfinalreport1.pdf

Constantine, W. L., Jerman, P., & Constantine, N. A. (2009). *Sex education and reproductive health needs of foster and transitioning youth in three California counties.* Center for Research on Adolescent Health and Development. : Public Health Institute. Retrieved from http://teenbirths.phi.org/

Courtney, M. E., & Dworsky, A. (2006). Early outcomes for young adults transitioning from out-of-home care in the USA. *Child and Family Social Work*, *11*(3), 209–219, doi:10.1111/j.1365-2206.2006.00433.x.

Dworsky, A., & DeCoursey, J. (2009). *Pregnant and parenting foster youth: Their needs, their experiences.* Chicago: Chapin Hall Center for Children at the University of Chicago. Retrieved from http://www.chapinhall.org/sites/default/files/Pregnant_Foster_Youth_final_081109.pdf

Gotbaum, B. (May, 2005). *Children raising children: City fails to adequately assist pregnant and parenting youth in foster care.* New York: Public Advocate for the City of New York. Retrieved from http://www.nyc.gov/html/records/pdf/govpub/2708children_raising_children.pdf

Haight, W., Finet, D., Bamba, S., & Helton, J. (2009). The beliefs of resilient African–American adolescent mothers transitioning from foster care to independent living: A case-based analysis. *Children and Youth Services Review*, *31*, 53–62, doi:10.1016/j.childyouth.2008.05.009.

Hamilton, B. E., Martin, J. A., & Ventura, S. J. (2010). *Births: Preliminary data for 2009.* 59 (3). National Vital Statistics Reports. Hyattsville, MD: National Center for Health Statistics. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_03.pdf

Jaffee, S. R., Caspi, A., Moffitt, T. E., Belsky, J., & Silva, P. (2001). Why are children born to teen mothers at risk for adverse outcomes in young adulthood? Results from a 20-year longitudinal study. *Development and Psychopathology*, *13*(2), 377–397.

James, S., Montgomery, S. B., Leslie, L. K., & Zhang, J. (2009). Sexual risk behaviors among youth in child welfare system. *Children and Youth Services Review*, *31*, 990–1000, doi:10.1016/j.chldyouth.2009.04.014.

Jemmott, J. B., Jemmott, L. S., III, & Fong, G. (1998). Abstinence and safer sex HIV risk-reduction interventions for African–American adolescents: A randomized control trial. *Journal of American Medical Association (JAMA)*, *279*(19), 1529–1536, doi:10.1001/jama.279.19.1529.

Kalil, A., & Kunz, J. (2002). Teenage childbearing, marital status, and depressive symptoms in later life. *Child Development*, *73*(6), 1748–1760. Retrieved from http://www.jstor.org/pss/3696414

Kerr, D. C. R., Leve, L. D., & Chamberlain, P. (2009). Pregnancy rates among juvenile justice girls in two randomized controlled trials of multidimensional treatment foster care. *Journal of Consulting and Clinical Psychology*, *77*(3), 588–593, doi:10.1037/a0015289.

Kirby, D. (2002). Antecedents of adolescent initiation of sex, contraceptive use, and pregnancy. *American Journal of Health Behavior*, *26*(6), 473–485.

Krebs, B., & de Castro, N. (1995). *Caring for our children: Improving the foster care system for teen mothers and their children.* New York: NY: Youth Advocacy Center. Retrieved from http://www.youthadvocacycenter.org/pdf/CaringforOurChildren.pdf

Lee, Y. (2009). Early motherhood and harsh parenting: The role of human, social, and cultural capital. *Child Abuse & Neglect*, *33*(9), 625–637, doi:10.1016/j.chiabu.2009.02.007.

Lee, B. J., & Goerge, R. M. (1999). Poverty, early childbearing, and child maltreatment: A multinomial analysis. *Children and Youth Services Review*, *21*(9/10), 755–780, doi:10.1016/S0190-7409(99)00053-5.

Leslie, L. K., James, S., Monn, A., Kauten, M. C., Zhang, J., & Aarons, G. (2010). Health-risk behaviors in young adolescents in the child welfare system. *Journal of Adolescent Health*, *47*, 26–34, doi:10.1016/j.jadohealth.2009.12.032.

Levine, J. A., Emery, C. R., & Pollack, H. (2007). The well-being of children born to teen mothers. *Journal of Marriage & Family*, *69*(1), 105–122.

Lipman, E. L., Georgiades, K., & Boyle, M. H. (2011). Young adult outcomes of children born to teen mothers: Effects of being born during their teen or later years. *Journal of the American Academy of Child and Adolescent Psychiatry*, *50*(3), 232–241.

Love, L. T., McIntosh, J., Rosst, M., & Tertzakian, K. (2005). *Fostering hope: Preventing teen pregnancy among youth in foster care.* Washington, DC: National Campaign to Prevent Teen Pregnancy. Retrieved from http://www.thenationalcampaign.org/fostercare/resources.aspx

Max, J., & Paluzzi, P. (2005). *Promoting successful transition from foster/group home settings to independent living among pregnant and parenting teens.* Washington, DC: Healthy Teen Network. Retrieved from http://www.healthyteennetwork.org/vertical/Sites/%7BB4D0CC76-CF78-4784-BA7C-5D0436F6040C%7D/uploads/%7B00082110-F746-475C-B068-2B2069DEEFA4%7D.PDF

Mollborn, S., & Morningstar, E. (2009). Investigating the relationship between teenage childbearing and psychological distress using longitudinal evidence. *Journal of Health and Social Behavior*, *50*(3), 310, doi:10.1177/002214650905000305.

Newton, R. R., Litrownik, A. J., & Landsverk, J. A. (2000). Children and youth in foster care: Disentangling the relationship between problem behaviors and number of placements. *Child Abuse & Neglect*, *24*(10), 1363–1374, doi:10.1016/S0145-2134(00)00189-7.

Overpeck, M. D., Brenner, R. A., Trumble, A. C., Trifiletti, L. B., & Berendes, H. W. (1998). Risk factors for infant homicide in the United States. *The New England Journal Of Medicine*, *339*(17), 1211–1216.

Phipps, M. G., Sowers, M., & DeMonner, S. M. (2002). Research Support, Non-U.S. Gov't. *Journal Of Women's Health*, *11*(10), 889–897.

Polit, D., Morton, T., & Morrow White, C. (1989). Sex, contraception and pregnancy among adolescents in foster care. *Family Planning Perspectives*, *21*(5), 203–208.

Pryce, J. M., & Samuels, G. M. (2010). Renewal and risk: The dual experience of motherhood and aging out of the child welfare system. *Journal of Adolescent Research*, *25*(2), 205–230.

Sakai, S., Lin, H., & Flores, G. (2011). Health outcomes and family services in kinship care. *Archives of Pediatrics & Adolescent Medicine*, *165*(2), 159–165.

Serbin, L. A., Stack, D. M., De Genna, N., Grunzeweig, N., Temcheff, C. E., Schwartzman, A. E., & Ledingham, J. (2004). When aggressive girls become mothers: Problems in parenting, health, and development across two generations. In M. Putallaz, & K. L. Bierman (Eds.), *Aggression, antisocial behavior, and violence among girls: A developmental perspective* (pp. 262–285). New York, NY: Guilford Publications.

Shaw, T. V., Barth, R. P., Svoboda, D. V., & Shaikh, N. (2010). *Fostering safe choices: Final report.* School of Social Work, Ruth H. Young Center for Families and Children. Baltimore, MD: University of Maryland Baltimore. Retrieved from http://www.family.umaryland.edu/ryc_research_and_evaluation/child_welfare_research_files/FosteringSafeChoices_final_finalreport.pdf

Smith, D. K., Leve, L. D., & Chamberlain, P. (2011). Preventing internalizing and externalizing problems in girls in foster care as they enter middle school: Impact of an intervention. *Prevention Science*, *12*(3), 269–277, doi:10.1007/s11121-011-0211-z.

St. Lawrence, J. S., & Jackson State University Community Health Program (1994). *Becoming a responsible teen: An HIV risk reduction intervention for African–American adolescents.* Jackson, MS: Jackson State University Community Health Program.

Stock, J. L., Bell, M. A., Boyer, D. K., & Connell, F. A. (1997). Adolescent pregnancy and sexual risk-taking among sexually abused girls. *Family Planning Perspectives*, *29*(5), 200–227. Retrieved from http://www.jstor.org/stable/2953395

The National Campaign to Prevent Teen and Unplanned Pregnancy (2010). *Teen pregnancy prevention among youth in foster care multi-state project.* Retrieved from http://www.thenationalcampaign.org/fostercare/casey_project.aspx

U. S. Census Bureau (2001). Resident population by sex, race, and Hispanic-Origin status. Retrieved from http://www.census.gov/compendia/statab/2012/tables/12s0006.pdf

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, & Children's Bureau (2010). *Reports and results of the Child and Family Service Reviews (CFSRs).* Retrieved from http://library.childwelfare.gov/cwig/ws/cwmd/docs/cb_web/SearchForm

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Youth and Families, & Children's Bureau (2011). *Adoption and Foster Care Analysis and Reporting System (AFCARS) preliminary FY 2010 estimates as of June 2011 (18).* Retrieved from www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report18.htm

Summary of Research on Crisis Nurseries in the United States

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Background

Crisis nurseries in the United States evolved from a grassroots movement to develop immediate interventions for stressed caregivers of young children to prevent abuse and neglect and the need for out-of-home placements (De Lapp, Denniston, Kelly, & Vivian, 1998). Because crisis nurseries were established based on the family support needs of local communities, each crisis nursery offers a range of emergency and follow-up services that meet the unique needs of the caregivers and young children they serve.

Services: Crisis nurseries provide initial crisis assessment and intervention services (e.g., respite child care, caregiver counseling), after-crisis interventions such as follow-up care, and/or referral to other community services (Andrews, Bishop, & Sussman, 1999). The services are usually provided with no waiting period and often without charge to the client families.

Funding: The first crisis nurseries were funded by private donations and in-kind support from hospitals or other family service organizations (Clark, 1990). The Temporary Child Care for Children with Disabilities and Crisis Nursery Act of 1986, and the Child Abuse, Domestic Violence, Adoption and Family Services Act and Temporary Child Care for Children with Disabilities and Crisis Nurseries Act Amendments (1992) provided federal funding for establishing crisis nurseries. Forty-seven states in the United States obtained funding to establish a total of 175 crisis nurseries and two respite centers (ARCH National Respite Network and Resource Center, 1994).

Crisis Nurseries in Illinois: Five crisis nurseries were established in Illinois in 1985 with support from federal and state funding. Two of the five are independent 501-C-3, non-profit organizations. Three crisis nurseries are part of the services provided by an umbrella agency. A sixth nursery, established in Chicago in 2005 is also under another umbrella agency.

Evaluation

Aggregate Data Evaluation Studies. For nine years the crisis nurseries in Illinois provided descriptive and outcome data to the Illinois Department of Human Services (IDHS) based on a Crisis Nursery Survey developed by ARCH (ARCH National Respite Network and Resource Center, 2000). The first evaluation study was done in 2005 and analyzed the IDHS aggregate data from FY 2001 - 2004 (Cole et al., 2005). The results of these analyses showed that the demand for crisis nursery services was increasing in Illinois. The number of families served increased from 7,007 in FY 2001 to 10,282 in FY 2003. Although seeking assistance for parental stress remained high throughout the eight years, the complexity and severity of problems of caregivers shifted from school or job related issues to more serious issues such as home crisis, substance abuse, and domestic violence. In addition, caregivers reported that they were very satisfied with the services provided. They perceived that the crisis nurseries were very effective in decreasing stress, lowering the risk of abuse and neglect, and enhancing parenting skills. The upward trend for usage and the perceived positive effects of services continued in subsequent years (Cole & Record, 2010).

Case Level Data Study. Another study based on the ARCH survey and case level data that used logistic regression analysis to identify factors associated with positive changes in caregiver perception of the effects of crisis nursery services on parental stress, risk of abuse and neglect, and parenting skills was conducted (Cole & Hernandez, 2008) for program evaluation and planning purposes. Caucasian single parents, with higher incomes that had children, who were four years of age or older, reported higher levels of stress reduction than caregivers with other characteristics. Those who accessed crisis nursery services because of homelessness, mental health, or family violence problems also reported higher stress reduction than caregivers accessing services for other reasons.

Program Outcomes Survey 2.0 (POS 2.0). In an attempt to obtain more objective data, the Crisis Nursery Coalition with the School of Social Work, UIUC, developed a pre- and post-test evaluation form based on a FRIENDS (Family Resource Information, Education, and Network Development Services) assessment tool. They piloted and implemented the instrument. A 4-item Perceived Stress Scale (PSS-4) (Cohen, Kamarck, & Mermelstein, 1983; Cohen & Williamson, 1988) was embedded in the instrument. The PSS-4 is a pre- and post-test measure for stress that is short and found to be effective in use with a wide range of adults experiencing stressful life events. New items included in the POS 2.0 give a more in depth perspective on how crisis nursery

services support caregivers, decrease stress and the risk of abuse. These include items that query caregivers at post-test about caregivers' support systems, knowledge of community assistance programs, ability to budget time and resources, and skills for advocating for their children. A Spanish and English version of the POS 2.0 is in use.

Crisis Nurseries and Child Welfare. A California study conducted to ascertain the effects of crisis nursery service on abuse and neglect beyond caregiver self-report used state administrative data to test if counties served by crisis nurseries had lower abuse and neglect rates than counties without crisis nurseries (FRIENDS National Respite Network and Resource Center, 2006). Researchers found that the families in counties served by crisis nurseries actually had higher numbers of reports for abuse and neglect, but fewer substantiated cases of abuse and neglect than families served in counties that did not have crisis nursery services.

An Illinois study (Cole & Hernandez, 2007) compared the results of crisis nursery evaluation outcomes for caregivers who reported receiving crisis nursery services and child welfare services with caregivers who only received crisis nursery services using the ARCH survey. The researchers found that caregivers in the two groups were not different in their perceptions of the role of crisis nurseries in decreasing stress and the risk of abuse. The ratings for the crisis nurseries' ability to enhance parenting skills was significantly higher for caregivers that only received crisis nursery services as compared to caregivers that received both child welfare and crisis nursery services.

Another Illinois study (Cole & Hernandez, 2011) examined the effects of crisis nursery services on children and families that entered the child welfare system. It found that children whose families had received crisis nursery services and entered out-of-home foster care placements were twice as likely to be reunited with their families when they left foster care as compared to children whose families had never received crisis nursery services. There was no significant difference in the length-of -stay in out-of-home care when the two groups were compared.

Crisis nurseries seem to help families in times of crisis. The lack of evaluation funding has limited the study to the use of secondary data collected by the nurseries and states of Illinois and California.

References

Andrews, B., Bishop, A. R., & Sussman, M. S. (1999). Emergency child care and overnight respite for children from birth to 5 years of age. In J. A. Silver, B. J. Amster, & T. Haecker (Eds.), *Young children and foster care* (pp. 325-345). Baltimore: Brookes.

ARCH National Resource Center for Respite and Crisis Services (1994). *Factsheet number 31*. http://www.archrespite.org/archfs31.htm. Retrieved 5/6/2004.

ARCH National Respite Network and Resource Center (2000). *ARCH 5.2.* Chapel Hill, NC: ARCH National Respite Network and Resource Center. (2006). *Crisis respite: Evaluating outcomes for children and families receiving crisis nursery services: Final report*.

Clark, Mary K. (1990). *A dream come true: The story of casa de los niños. (2nd ed.).* Tucson, AZ: Casa de Los Niños.

Cole, S. A., & Hernandez, P. (2008). Crisis nursery outcomes for caregivers served at multiple sites in Illinois. *Children and Youth Services Review*, *30*, 452-465.

Cole, S. A. & Hernandez, P. (2009). "Using Crisis Nurseries to Support Permanency." 17th National Conference on Child Abuse and Neglect, March 30 – April 4, 2009, Atlanta,GA.

Cole, S. A., Hernandez, P., & Swinford, L. (2007). *Evaluating crisis nursery services at multiple sites in Illinois: A report to the Illinois Department of Children and Family Services.* Urbana, IL: Children and Family Research Center, University of Illinois.

Cole, S. A., & Record, S. (2010). *Summary of Data: Illinois Crisis Nurseries: 2001 – 2009.* Urbana-Champaign: School of Social Work, University of Illinois at Urbana-Champaign.

Cole, S. A., Wehrmann, K. C., Dewar, G., & Swinford, L. (2005). Crisis nurseries: A vital component in the system of care for families and children. *Children and Youth Services Review, 27,* 995-1000.

DeLapp, J., Denniston, J., Kelly, J., & Vivian, P. (1998). *Respite, crisis care, and family resource services: Partners in family support* (ARCH Factsheet Number 51). Chapel Hill, NC: National Center for Respite and Crisis Care Service.

Dougherty, S., Yu, E., Edgar, M., Day, P., & Wade, C. (2002). *Planned and crisis respite for families with children: Results of a collaborative study*. Chapel Hill, NC: ARCH National Respite Network and Resource Center.

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Crisis nursery effects on child placement after foster care ☆

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ABSTRACT

The results of a study of the relationship between receiving crisis nursery services and the placement outcomes for young children leaving the child welfare system in Illinois are reported in this paper. The placement outcomes for children leaving foster care whose families received crisis nursery support prior to the children's placement in foster care is compared to the placement outcomes for children whose families received only foster care services. The children in two samples were identified by matching crisis nursery children's data from FY 2006 with children's data in the Illinois Child Abuse and Neglect Tracking System and Children Youth and Services Information System databases. After children served by crisis nursery and foster care services were identified, a comparison group of children with like-characteristics whose families received only foster care services was identified using propensity score matching. The children were followed until their out-of-home placement was terminated or until June 30, 2009. The placement outcomes and the length of stay were compared for the two groups. Using logistical regression analysis the results showed that children whose families received crisis nursery services prior to foster care placement were twice as likely to be reunited with their biological families (birth or extended family members) when compared to children whose families received only foster care services. The difference in the length-of-stay in foster care was not statistically significant when the two groups were compared. This preliminary study using administrative data shows that receiving crisis nursery services may have positive effects on the children's ultimate placement outcome after foster care. Additional research is needed to further explore the relationship between placement outcome and crisis nursery services.

1. Introduction

The stress and isolation many caregivers of young children experience linked with the developmental vulnerability of infants and young children make them the age group that is most at risk for placement in foster care. Thirty-eight percent (121,352) of children who entered foster care in the United States in FY 2008 were infants and young children aged birth to five years. Sixteen percent (44, 365) of the children entering out-of-home care were less than a year old (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2009). Emergency support services (such as crisis nurseries) that assist caregivers during the stressful periods of infancy and early childhood often prevent the need for out-of-home foster care placement (Cole, Wehrmann, Dewar, & Swinford, 2005). It is not known if the length of stay of out-of-home care for infants and young children who are removed from their home is affected by receiving crisis nursery interventions. The study discussed in this paper investigated the effect of crisis nursery services on the length of stay in foster care of infants and young children in Illinois. It also investigated if children in families who received crisis nursery services were placed differently when child welfare services were terminated as compared to children in families who received only child welfare services.

1.1. Infants and young children in child welfare

With the mean length of stay for children in the foster care system at 27.2 months (about 2.25 years) many infants and young children spend their critical early developmental years in foster care. In an early study of infant placement in foster care, Wulczyn, Hislop, and Hardin (2002) found that the youngest infants (less than four months of age) stayed in foster care longer than children of other ages and were less likely to be reunited with their birth families when they left care. They were also more likely to be adopted. In a longitudinal study of infants and young children entering foster care in six counties in California, Frame (2002) and Frame, Berrick, and Brodowski (2000) found that drug and alcohol exposed infants were more likely to stay in care during the four-year study period. If the children were

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reunified with their families, they were more likely to re-enter foster care than children placed for other reasons.

Considering the struggles of their caregivers, one might think that placement in foster care is a better option for these vulnerable infants. In fact, some children are not adversely affected by foster care placement. A recent study (Proctor, Skinner, Roesch, & Litrownik, 2010) shows that children who enter foster care with positive developmental attributes (positive cognitive ability and social competence), who have stable foster placements, and who experience low abuse and neglect in later life, have good outcomes in later life. This study indicates that the children placed in foster care with optimum personal traits, placements, and care after permanency can develop positively. Unfortunately, not all infants and young children who enter care are so robust nor do they receive such optimum care during or after out-of-home placements (American Academy of Pediatrics, Committee on Early Childhood, Adoption, and Dependent Care, 2000; Dozier & Albus, 2000; Dozier, Albus, Fisher, & Sepulveda, 2002; Dozier, Stovall, Albus, & Bates, 2001; Stovall & Dozier, 2000; Tyrrell, Dozier, Teague, & Fallot, 1999).

Other longitudinal studies investigating the effects of foster care placement over time show that society ultimately pays a high price for many infant and young children in foster care placements. Poor physical, cognitive, social, and emotional outcomes are often associated with early and lengthy foster care placement at an early age (Dozier & Albus, 2000; Lawrence, Carlson, & Egeland, 2006; Stovall & Dozier, 2000).

1.2. Crisis nurseries in the United States

Crisis nurseries in the United States evolved from a grassroots movement to develop immediate interventions for stressed caregivers of young children to prevent abuse and neglect and the need for out-of-home placement (DeLapp, Denniston, Kelly, & Vivian, 1998). Because crisis nurseries grew reflecting the family and support needs of local communities, each crisis nursery offers a range of emergency and follow-up services that support the unique needs of caregivers and the infants and young children they serve. Most crisis nurseries offer initial crisis assessment and intervention services (e.g., respite child care, caregiver counseling), after-crisis interventions such as follow-up care, and/or referral to community services (Andrews, Bishop, & Sussman, 1999; ARCH National Resource Center for Respite and Crisis Services, 1994; Clark, 1990; Dougherty, Yu, Edgar, Day, & Wade, 2002; Subramanian, 1985). The services are usually provided with no waiting period and often without charge to the client families.

1.3. Crisis nurseries in Illinois

Five crisis nurseries were established in Illinois in 1985 with the support of federal funding. Two of the five crisis nurseries are independent 501-C-3, non-profit organizations. Two crisis nurseries are part of the services provided by a large statewide social service agency that provides prevention and intervention services to children and families. One nursery is one of the support services for the families of infants and young children. All the initial agencies were located in medium and small cities in the central part of Illinois. A sixth nursery was established in Chicago in 2005 as a service of an independent, non-profit agency that provides support services to children and youth in the Chicago area. The type of agencies that provide services are as different as are the needs of local communities, but the needs of stressed parents are similar across service providers—support and respite for caring for fragile infants and young children.

1.4. Crisis nursery evaluation

Although crisis nurseries have provided services to vulnerable families in Illinois since 1985, the impact of their services using empirical strategies that could provide an evidence base to evaluate their effects for children and families has been elusive. Crisis nursery evaluation, like crisis nursery services, needs to be immediate, appropriate, and responsive to the unique characteristics of the community and agencies in which they are located as well as responsive to the monitoring requirements of state and private funders (Cole et al., 2005). Crisis nursery service recipients may access the range of services provided or only crisis care one time in a stressful situation. It became clear early in the work that trying to ascertain the effects on children would not be possible because of their rapid developmental changes and limited stay at the crisis nurseries (at times as little as a single visit for 2 h). The decision was made to focus on caregivers' perceptions of the effect of crisis nursery services. Working with crisis nursery staff and directors over a period of nine years, the authors conducted a number of non-intrusive evaluation studies and reports using data previously collected by the nurseries to ascertain the effects of crisis nursery interventions. These studies and reports included evaluating trends of aggregate data reported to the Department of Human Services from 2001 to 2009 and using geo-coding to map the location of crisis nursery users in counties surrounding crisis nurseries (Cole & Hernandez, 2008, 2009; Cole, Hernandez, & Swinford, 2007; Cole & Record, 2010). Unfortunately, the crisis nature of the services provided makes double blind assignment and random selection of caregivers and infants to receive services unethical. Even pre- and post-tests, quasi-experimental designs prove difficult and intrusive when caregivers are in crisis. The studies and research reports cited used administrative data collected and reported by the individual crisis nurseries to the Illinois Department of Human Services (monitoring agency for state funding) using the ARCH Survey 5.2 (ARCH National Respite Network and Resource Center, 2000), a retrospective, caregiver self-report instrument. Caregivers' reports of the change in stress, change in potential for abuse and neglect, and change in parenting skills after receiving crisis nursery services were used as outcome variables in these studies and evaluation reports. Significantly positive changes in stress were reported by caregivers in these studies at the $p<0.05$ level. Single-parenting caregivers reported the greatest change in stress. Change in potential for abuse and neglect and change in parenting skills were positive, but not significant at the $p<0.05$ level.

1.5. Crisis nurseries and child welfare research

Although the evaluations of crisis nursery services showed perceptions of positive changes by caregivers, objective study of the effect of crisis nursery services on the prevention of the need for child welfare services was more difficult.

To investigate the effects of crisis nursery service on abuse and neglect beyond caregiver self-report, a study in California used administrative data to test if counties served by crisis nurseries had lower abuse and neglect rates (ARCH National Respite Network and Resource Center, 2006). The effects of crisis nursery services on child abuse and neglect rates in counties served by crisis nurseries were compared with counties that did not have crisis nursery services. Researchers found that the families in counties served by crisis nurseries had higher numbers of reports for abuse and neglect. This demonstrated the child abuse and neglect monitoring function of crisis nurseries. The study also found that counties with crisis nurseries had fewer substantiated cases of abuse and neglect than families served in counties that did not have these services. This outcome shows the family skills development and support function of crisis nurseries. This study compared counties' data on abuse and neglect, but not the effects of crisis nursery service on individual children or caregivers.

In order to investigate the effectiveness of crisis nursery services, Cole and Hernandez (2009) used data reported by crisis nursery served caregivers who also reported using child welfare. Based on the

data from the crisis nurseries that were used for this analysis (from FY 2006), approximately 14% of caregivers served by the crisis nursery, reported involvement with child welfare services. Using propensity score matching, the caregivers who received crisis nursery services were matched with a like group of caregivers who only received crisis nursery services. The caregivers' outcomes on three variables (change in stress, change in risk of abuse and neglect, and change in parenting skills) of the ARCH 5.2 Survey (ARCH, 2000) were compared. The researchers found that although both groups reported positive changes on all three variables, there was no statistical difference between the outcomes reported by the two groups in their reported perceptions of decreased stress and risk of abuse. There was a statistically significant difference in the change reported in parenting skills when the outcomes of the two groups were compared. The caregivers served only by the crisis nursery services reported significantly higher changes in parenting skills after using crisis nursery services than the caregivers served by child welfare and crisis nursery services.

No current study has investigated what happens to the infants and young children whose families receive crisis nursery care and then enter out-of-home care. We studied if receiving crisis nursery services prior to placement in out-of-home care affects length of stay and placement at termination of care or the end of the study period. We investigated the following questions. Considering the many factors that affect outcomes in child welfare, with the information available in the crisis nursery, Child Abuse and Neglect Tracking System (CANTS), and Children and Youth Services Information System (CYSIS) databases, do infants and young children whose families receive crisis nursery care have different out-of-home placement outcomes than infants and young children in substitute care who did not receive these services? We also investigated what factors are associated with the differences in length of stay and placement at termination of out-of-home placement. We hypothesized that the children in families who received crisis nursery services would have a shorter duration in out-of-home care and that they would be more likely to be returned to the families they were removed from at placement.

2. Theoretical model

Crisis nursery services in Illinois are based on current child development research. Early and continuing research show the significant effects that secure infant–caregiver attachment has on development in infancy and over the life course of children (Egeland & Sroufe, 1981; Shonkoff & Phillips, 2001; Sroufe, Egeland, Carlson, & Collins, 2005). Other attachment research shows that contextual factors in which the infant–caregiver relationships are embedded can support or impede positive long-term development of children (Belsky, 1984, 1996, 1998, 2005; Belsky, Bakermans-Kranenburg, & van Ijzendoorn, 2007; Belsky & Jaffee, 2006). Belsky's research shows how various contextual factors affect, such as the mother's psychological state, the presence of fathers who provide infant care, the quality of the intimate relationships of the mother, and length time in daycare, all affect the quality of attachment relationships and subsequently the overall development of the child. This relationship has been confirmed in recent large studies of developmental trajectories and the factors that affect them (National Institute of Child Health and Development (NICHD) Early Child Care Research Network, 2005).

Based on this theory, we hypothesize that crisis nurseries provide positive contextual support for caregivers who are in stress, have limited positive home support, or are in challenging environments such as domestic violence or poverty that affect their ability to maintain their children in their homes. This hypothesis is supported by the earlier study of Cole and Hernandez (2008) that showed single-parenting caregivers reporting the greatest decrease in stress. For a majority of parents who access crisis nursery services the immediate crisis support they receive and ongoing individual case management is sufficient to assist them in maintaining their children in the home.

The services that crisis nurseries provide are often not sufficient to prevent child abuse and neglect from occurring. Crisis nursery employees and volunteers are trained to identify signs of abuse, neglect, and trauma. Employees are mandated reporters and are required to report families to protective services when they perceive children are at-risk. When abuse or neglect is suspected in infants and young children served by crisis nurseries, the situation is discussed with families and then reported to child protective services. If the abuse or neglect is indicated (substantiated), the family can be assigned to intact child welfare services and receive both child welfare and crisis nursery services or the child could be placed in out-of-home care (e.g., foster or kinship care). The crisis nursery services are discontinued while the child is in out-of-home care.

About 9.5% of the families who received services from crisis nurseries personally disclosed that they were also receiving child welfare services when they entered crisis nursery programs in Illinois (Cole & Hernandez, 2008). Families served by crisis nurseries seem to under-report their involvement with child welfare services. When families served by crisis nurseries were matched with the CANTS database in 2006 in Illinois, about 35% of families served by crisis nurseries in Illinois were reported to protective services for follow-up investigations. Fifty-three percent of these families had indicated cases as shown in the CYCIS database.

Most infants and young children in families with indicated reports remain in their homes, often with crisis nursery and other intact family support (Cole & Hernandez, 2009). In addition to providing emergency interventions to temporarily stressed families, crisis nurseries provide close supervision and support to at-risk families. This is a collaborative effort between families, crisis nursery staff, and child welfare case managers (Cole & Hernandez, 2009) to ensure that the infants and children are safe and remain with their birth families to support optimum development of infants and young children who are at-risk.

There is no current study evaluating if and how receiving crisis nursery interventions prior to out-of-home placement affects the length of stay of infants and young children or their ultimate placement at the termination of out-of-home child welfare placements. In this study, we investigate if receiving crisis nursery services has an effect on the outcomes of child welfare services for families that have their young children removed and placed in substitute care. We compare the differences in length of stay and placement outcomes over a three-year period for infants and young children whose families received crisis nursery services prior to entry into substitute care with a comparison group of infants and young children with like-characteristics who did not receive crisis nursery services prior to entry into substitute care. We hypothesized that because of the enhanced contextual support of crisis nurseries, infants and young children whose families received crisis nursery interventions would stay in care significantly less time and ultimately be returned to their parents or birth families more frequently than children whose families only received child welfare services.

3. Method

The study discussed in this paper was undertaken as a result of requests from the Illinois Department of Human Services, Illinois Department of Children and Family Services, and the Crisis Nursery Coalition to examine empirical data, beyond caregiver self-report, to test the effect of crisis nursery services on children in out-of-home placements in the child welfare system in Illinois.

3.1. Study sample

The present study is based on a sample from the administrative data of the five crisis nurseries in Illinois, the Illinois Department of

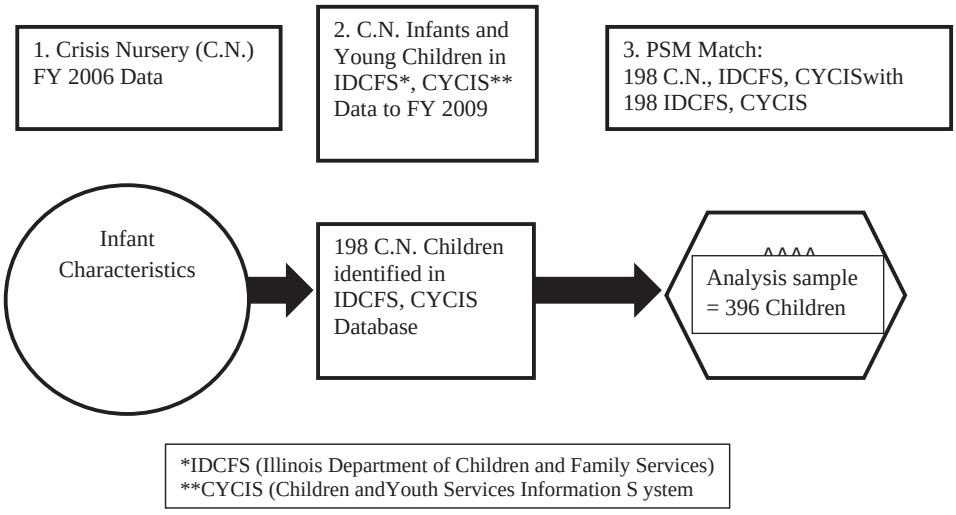

Fig. 1. Sampling method.

Children and Family Services CANTS and CYSIS. All children served by crisis nurseries in Illinois in FY 2006 were matched with children in the CANTS database to identify children served by crisis nurseries who were reported for abuse and neglect. A second match with the CYCIS database identified the children who were placed in out-of-home care (i.e., foster care, kinship care, institutional care, etc.). After the determinant match was completed all names and other identifying information were deleted and each case continued using its respective CYSIS case number. The CYCIS case numbers were used to follow the infants and young children until they were either placed in a permanent home or the completion of the study (June 30, 2009), In FY 2006, 2065 children from 1303 families served by five crisis nurseries in Illinois were identified. Of these, 198 infants and young children that received both crisis nursery and child welfare services between FY 2006 and FY 2009 were identified for this study.

In order to compare how the length of stay and placement outcomes of these infants and young children served by the crisis nurseries differed from infants and young children who did not receive crisis nursery services, a comparison group of infants and young children with like characteristics was identified using propensity score matching. Propensity score matching (PSM) allows the outcomes for differently served children with like attributes to be matched and compared for outcome variables of interest without the ethical issues of being assigned randomly to an intervention and control group (Guo, Barth, & Gibbons, 2006; Guo & Fraser, 2010; Rosenbaum & Rubin, 1984). Thus, the impact of program participation can be assessed without randomization in cases such as crisis nursery services where the use of random assignment to a treatment or a control group could endanger the infant and young children in families seeking crisis care. PSM requires the use of unique variables to identify an adequate comparison group. For this study, the use of existing administrative data narrowed the unique variables available for matching. This may affect the outcomes observed. Although these variables are limited, studies have shown that such child characteristics affect permanency outcomes (Wulczyn et al., 2002). The child variables used for the match were age, gender, race/ethnicity, caregiver, type of abuse, and county of residence. When the match was completed the sample contained 396 cases (See Fig. 1).

3.2. Study design and procedures

When the sampling design was completed, logistic regression was used to identify the relationship between the independent variables and the effect of receiving crisis nursery service on the outcome variables.

3.2.1. Independent child variables

Independent child variables in the administrative data used in the analyses were defined in the following way. “Age” was the age at first report and the categories were defined in the following way: “less than one year” represented children birth to less than one year; “one year” represented children one year old and less than two years old; “two years” represented children two years old but less than three years old; “three years” represented children three years old but less than four years old; and “four years or older” represented children four years of age or older. “Gender” was the reported sex of the child and defined as “female” or “male”. “Child ethnicity” was the child's ethnicity identified in the CANTS database. The categories identified were “African-American,” “Caucasian,” “Hispanic,” and “Other.”

“Type of abuse” was defined as the initial type described in the database. These were “physical abuse,” “sexual abuse,” “neglect,” and “lack of supervision”. “County of residence” was defined as the county in the Illinois in which the infants and young children were residing at the time of the first reported abuse. “Type of placement” was defined as the type of out-of-home placement the child received: “foster care,” “kinship care,” or “other”. **“**Permanency goal” was defined as the goal at termination of out-of-home placement. These categories included: “remain in home,” “birth home,” “substitute care,” “adoption,” “guardianship,” “unable to return due to developmental disability.”

3.2.2. Independent caregiver variables

Independent caregiver variables in the administrative data used in the analyses were defined in the following way. “Age” was the age of the caregiver at first report of abuse and neglect for this child. “Gender” was the reported sex of the caregiver and defined as “female” or “male”. “Caregiver ethnicity” was the caregiver's ethnicity identified in the CANTS database. The categories identified were “African-American,” “Caucasian,” “Hispanic,” and “Other.”

3.2.3. Outcome variables

Outcome variables were defined in the following ways. “Length of stay in substitute care” is defined as the total number of days the infants and young children in the treatment and comparison group were in out-of-home care before they were placed in a stable, permanent home. “Child placement outcome” was defined as the type of home the infants or young children were placed in at the termination of out-of-home placement or as of June 30, 2009. The categories for last type of

placement from the CANTS and CYCIS data bases were: "Return home within five months," "return home within one year," and "return home pending court hearing" were identified as "returned to the family of origin." "Remaining in substitute care" were those infants and young children that were still in substitute care as of FY 2009. "Adoption" was the designation for the infants and young children that were placed in adoptive homes. "Guardianship" was the designation for the infants and young children that were placed in homes of extended family members in a permanent subsidized guardianship arrangement. "Other" was defined as those infants who were identified as being too impaired due to developmental disabilities to be returned to their home.

3.2.4. Procedures

Using STATA 9.2 statistical software (2006), children with like characteristics served only by the IDCFS were identified using the variables available in the crisis nursery data base, CANTS and CYSIS data base: age, gender, child ethnicity, caregiver, and county of residence. Then the probability of similarity of the two groups based on the estimated logistic regression was calculated. The log of the predicted probability (i.e., log [p/(1−p)]) is defined as a propensity score. The sample used in the PSM procedures included 30,181 children. Before matching, the group who had received crisis nursery services before being removed from their homes had an n = 198 and a mean propensity score of 0.0319 (SD = 0.0253, min = 0.0003 and max = 0.1043). We used the variables described to create the matched groups. There were 29,983 children with a mean propensity score of 0.0034 (SD = 0.0131, min = 0.00002 and max = 0.1201) who did not receive crisis nursery services prior to placement in out-of-home care. Subsequent to matching, the children whose families had received crisis nursery care had an n = 198 and a mean propensity score of 0.0319 (SD = 0.0253, min = 0.0003 and max = 0.1043). The group of children whose families had not received crisis nursery services prior to their out-of-home placement had an n = 198 and a mean propensity score of 0.0319 (SD = 0.0253, min = 0.0003 and max = 0.1043). The mean propensity score for the matched treatment group (0.03) was the same as the mean propensity score for the non-treated group (0.03).

It is important to note that there were some differences in the two groups prior to the propensity score matching procedure. For example, the ethnicity of children who received crisis nursery services prior to their placement in out-of-home care had a higher percentage of African Americans (64% versus 52%) and a lower percentage of Caucasians (32% versus 39%) than the children in out-of-home care that did not receive crisis nursery services prior to placement. In addition, the percentage of Hispanics was lower (4% versus 6%) in the group of children who received crisis nursery services prior to placement compared with the children who had not received these services prior to placement. The group of children who received crisis nursery services prior to placement did not contain children of "Other" ethnicity as compared to 3% in the group who had not received crisis nursery services.

Although the infants and young children in the current study were similar to each other, they were different from the other children who had indicated reports in Central Illinois where the crisis nurseries were located. Overall approximately 61% (16% sexual abuse) of children in Illinois had indicated reports of physical abuse in 2006, while 80.3% (10% sexual abuse) of the study sample experienced some type of physical abuse (Child Abuse and Neglect Statistics—CANS, 2006). Twenty-three percent of the children in Central Illinois had indicated reports for neglect while the infants and young children in the study 25.9% of the infants in the study group had indicated reports for neglect.

The county the children resided in when the abuse was reported was another important variable to use in the PSM due to the differences in out-of-home placements in the five counties studied. In County 1 the percent of children who received crisis nursery services and were placed in out-of-home care was 15%, County 2 was 15%, County 3 was 21%, County 4 was 20%, and County 5 was 18%.

In the current study we used propensity score matching procedures to minimize selection bias. The new PSM-created sample allowed us to control the differences in the two groups in order to better assess the effect of crisis nursery participation. After the samples were identified, the length of time in out-of-home care was compared in the two groups as well as the children's placement at termination of out-of-home care. SPSS (2006) statistical software for analysis of variance, logistic regression analysis, and multiple regression analysis were used to identify associations between the independent variables and the outcome variables.

4. Results

4.1. Demographics

Although propensity score matching identifies an overall like-comparison group, the characteristics in each group are statistically similar, but not the same. The demographic characteristics of the children in the crisis nursery served group are statistically similar, but not the same as the children whose families received only child welfare services.

4.1.1. Characteristics of children

4.1.1.1. Crisis nursery and child welfare served. The children in the sample who had crisis nursery intervention services and out-of-home placements had the following characteristics. Of the 198 infants and young children served by the crisis nurseries and in out-of-home placement, 47% (93) were female and 53% (105) were male. The mean age of the children was 1.04 (SD = 1.39) and varied from birth to six years old. A majority of children in this group were African-American, 64.1% (127). The next highest were identified as Caucasian, 31.8% (63). Only 4% (8) were identified as Hispanic.

The infants and young children who were in the group who received crisis nursery and child welfare services entered out-of-home care due to the following types of abuse and neglect: 70.2% (139) physical abuse; 9.6% (19) sexual abuse; 19.2% (38) neglect; and 26.8% (53) lack of supervision. Children were placed in foster care and kinship care for their out-of-home placements. The mean length of stay in out-of-home care for children served by crisis nurseries and who were in foster care was slightly more than one year. The mean length of stay in kinship care was slightly less than one year (See Table 1). Reunification with their birth families was the permanency plan for 54% (107) of these infants and young children. About 23% (46) were headed for adoption and only 1% (2) for subsidized guardianship. The largest percentage and number of children were from County 4, 0.7% (41). The smallest percentage and number of children were from County 1 and County 2 15.2% (30). At termination of out-of-home placement or the end of the study, about 49.5% (98) of the infants and young children in the group who had received crisis nursery services prior to placement were returned to their families and about 17.7% (35) were placed in adoptive homes or subsidized guardianship (See Table 1).

4.1.1.2. Child welfare only served. The children in the sample who received only child welfare services were matched with the variables available of the children who were served by CN and IDCFS. Although PSM uses a statistical number (propensity score) for the match, the samples were very similar. Of the 198 infants and young children served by the crisis nurseries and in out-of-home placement, 48% (95) were female and 52% (103) were male. The mean age of children was 1.03 (SD = 1.43) and varied from birth to six years old. The children in the sample were identified by their caregivers as being from the following ethic groups: 63.6% (126); African-American; 32.8% (65) Caucasian; and 3.5% Hispanic. During the initial child abuse and

Table 1
Characteristics of children in the study sample.

Child characteristic	IDCFS (N = 198)	CN/IDCFS (N = 198)
Gender		
Female	95 (48%)	93 (47%)
Male	103 (52%)	105 (53%)
Age	Range = 0–6; Mean = 1.03 (SD = 1.43)	Range = 0–6; Mean = 1.04 (SD = 1.39)
>0 to <1	51.5% (102)	50.5% (100)
>1 to <2	23.2% (46)	23.7% (47)
>2 to <3	9.1% (18)	9.1% (18)
>3 to <4	7.6% (15)	8.6% (17)
>4 to <5	5.1% (10)	5.1% (10)
>5	3.5% (7)	3.0% (6)
Ethnicity		
African-American	63.6% (126)	64.1% (127)
Caucasian	32.8% (65)	31.8% (63)
Hispanic	3.5% (7)	4.0% (8)
Other	0 (0)	0 (0)
County	20 counties	19 counties
Champaign	15.2% (30)	15.2% (30)
McLean	16.2% (32)	15.2% (30)
Peoria	19.7% (39)	20.7% (41)
Sangamon	20.2% (40)	19.7% (39)
Winnebago	17.2% (34)	17.7% (35)
Others	11.5% (23)	11.5% (23)
Type of abuse*		
Physical abuse	70.7% (140)	70.2% (139)
Sexual abuse	9.6% (19)	9.6% (19)
Neglect	19.2% (38)	19.2% (38)
Lack of supervision	6.7% (33)	26.8% (53)
*>1 type reported for child		
Permanency goal		
Remain in home	4.0% (8)	1.5% (3)
Birth home	44.4% (88)	52.5% (104)
Substitute care (TPR)	6.0% (12)	11.1% (22)
Adoption (TPR)	32.8% (65)	23.2% (46)
Guardianship	1.5% (3)	1.0% (2)
Unable to return (DD)	0.5% (1)	1.0% (2)
Missing information	10.6% (21)	9.6% (19)

neglect report the children served by child welfare services were reported for experiencing the following types of abuse and neglect—70.7% (140) physical abuse, 9.6% (19) sexual abuse, 19.2% (38) neglect, and 16.7% (33) lack of supervision. The mean length of stay in foster care for children in this group was slightly less than the group who received crisis nursery services prior to placement (368.75 days), while the mean length of stay in kinship care was slightly less than one year (274.64 days). The permanency goal for 44% (88) of the children was reunification with their birth families. About 33% (65) had a permanency goal of adoption. Only 1.5% (3) had the permanency goal of subsidized guardianship. At termination of out-of-home placement or the end of the study (June 30, 2009), about 31.3% (62) of the infants and young children in this group were returned to their families at the termination of out-of-home placement. Almost the same percent of infants and young children 30.8% (61) were placed in adoptive homes or subsidized guardianship, almost twice the number of crisis nursery served infants and young children placed in adoptive homes (See Table 1). The largest percentage and number of children were from Sangamon County 20.2% (40) while the smallest percentage and number of children were from Champaign County 15.2 % (30). (See Table 1 for a full summary of child characteristics of the intervention and control groups).

4.1.2. Characteristics of caregivers

4.1.2.1. Crisis nursery and child welfare served. The caregivers of the infants and young children in the sample had the following characteristics. Although there were 198 infants and young children that were followed who received crisis nursery services and were in out-of-home placement, fifteen of the families had two caregivers in the home. Of these, nine families had male and female caregivers of approximately the same age at the termination of out-of-home care. There was no information regarding the relationship between the caregivers. When the head of household was identified in the data it left 158 caregivers for analysis. Eighty-seven percent (138) of the primary caregivers were female and 12.7% (20) of the primary caregivers were male. The mean age of caregivers was 29.3 (SD = 7.79 years) years of age and varied from 17 to 61. The modal age of caregivers in the treatment group was 26 years. About 51.3% (81) of the caregivers who had received crisis nursery services were Caucasian and 44.3% (70) were African-American. About 3.1% (5) were Hispanic and 0.06% (1) was Asian or Other.

4.1.2.2. Child welfare only served. The characteristics of the caregivers of the children in the sample who only received child welfare services had the following characteristics. There were 198 infants and young children that were identified who received only child welfare services with statistically similar characteristics to the crisis nursery served group, when the caregiver duplications were eliminated by choosing the caregiver for whom the allegation of abuse was made, there were 127 unique caregivers in the group who received only child welfare services. About 93.7% (119) were females and 8 (6.3%) were males. No information was available on the number of families that had a male and female in the household at the termination of out-of-home care. There was no information regarding the relationship between the caregivers. Eighty-seven percent (138) of the caregivers were female and 12.7% (20) of the primary caregivers were male. The mean age of caregivers was 29.3 (SD = 7.79 years) years of age and varied from 17 to 61. The modal age of caregivers in the comparison group was 27. About 48.8% (62) of the caregivers who received only child welfare services were African-American and 45.7% (58) were Caucasian. About 4.0% (5) were Hispanic (Table 2).

4.1.2.3. Factors associated with length of stay. The length of stay for infants and young children served by crisis nurseries and child welfare services compared with infants and young children that received child welfare services was not statistically different when bi-variate analyses were conducted. Infants and young children served by crisis nursery and child welfare services stayed in out-of-home care longer than children served only by child welfare services. The average length of stay for infants and children who served by crisis nurseries placed in foster care was slightly longer (379.55 days) when compared to the infants and young children in the comparison group (368.75 days). The average length of stay for infants and young children in out-of-home placements that received crisis nursery services and were placed in kinship care was 349.81 days. The infants and young children who received only child welfare services were in kinship care for 274.64 days (See Table 3).

To compare the factors associated with the length of stay in out-of-home placements ordinary least square multiple regression analysis (Neter, Kutner, Wasserman, & Nachtseim, 1996) was applied. The effects of the child and caregiver characteristics and the dichotomous variable "received crisis nursery services or not" on Length of Stay was investigated. The model was not significant.

4.1.2.4. Factors associated with child placement outcomes. We also investigated the factors that significantly predicted the placement the infants and young children received at the termination of out-of-home placement. Using logistic regression, the model that tested the effect on the dichotomous variable of "returned to their home or not returned to their home" was significant. The independent child variables tested were: type of abuse, gender, age, ethnicity, and "received crisis nursery services or not." The variable "received crisis

Table 2
Caregiver characteristics in study sample.

Characteristics of caregivers in the study sample		
Caregiver characteristics	IDCFS (N = 127)*	CN/IDCFS (N = 158)*
Age	Range = 12–47 years Mean = 29.70 years SD = 6.56 years	Range = 17–61 years Mean = 29.61 years SD = 7.79
Gender		
Female	93.7% (119)	87.2% (138)
Male	6.3% (8)	12.7% (20)
Ethnicity		
Asian	0.0% (0)	0.6% (1)
African-American	48.8% (62)	44.3% (70)
Caucasian	45.7% (58)	51.3% (81)
Hispanic	4.0% (5)	3.1% (5)
Unknown	0.0% (0)	0.6% (1)

* Caregivers can have more than one infant or young child in out-of-home care.

nursery services" was significant ($p<0.000$ level, $\beta = 0.741$, S.E. = 0.213, Exp $\beta = 2.099$). The infants and young children that received crisis nursery services were twice as likely to be returned to their homes.

We also analyzed the effect of receiving crisis nursery services on children who remained in foster care at the termination of the study period. The effect of the same independent child variables (type of abuse, gender, age, ethnicity, and "received crisis nursery services or not") on the dichotomous variable "foster care or not." This model was also significant at the $p<0.000$ level. For this group, receiving crisis nursery services was not significant. The child's age at report was significant at the $p<0.000$ level ($\beta = 0.741$; S.E. = 0.213, Exp $\beta = 1.330$). Older children were more likely to still be in foster care at the end of the study period than younger children.

The type of abuse was also a significant factor in predicting the likelihood of infants and young children in foster care. Having an indicated report of "sexual abuse" was significant at the $p<0.028$ level. The infants and young children who experienced sexual abuse were about one-third as likely to remain in foster care at the end of the study period ($\beta = -0.954$; S.E. = 0.434, Exp $\beta = 0.385$) as children placed in out-of-home care for other types of abuse. Having an indicated report of "lack of supervision" was significant at the $p<0.019$ level. The infants and young children who were placed in out-of-home care due to "lack of supervision" were about half as likely to remain in foster care at the end of the study period ($\beta = -0.689$, S.E. = 0.293, Exp $\beta = 0.502$) when compared to children placed for other types of abuse. Other variables tested were not significant.

Table 3
Outcome variables.

Variables	IDCFS (N = 198)	CN/IDCFS (N = 198)
1. Mean length of stay in out-of-home care (days)	M = 689.4, SD = 623.31 Range = 0–3007	M = 774. 31, SD = 420.70 Range = 0–1900
Foster care	M = 368.75 (SD = 528.56) Range = 0–2851	M = 379.55 (SD = 430.14) (Range = 0–1341)
Kinship care	M = 274.64 (SD = 466.00) Range = 0–3007	349.81 (SD = 395.59) Range = 0–1341
2. Placement at termination of out-of-home placement or June 30, 2009		
Remain in home	31.3% (62)	49.5% (98)
Birth home	30.3% (60)	17.2% (34)
Substitute care (TPR)	0.5% (1)	0.5% (1)
Adoption (TPR)	18.2% (36)	15.2% (30)
Guardianship	19.2% (38)	17.2% (34)
Unable to return (DD)	0% (0)	0.5% (1)
Missing information Unknown	0.5% (1)	0% (0)

5. Discussion

Earlier studies of crisis nursery services reported the results of the perceptions of caregivers of infants and young children that received crisis intervention services. Caregivers in these studies consistently provided positive effects for the crisis intervention services they received (Andrews et al., 1999; Cole et al., 2005; Cole & Hernandez, 2008; Stein, 1985). These earlier studies show that caregivers that receive the immediate support provided by crisis interventions support services can experience decreases in parental stress and the potential for abuse and neglect of the vulnerable infants and young children in their care. Only one previous study looked at the effect of crisis nursery services on child abuse and neglect, but this study did not assess the impact of crisis nursery services on individual service recipients who subsequently entered the child welfare system The current study followed a specific group of infants and young children over time and compared those who received crisis nursery services and child welfare services with those who received only child welfare services. It controlled for such factors as child gender, ethnicity, and age at placement, as well as type of abuse and county of residence at the time of the report.

The infants and young children whose families received crisis nursery services were twice as likely to be returned to their families when compared with infants and young children with similar characteristics who did not receive crisis nursery services. These positive results seem to show that families who receive crisis nursery services of any dosage have a better chance of having their infants and young children returned to them. This can result in positive outcomes for children and families if they remain with their birth families. It is uncertain why this occurs, but we hypothesize that child welfare service providers may be more confident in returning children to their homes when they reside in counties that have crisis nursery services. Child welfare case managers are aware that these crisis and after-care services can be accessed until the children are school age and that close monitoring of caregiver–child interactions is available through crisis nursery services as well as consistent coaching for positive parenting skills. Child welfare agencies may also view families that sought crisis nursery services prior to the child's out-of-home placement as more resourceful than other families because they were willing to admit their difficulties and obtained assistance from crisis nurseries. These hypotheses need further study. Subsequent evaluation research of crisis nursery service effects could benefit from direct interviews with county child welfare workers and caregivers who use crisis nursery services.

Unfortunately, having received crisis nursery services was not shown to significantly affect the lengths of stay in out-of-home placements for the infant and young child. The average length of stay in foster care for infants and children who were served by crisis nurseries was not statically different, but slightly longer (379.55 days or 1.03 years) than the average length of stay in out-of-home care for infants and young children served only by child welfare services in the comparison group (368.75 days or 1.01 years). One year is a significant period of time in the life of an infant or young child. If an infant is placed in out-of-home care early in its first year of life the primary attachment relationship is with the out-of-home caregiver during that period. Although visitations with birth family caregivers may provide opportunities for interactions, the primary attachment bond with the infant may be with the foster care provider (Haight, Kagle, & Black, 2003; Scott, O'Neill, & Minge, 2005). When the infant is returned to the birth family or placed in an adoptive home the loss of their substitute out-of-home caregiver can make it difficult to form a positive relationship with the birth family. Although removal from the family is often necessary to ensure the safety of vulnerable infants and

young children, every effort should be made to place them in a permanent setting as soon as possible. If the plan is to return the child to their birth family, consistent and frequent efforts to support the birth caregiver–infant relationship during out-of-home placement must be made (Lawrence et al., 2006; Kammerman & Kahn, 1995; Bakersmans-Kranenburg, van Ijzendoorn, & Juffer, 2003). This can be accomplished through frequent supervised visitations in which parents are encouraged to use strategies for developing and maintaining secure relationships. Crisis nurseries could support visitations with birth parents by serving as visitation sites for supervised parent–child interactions. In addition, parents could also participate in parent–child interaction groups provided by the nurseries to begin to have a supportive network of other caregivers to practice positive parenting strategies prior to the child's return. The role of crisis nurseries in supporting transitions needs further study.

Another difference between the two groups was the length-of-stay for infants and young children who received kinship care placements as opposed to those who received foster care placements. The length of stay was shorter for infants placed in kinship care when compared to the length of stay for infants and young children placed in foster care. When the two groups of infants placed in foster care were compared, the average length of stay for infants and young children placed in kinship care and received crisis nursery services prior to placement was 322.77 days or about ten months. The average length of stay for infants and young children who received only kinship care was 274.64 days or about nine months. The reason for the shorter length-of-stay is unclear. Often kinship care providers are significantly older than unrelated foster care providers and can be more invested in returning the child to their families, especially if they are not aware of support services such as crisis nurseries that can provide respite care. Crisis nursery services support caregivers of all types—parents, grandparents, aunts, uncles, sisters or brothers—who are experiencing stress in caring for infants and young children. Several of the crisis nurseries in Illinois have seen a rise in kinship caregivers, especially grandparents, accessing their services for respite care (personal communication, Chrystal Chaddock and Laura Swinford). How crisis nursery services support kinship caregivers also needs study. The support kinship caregivers receive from crisis nurseries may decrease their motivation for returning the infants and young children to their birth caregivers while caring for infants without support may increase the motivation to terminate kinship care.

Children who remained in foster care at the end of the study period were more likely to be older and may reflect ongoing difficulties in their birth homes. Children, who had indicated reports of sexual abuse, also were more likely to still be in longer in foster care at the termination of the study. During the study year approximately 92% of the perpetrators of sexual abuse were family members (CANS, 2006). This may account for the continuation of children in foster care. A safe permanent home may not have been identified for the child among family members.

Although the current study of the longitudinal effects of crisis nursery participation on out-of home placement outcomes moves crisis nursery service research into new areas, the study has a number of limitations. Like most secondary data analyses, this study was constricted by the data available for infants and young children in both the crisis nurseries and the Illinois Department of Children and Family Services databases. Matching was only possible using the variables that were the same in both databases. Other child variables of interest that could expand our understanding of the results such as the prenatal substance exposure of the infant, pre-maturity, substitute care (daycare center or family daycare home), and child development data were not available. Other caregiver variables of interest such as the number of caregivers in the home, caregivers supports beyond the crisis nurseries, relationships among primary caregivers (e.g., domestic violence) caregivers' education levels, caregivers' employment outside the home, caregivers' economic resources, number of caregivers in the home, caregivers' history of psychiatric illness (e.g., post-partum depression), and caregivers' history of substance use were also not available.

Information on the dosage of crisis nursery services received by families prior to the children's placement in out-of home care was not available for this analysis. The type of crisis nursery services (crisis care and/or post-crisis care) the families received was not available for these analyses. Both dosage and type of care could affect the length of stay in out-of-home care and the placement at the termination of out-of-home care. These factors await subsequent study of crisis nursery effects.

Another limitation of this study is the identification of the infants and young children in the control group. Propensity score matching was able to identify infants and young children with like-characteristics in the CYCIS database to form a comparison group for the study. The infants and young children in the comparison group were not from families who had sought crisis nursery services. It is uncertain if the families who seek crisis nursery services are different from families with like-characteristics who do not seek those services. It is anxiety provoking and difficult for caregivers to seek crisis nursery services and could account for some of the decrease in stress caregivers report when they have finally accessed crisis nursery services (Cole & Hernandez, 2008). There is always the risk of being judged unfit to care for their children. The families who seek crisis nursery assistance and have their children removed may be different from those who never sought crisis nursery assistance. Study is needed that directly queries caregivers and compares caregivers with like-characteristics who seek and access crisis nursery services with those who do not seek or use crisis nursery services.

6. Conclusion

This study adds to the research base of crisis nursery outcome studies by using administrative data from the Illinois crisis nurseries and the Illinois Children and Family Services CANTS and CYSIS databases to compare how the length of stay and placement outcomes for infants and young children is affected when their families receive crisis nursery services prior to out-of-home placement. The greater likelihood of children returning to their families when the families received crisis nursery services prior to placement in out-of-home care shows that the impact of crisis nursery service use can extend beyond immediate use of the service, but further study is needed to identify more discrete factors that explain this phenomenon. Crisis nurseries are part of a continuum of care of child welfare services. When families use crisis nursery services, crisis nurseries can prevent the out-of-home placement of infants and young children by reducing stress and enhancing parenting skills. This study shows that crisis nursery services can have long term effects even for young children who ultimately enter out-of-home care.

References

American Academy of Pediatrics, Committee on Early Childhood, Adoption, and Dependent Care (2000). Developmental issues for young children in foster care. *Pediatrics*, *106*, 1145–1150.

Andrews, B., Bishop, A. R., & Sussman, M. S. (1999). Emergency child care and overnight respite for children from birth to 5 years of age. In J. A. Silver, B. J. Amstar, & T. Haecker (Eds.), *Young children and foster care* (pp. 325–345). Baltimore: Brookes.

ARCH National Resource Center for Respite and Crisis Services (1994). *Factsheet number 31.* http://www.archrespite.org/archfs31.htm Retrieved 5/6/2004

ARCH National Respite Network and Resource Center (2000). *ARCH 5.2. Chapel Hill, NC.* .

ARCH National Respite Network and Resource Center (2006). *Crisis respite: Evaluating outcomes for children and families receiving crisis nursery services: Final report.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children, Youth and Families, Office of Child Abuse and Neglect.

Bakersmans-Kranenburg, M. J., van Ijzendoorn, M. H., & Juffer, F. (2003). Less is more: Meta-analyses of sensitivity and attachment interventions in early childhood. *Psychological Bulletin*, *129*, 195–215.

Belsky, J. (1984). The determinants of parenting: A process model. *Child Development*, *55*, 83–96.

Belsky, J. (1996). Parent, infant and social–contextual antecedents of father–son attachment security. *Developmental Psychology*, *32*, 905–914.

Belsky, J. (1998). Paternal influence and children's well-being: Limits of and new directions for understanding. In A. Booth (Ed.), *Men in families: When do they get involved? What difference does it make?* (pp. 279–294). Mahwah, NJ: Erlbaum.

Belsky, J. (2005). Attachment theory and research in ecological perspective. In Klaus Grossmann, Karin Grossmann, & E. Waters (Eds.), *Attachment from infancy to adulthood: The major longitudinal studies* (pp. 71–97). New York: Guilford Press.

Belsky, J., Bakermans-Kranenburg, M. J., & van Ijzendoorn, M. (2007). For better and for worse: Differential susceptibiilty to environmental influences. *Current Directions in Psychological Science*, *16*, 305–309.

Belsky, J., & Jaffee, S. (2006). The multiple determinants of parenting. In D. Cicchetti, & D. Cohen (Eds.), *Developmental psychopathology (2nd Ed.). Risk, disorder and adaptation*, *Vol. 3*. (pp. 38–85) NY: Wiley.

Child Abuse and Neglect Statics (CANS) (2006). *Fiscal Year 2006.* Chicago, Illinois: Illinois Department of Children and Family Services Downloaded January 28, 2011. http://www.state.il.us/DCFS/docs/CANTS2006.pdf

Clark, Mary K. (1990). *A dream come true: The story of casa de los niños* (2nd ed.). Tucson, AZ: Casa de Los Niños.

Cole, S. A., & Hernandez, P. (2008). Crisis nursery outcomes for caregivers served at multiple sites in Illinois. *Children and Youth Services Review*, *30*, 452–465.

Cole, S. A., & Hernandez, P. (2009). Using crisis nurseries to support permanency. *17th National Conference on Child Abuse and Neglect, March 30–April 4, 2009, Atlanta,GA.*

Cole, S. A., Hernandez, P., & Swinford, L. (2007). *Evaluating crisis nursery services at multiple sites in Illinois: A report to the Illinois Department of Children and Family Services.* Urbana, IL: Children and Family Research Center, University of Illinois.

Cole, S. A., & Record, S. (2010). *Summary of data: Illinois crisis nurseries: 2001–2009.* Urbana-Champaign: School of Social Work, University of Illinois at Urbana-Champaign.

Cole, S. A., Wehrmann, K. C., Dewar, G., & Swinford, L. (2005). Crisis nurseries: A vital component in the system of care for families and children. *Children and Youth Services Review*, *27*, 995–1000.

DeLapp, J., Denniston, J., Kelly, J., & Vivian, P. (1998). *Respite, crisis care, and family resource services: Partners in family support (ARCH Factsheet Number 51).* Chapel Hill, NC: National Center for Respite and Crisis Care Service.

Dougherty, S., Yu, E., Edgar, M., Day, P., & Wade, C. (2002). *Planned and crisis respite for families with children: Results of a collaborative study*. Chapel Hill, NC: ARCH National Respite Network and Resource Center.

Dozier, M., & Albus, K. E. (2000). Attachment issues for infants in foster care. In R. Barth, M. Freundlich, & D. Brodzinsky (Eds.), *Adoption and prenatal drug exposure: The research, policy, and practice challenges. Infant Mental Health Journal*, *25*. (pp. 541–554) Washington, DC: The Child Welfare League of America caregivers: Targeting three critical needs.

Dozier, M., Albus, K., Fisher, P. R., & Sepulveda, S. (2002). Interventions for foster parents: Implications for developmental theory. *Development and Psychopathology*, *14*, 843–860.

Dozier, M., Stovall, K. C., Albus, K. E., & Bates, B. (2001). Attachment for infants in foster care: The role of caregiver state of mind. *Child Development*, *72*, 1467–1477.

Egeland, B., & Sroufe, L. A. (1981). Attachment and early maltreatment. *Child Development*, *52*, 44–52.

Frame, L. (2002). Maltreatment reports and placement outcomes for infants and toddlers in out-of-home-care. *The Infant Mental Health Journal*, *23*, 517–540.

Frame, L., Berrick, J. D., & Brodowski, M. (2000). Understanding reentry to out-of-home care for reunified infants. *Child Welfare*, *79*, 339–369.

Guo, S., Barth, R., & Gibbons, C. (2006). Propensity score matching strategies for evaluating substance abuse services for child welfare clients. *Children and Youth Services Review*, *28*, 357–383.

Guo, S., & Fraser, M. (2010). *Propensity score analysis: Statistical methods and applications.* Los Angeles: Sage.

Haight, W., Kagle, J. D., & Black, J. E. (2003). Understanding and supporting parent–child relationships during foster care visits: Attachment theory and research. *Social Work*, *45*, 195–207.

Kammerman, S. B., & Kahn, A. J. (1995). *Starting right: How America neglects its youngest children and what we can do about it.* New York: Oxford Press.

Lawrence, C. R., Carlson, E. A., & Egeland, B. (2006). The impact of foster care on development. *Development and Psychopathology*, *18*, 57–76.

National Institute of Child Health and Development (NICHD) Early Child Care Research Network (2005). Early child care and children's development in the primary grades: Follow-up results from the NICHD study of early child care. *American Educational Research Journal*, *43*, 537–570.

Neter, J., Kutner, M. H., Wasserman, W., & Nachtscheim, C. J. (1986). *Applied linear regression models.* New York: McGraw-Hill.

Proctor, L. J., Skinner, L. C., Roesch, S., & Litrownik, A. J. (2010). Trajectories of behavioral adjustment following early placement in foster care: Predicting stability and change over 8 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, *49*, 464–473.

Rosenbaum, P. R., & Rubin, D. B. (1984). Reducing bias in observational studies using sub-classification on the propensity score. *Journal of the American Statistical Association*, *79*, 516–524.

Scott, D., O'Neill, C., & Minge, A. (2005). *Literature review: Contact between children in out-of-home care and their birth families.* Melbourne, Australia: School of Social Work - University of Melbourne.

Shonkoff, J. P., & Phillips, D. A. (2001). *From neurons to neighborhoods: The science of early childhood development.* Washington, DC: National Academy Press.

SPSS 15.0 [Computer software]. (2006).Chicago, IL: SPSS, Inc.

Sroufe, L. A., Egeland, B., Carlson, E., & Collins, W. A. (2005). Placing early attachment experiences in developmental context. In K. E. Grossmann, K. Grossmann, & E. Waters (Eds.), *The power of longitudinal attachment research: From infancy and childhood to adulthood* (pp. 48–70). New York: Guilford Publications.

STATA 9.2 [Computer software]. (2006).College Station, TX: Stata Corp.

Stein, T. J. (1985). Projects to prevent out-of-home placement. *Children and Youth Services Review*, *7*, 109–121.

Stovall, C., & Dozier, M. (2000). The development of attachment in new relationships: Single subject analyses for 10 foster infants. *Development and Psychopathology*, *12*, 133–156.

Subramanian, K. (1985). Reducing child abuse through respite center intervention. *Child Welfare*, *64*, 501–509.

Tyrrell, C., Dozier, M., Teague, G. B., & Fallot, R. D. (1999). Effective treatment relationships for persons with serious psychiatric disorders: The importance of attachment states of mind. *Journal of Consulting and Clinical Psychology*, *67*, 725–733.

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2009). *Preliminary Estimates for FY 2008 as of October 2009 (16).* www.acf.hhs.gov/programs/cb

Wulczyn, F. H., Hislop, K. B., & Hardin, B. J. (2002). The placement of infants in foster care. *The Infant Mental Health Journal*, *23*, 454–475.

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Crisis nurseries: Important services in a system of care for families and children

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Abstract

This paper reports the results of an evaluation of crisis nursery services for five crisis nurseries in Illinois from 2000 to 2003 based on analysis of administrative data reported to the Illinois Department of Human Services (IDHS). Crisis nursery services, sometimes called "respite" services, provide temporary emergency care for children. The results demonstrate the vital importance of availability of emergency support services for young children and their caregivers. By describing how crisis nurseries respond to needs of families of young children and provide the after-crisis care. It describes the important role crisis nurseries currently play in crisis intervention and after-crisis services for children and their families.

Keywords: Crisis nurseries; Illinois; IDHS; Emergency; Respite; Infants; Young children

1. Introduction

Crisis nursery services, sometimes called "respite" services, provide temporary emergency care for children (Andrews, Bishop, & Sussman, 1999; Franz, 1980). The

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"emergency" or "crisis" for which the family requests services can range from the need for child care due to a medical emergency (i.e., an automobile accident or surgery) to an unexpected stressful home situation (i.e., domestic violence or homelessness) to a risk of abuse and neglect (i.e., stressed single parent with no support) (Andrews et al., 1999).

Sometimes dismissed as emergency "babysitting" services, crisis nurseries provide specialized crisis interventions to infants and young children and their families. When families experience crisis situations, the primary caregivers are often unavailable physically or psychologically to meet the needs of their children (Webb, 1999). The caregivers' may be unable to perceive what their young children need or how to best address their needs in the family crisis (Webb, 1999). When this occurs, both the young children and their caregivers need timely interventions in a safe place where the workers are trained to understand how crisis affects each member of the family (Webb, 1999).

When the environment of pre-school children is chaotic, dangerous, or uncertain, children need the support of people who understand their developmental needs and can provide appropriate interventions until their primary caregivers can again be attentive to them (Webb, 1999). Studies of the effects of the traumatic events of September 11th and the long-term effects of traumatic experiences in children from otherwise stable families (Gaensbauer, 2004) underscored the importance of specialized crisis intervention for young children (Thomas, 2001–2002; Schechter, Coates, & First, 2001–2002). Crisis nursery workers have understood the need for these services and have provided crisis intervention services to children 0–5 years old and their families since the 1960s (DeLapp, Denniston, Kelly, & Vivian, 1998). Crisis nursery workers are experts in ameliorating the effects of the traumas young children experience. The crisis nursery workers have the knowledge and the skills to provide developmentally appropriate interventions for children. Young children in family crises may not have the cognitive sophistication to understand what is happening to them or their families, but they sense the emotionality of the situation and respond to it (Pynoos, 1994; Schechter et al., 2001–2002). They and their families need assistance in negotiating the immediate crisis and the after effects of the event in order to ensure positive post-trauma child development (Osofsky, 1997).

Although crisis nurseries vary in the services they offer to families, many provide an array of choices that include initial crisis assessment and intervention services, after-crisis interventions, follow-up care, and/or referral to other community services (Andrews et al., 1999). Crisis nursery service delivery is limited by the capacities of the nurseries. To insure that the children most in need get immediate service, the crisis nurseries maintain a list of emergency priorities for providing care when the facilities are at maximum capacity. When licensing capacity is reached, the crisis intake workers assist the family in resolving the immediate crisis and provide referral and transportation to another agency that can provide ongoing care (Dougherty, Yu, Edgar, Day, & Wade, 2002).

Historically, crisis nurseries in the United States developed from a grassroots movement in the 1960s to provide respite to parents in stress and prevent child abuse and neglect (DeLapp et al., 1998). The crisis nurseries were initially funded by private donations (Clark, 1990). Impetus for federal legislation resulted from a year-long U.S. House of Representatives Select Committee on Children, Youth and Families investigation that documented a need to be responsive to families with children who have special needs including teen parents, families of children with disabilities, and stressed caregivers at risk

of abusing or neglecting their children (ARCH, 1994). In 1986, funding for effective temporary care to help preserve and support families and strengthen the parent bond was established in the Temporary Child Care for Children with Disabilities and Crisis Nursery Act of 1986. This was reauthorized in the Child Abuse, Domestic Violence, Adoption and Family Services Act, Temporary Child Care for Children with Disabilities and Crisis Nurseries Act Amendments (1992). Since 1988, 47 states have obtained funding to establish a total of 175 crisis nurseries and two respite centers (ARCH, 1994). They provide support for all families who need emergency care.

Although crisis nurseries are of vital importance in providing emergency support services for young children and their caregivers, little recent research has investigated the role that crisis nurseries play in a system of care for young children and their families (Knitzer, 1982, 2000). An important early study highlighted the role that crisis nurseries can play in preventing child abuse and neglect. The Nashville Comprehensive Emergency Services Demonstration Project in the early 1970s implemented a coordinated emergency system of services for neglected and abused children in Nashville, Tennessee. The demonstration project included services that provided emergency care for children in their own homes or in emergency foster homes (Burt & Balyeat, 1974). The evaluation of this program demonstrated the project's success in meeting a variety of program objectives. It found that the number of neglect and dependency petitions was reduced and fewer children were removed from their families and placed in substitute care. The program was also found to reduce the numbers of children on whom abuse and neglect petitions were filed who were subsequently abused and neglected by the end of the next year (Burt, 1976).

Stein's (1985) review of the results of seven programs to prevent out-of-home placement for children at-risk for abuse and neglect reported mixed results. Three studies that incorporated emergency services (including the Burt & Balyeat, 1974 reported above) and two prevention projects in New York that incorporated emergency child care, reported positive outcomes. Design flaws (risk assigned by worker judgement rather than objective criteria) and the change in child welfare policy (to maintain children in their own homes as opposed to foster care placements) made it difficult to come to definitive conclusions about the impact of emergency services on prevention of placement for risk of abuse and neglect.

In his review of the literature on prevention of child abuse and neglect, Schmitt (1980) identified crisis nurseries along with access to counseling for parents as "extremely inexpensive forms of prevention" (p. 176), when compared to the cost of foster care placements. Other studies have also reported on the impact of crisis nursery interventions on the impact of child abuse and neglect (Andrews et al., 1999; Dougherty et al., 2002; Subramanian, 1985). Thirty-six parents reported a decrease in parenting stress for problems related to their children as well as financial and housing problems when they accessed crisis nursery services (Subramanian, 1985). Parents using crisis nursery services also reported significant improvements in parenting stress based on pre- and post-test scores on the Parenting Stress Index/Short Form (Cowen, 1998). Some research suggests that those who use crisis nursery services perceive them as safe places for children (Dougherty et al., 2002). In an ARCH survey of users of crisis nursery services, caregivers reported that if crisis nursery services were not available they might choose to leave their children alone, in the care of an inappropriate caregiver, or have the child accompany them

to a place the parent perceived as dangerous for the child (Dougherty et al., 2002). Limited research addresses the role crisis nurseries play in strengthening families and developing independence beyond time-limited crisis intervention (Andrews et al., 1999).

This paper is an analysis of the aggregate, administrative data collected by the Illinois Department of Human Services (IDHS) for monitoring and funding purposes. The data used for the analysis were collected for the funding years 2001–2003 by five crisis nurseries in Illinois. By analyzing the data requested by DHS, we gain an understanding of who the nurseries serve, the types of services delivered, and the changes in service demand over time. While the data available for analysis are limited to the reporting parameters of the DHS monitoring criteria, the analysis of these data provides new information on how crisis nurseries serve families of children 0–5 and sets the agenda for future research into the place of crisis nurseries in a comprehensive system of care for young children and families.

2. Methodology

2.1. Study participants

The five nurseries that participated in this study use two different organizational structures to provide services to families. Two of the nurseries are incorporated with the State of Illinois as independent non-profits with boards of directors and executive directors who manage the day-to-day operations of the nurseries. Three of the nurseries are subsumed under larger non-profit organizations that provide a range of services from child care to child welfare services. All the nurseries use a similar mix of paid staff and trained volunteers and provide 24-h, 7-day respite, 365 days per year.

In 2000, the five crisis nurseries established an informal coalition called the Illinois Crisis Nursery Coalition. The coalition allowed the nurseries to work together to expand their crisis intervention and after-care programs. Through the work of the coalition, each of the nurseries was able to obtain partial funding from the IDHS. An IDHS requirement was that the nurseries establish a system of service tracking to demonstrate program effectiveness. The coalition worked closely with the IDHS to identify reporting variables that would be meaningful for the nurseries and fulfill IDHS monitoring requirements. Table 1 is a list of the variables all five nurseries agreed to report to IDHS on a quarterly basis.

As requested by IDHS, the total number of adults and children served was reported. No further identifiers were provided by crisis nurseries for families that accessed services. To better ascertain the types of at-risk families served by the crisis nurseries, IDHS also asked the nurseries to report on the number of children from three specific types of at-risk families served by them. Children served by crisis nurseries, who would have been removed from their homes and placed in foster care if their families did not obtain crisis nursery services was the first group. These were children from intact families currently served by the Illinois Department of Children and Family Services (IDCFS), who IDCFS identified that were in danger of being placed in foster care. Children from homeless families comprised the second group of interest to IDHS. Children with developmental delays served by crisis nurseries were the third group of interest.

Table 1
Variables reported to IDHS by crisis nurseries in Illinois

General information reported
Unduplicated count of adults receiving crisis nursery services
Unduplicated count of children receiving crisis nursery services
Total number of admissions/intakes of children for crisis nursery services
Total number of child care hours provided
Total number of counseling hours provided
Information reported on children served
Unduplicated count of children served who would have entered the child welfare system
Number of admissions for children served prevented from entering child welfare services
Unduplicated count of children whose families are homeless
Unduplicated count of children with developmental disabilities
Reasons for admission (provided by parents served at each admission for crisis services)
Parental stress
Domestic violence
Home crisis
Mental health (parent or child)
Substance abuse
Court related
Medical related
Public support services (TANF training or work requirements)
Other
Turn away information
Ineligible: Referral made
Capacity: Referral made
Capacity: No referral made
Family support services
Parent Education Classes
Adult Support Groups
Children's Groups
Amount of in-kind services for basic needs provided
Number of referrals provided to services in the community
Number of follow-up activities provided
Outcome measures
Percentage of parents who reported a decreased level of stress after receiving services
Percentage of parents who reported a positive change in their parenting skills
Percentage of parents who reported a reduced risk of maltreating their child

IDHS also required that the crisis nurseries identify outcome data that would show the effect of crisis nursery interventions on potential for parental child abuse and neglect, parental stress, and quality of parenting skills. The five nurseries agreed to use items from the ARCH National Respite Network and Resource Center Questionnaire for Families Using Respite Care 5.2 (ARCH Form 5.2) to report identified outcomes.

2.2. Measures

The ARCH Form 5.2 is a 15 item self-report evaluation instrument that is administered in person or by telephone by crisis nursery workers to caregivers at the completion of each crisis nursery service admission. The caregiver is queried about: the

reason for seeking crisis care; the length of time the caregiver was in crisis before contacting the agency; if the caregiver had used crisis nursery services before the present admission; would they use crisis nursery services again; the caregiver's perceived stress level pre- and post-receipt of nursery services; the caregiver's perception of how secure and safe nursery services were; the caregiver's perception of stress reduction; the caregiver's perception of increased parenting effectiveness; alternatives the caregiver would have used if crisis nursery services were not available; problem(s) the caregiver was able to address with the support of crisis nursery services; sufficiency of the respite provided to the caregiver; level of threat of the child's removal from the caregiver by child welfare without crisis nursery services; and availability of other emergency care.

The crisis nurseries reported the outcomes of their interventions by providing IDHS with the responses of caregivers to three specific items from ARCH Form 5.2. Responses to Items 5 ("When you brought your child or children to us for crisis care, how "stressed" were you in your role as a parent") and 6 ("Now that you have had crisis care, how "stressed" are you in your role as a parent") were used to evaluate the change in parental perceived stress level after using crisis nursery services. Caregivers respond to a seven item Likert scale (1=Not at all stressed, 2=Slightly stressed, 3=Somewhat stressed, 4=Moderately stressed, 5=Quite stressed, 6=Very stressed, 7=Extremely stressed) to report their level of perceived stress before and after using services.

Item 9 ("Do you feel that this program reduces the risk of harm to children?") was used to evaluate the caregivers' perception of the degree that the program changed the risk of harming children. A different seven item Likert scale (1=Not at all, 2=Slightly, 3=Somewhat, 4=Moderately, 5=Quite a bit, 6=Greatly, 7=Extremely) measured the degree to which caregivers reported their decreased risk of abuse and neglect. Using the same Likert scale used in Item 9, Item 10 ("Now that you have had crisis care, do you think you will be able to more effectively parent your child?") evaluated the caregiver perceived change in parenting skills.

In 2003, the chair of the Illinois Crisis Nursery Coalition contacted the researchers to request assistance in analyzing the data that the crisis nurseries reported to IDHS. The crisis nurseries wanted to understand how well the nurseries were fulfilling service needs over time. The authors met with the executive directors and crisis workers from the five nurseries of the coalition and IDHS to discuss strategies to use the existing data for program improvement. Based on these discussions, the crisis nursery research and evaluation project was initiated. It was a unique public/private/public university effort.

2.3. Procedures

The nursery executive directors and IDHS emailed the aggregate data on an Excel spread sheet from funding years 2001–2003 to the researchers. These data were summarized on a composite database. The nursery directors, program managers, and researchers met once per month to resolve any data reporting issues. When the data from the final quarter of 2003 were recorded, frequencies, percentages, and changes over time

were computed by the researchers. The aggregate data were summarized and presented to crisis nursery executive directors, program managers, and IDHS monitors in October 2003. During the presentation and review of the data summaries, the individual nursery personnel discussed the contextual factors in their organizations and local communities that affected the numbers they reported. The results of these discussions were recorded by the researchers in minutes from this meeting. They provide a qualitative context for interpreting the data analyzed for this study.

3. Results

This section reports the results of the analysis of the administrative data reported to IDHS by the five crisis nurseries. Three years of data are summarized in the results from the following variables: the number of hours of crisis care provided, how many children and adults were served, what types of crisis nursery services were used, the reasons why services were accessed, and the results of the three outcome measures reported to IDHS (Table 2).

Overall, the number of hours of crisis nursery care provided by the nurseries increased from about 66,000 in FY 2001 to over 82,000 h in FY 2003 (Table 3).

The number of adults served more than doubled. A small decline (about 7%) in the number of children served over the 3 year period is reported. When the number of hours of care per child is calculated over the 3 year period, by dividing the number of child care hours by the number of children receiving care, the number of hours of crisis care per child increased from about 28 h per child in FY 2001 to about 40 h per child in FY 2003 (Table 4).

Table 2
Number of hours of crisis nursery care provided

Variables	FY 2001	FY 2002	FY 2003
Number of hours of crisis care provided	65,937	65,393	82,493

Table 3
Total number of adults and children served by the crisis nurseries

Variables	FY 2001	FY 2002	FY 2003
Total children served[a]	2701	2693	2520
Total number of adults served	1197	2569	2613

Table 4
Children served from at-risk categories

Variable	FY 2001	FY 2002	FY 2003
Children co-served by crisis nurseries and IDCFS	270	441	555
Children served from families without homes	203	263	351
Children served with developmental disabilities	135	105	226

The number of children reported from three categories of risk identified by IDHS was examined. These included children at-risk for removal from their homes, children from homeless families, and children with developmental delays. Children from families co-served by IDCFS and the crisis nurseries, the first category of risk, increased during each of the 3 years studied. Between FY 2001 and FY 2003, the number of children co-served increased by 63% from 270 to 441. Between funding years 2002 and 2003, children co-served increased by and additional 26%, from 441 to 555. Over the 3 year period studied, the number of children co-served by IDCFS and crisis nurseries more than doubled.

The number of children from families who were homeless served by the crisis nurseries was the second category of risk identified for reporting by IDHS. Children from families that were homeless, increased by 73% (from 203 to 351) between FY 2001 and FY 2003.

The third risk category identified by IDHS was the number of children who had developmental disabilities. The number of children with developmental disabilities served by the crisis nurseries increased from FY 2001 to FY 2003, although there was a decline in children with developmental disabilities served from FY 2001 to FY 2002. During the 3 year period studied, the overall number of children with developmental disabilities served by crisis nurseries increased by 66% (Table 5).

An admission is the term used each time a child is brought to a crisis nursery site for crisis intervention service. The total number of crisis nursery admissions for all children served between FY 2001 and FY 2003 increased by 42% from 7287 to 10,333. The mean number of admissions per child for all children served almost doubled during the study period (2.1 in FY 2001; 3.2 in FY 2002; 4.1 in FY 2003) (Table 6).

When the average number of admissions per child served for all children is compared to the average number of admissions for children co-served by IDCFS and the crisis nurseries, in FY 2001, children co-served received almost twice as many admissions—3.9 per child as compared to 2.1 for all children. In FY 2002, the average number of admissions per child co-children fell to about 3.3, which was about the same as for children served overall (3.2), while in FY 2003, the average number of admissions per co-served child rose to 3.8. In FY 2003, the average number of admissions for of all children served by the nurseries (4.1 per child) was greater than

Table 5
Total number of admissions for all children and for children co-served by crisis nurseries and IDCFS

Variable	FY 2001	FY 2002	FY 2003
Number of crisis nursery admissions for all children	7287	8496	10,333
Number of crisis nursery admissions for children co-served	1057	1434	2107

Table 6
Number of admissions per child served

Variable	FY 2001	FY 2002	FY 2003
Number of crisis nursery admissions per child	2.1/child	3.2/child	4.1/child
Number of crisis nursery admissions per child co-served	3.9/child	3.3/child	3.8/child

the average number of admissions of children who were co-served (3.8 per child) (Table 7).

For each admission, the caregiver provided a reason why they were requesting crisis nursery services. The top three reasons caregivers reported for requesting crisis nursery services over the 3 year period remained fairly stable: job or school related (averaged about 35%), parental stress (averaged 28%) and medical related (14%).

Some shifts were noted in the percentage of parents who provided certain reasons for accessing services during the 3 year studied. Although the number of times parents giving "parental stress" as a reason for admitting their child for crisis nursery services increased from FY 2001 (1846) to FY 2002 (2163), the percentage of parents citing stress remained about the same (26%). In FY 2003, the number increased to 3141 and the percentage of parents citing stress as their reason for admission increased to 31%. The number and percentage of parents who indicated "substance abuse issues" more than doubled over the 3 years from 3% (234) in FY 2001 to 7% (726) in FY 2003. Although "medical related" remained one of the top three reasons for admissions, the percent who reported needing emergency care for this reason declined over the 3 year period studied as did the percent accessing crisis nursery services due to mental health and domestic violence issues. The percent of parents who reported accessing crisis nursery services due to "job and school related emergencies" (34%), "home crises" (6%), "court related issues" (3%), "maintenance of public support requirements" (2%) and "other" non-specified reasons (1%), remained stable over the 3 years studied (Table 8).

To maintain the gains made from crisis intervention services and family support services, many families needed follow-up services. The number of follow-up services

Table 7
Reasons for admission

	FY 2001	FY 2002	FY 2003
Job/school related	2471 (34%)	3017 (36%)	3485 (34%)
Parental stress	1846 (26%)	2163 (26%)	3141 (31%)
Medical related	1152 (16%)	1208 (14%)	1271 (12%)
Substance abuse	234 (3%)	354 (4%)	726 (7%)
Home crisis	364 (5%)	531 (6%)	601 (6%)
Domestic violence	199 (3%)	321 (4%)	243 (2%)
Court related	317 (4%)	288 (3%)	342 (3%)
Mental health	285 (4%)	305 (4%)	215 (2%)
Public support services	N/A[a]	161 (2%)	186 (2%)
Other	18 (<1%)	92 (1%)	72 (1%)
Total	7186	8440	10282

[a] Not tracked until 2001.

Table 8
Number of follow-up services crisis nurseries provided

Variables	FY 2001	FY 2002	FY 2003
Number of after-crisis follow-up services provided	N/A	1645	2191
Number of family support follow-up services provided	1999	1682	1508
Total number of follow-up services provided	1999	3327	3699

provided for the two types of services was also studied. The number of follow-up services (1999) was reported only for crisis nursery family support programs in FY 2001. The number of follow-up services was reported for both crisis nursery services and family support programs in FY 2002 and FY 2003. For these 2 years, the total number of follow-up services provided to caregivers from both the crisis nursery and family support programs increased by about 11% from 3327 in FY 2002 to 3699 in FY 2003 (Table 9).

To extend the effect of the work started during crisis nursery or family support interventions, specific follow-up interventions were provided by the crisis nurseries. Individual counseling at the crisis nurseries and in family homes was one type of after-crisis care provided. Individual counseling hours provided to children and adults increased from a low of about 350 h in FY 2001 to over 4700 h in FY 2003.

Group educational and counseling support (for adults and children) was another type of after-crisis care provided at the nurseries. The number of parent education groups that caregivers completed almost doubled from 105 in FY 2001 to 208 in FY 2003. The number of parent support groups completed by caregivers more than doubled from 65 in FY 2001 to 141 in FY 2003. The number of groups children completed increased by almost three times from 108 in FY 2001 to 302 in FY 2003.

In-kind support to families was an additional after-crisis service provided by the nurseries. In-kind support included food, clothing for children and adults, diapers, wipes, and developmentally appropriate toys. The dollar value of in-kind services provided to families from the crisis nurseries increased from about $14,000 in FY 2001 to about $59,000 in FY 2002 to over $82,000 in FY 2003 (Table 10).

Families using crisis nursery services may need special services that are beyond the scope of services that the nurseries can provide. The crisis nurseries have referral links

Table 9
Number of individual counseling hours and counseling groups completed (parenting education, adult and child support groups)

Variables	FY 2001	FY 2002	FY 2003
Number of individual counseling hours provided	351	629	4750
Number of parent education groups completed	105	144	208
Number of adult support groups completed	65	92	141
Number of children's support groups completed	108	147	302

Table 10
Number of referrals to community programs: Families served and families turned away

Variables	FY 2001	FY 2002	FY 2003
Number of referrals provided to community services for families served			
Number referred after crisis nursery program	727	3506	3986
Number referred after family support programs	431	393	357
Total number of referrals for community services	1158	3899	4343
Number of referrals for community services for families turned away			
Number referred who requested services not provided by crisis nurseries	500	212	228
Number of eligible turned away due to capacity	365	467	464
Total number turned away with referrals	865	679	692

with community agencies that provide specialized services for domestic violence, shelter, substance abuse counseling, and ongoing mental health counseling. The total number of referrals provided to families for other community services increased by about 11% from 1158 in FY 2001 to 4343 in FY 2003.

Potential service recipients sometimes request services not provided by the nursery (i.e., requests for regular daycare services, housing services, or adult shelter for domestic violence). The number of clients who were turned away due to requests for services the nurseries could not provide decreased by more than half from 500 in FY 2001 to 212 in FY 2002 and remained about the same (228) for FY 2003. At other times, the nurseries do not have sufficient capacity to meet the crisis needs of all the families who request services. The number of clients turned away due to capacity problems increased by about 28% from 365 in FY 2001 to 467 in FY 2002 and remained about the same (464) for FY 2003 (Table 11).

Caregivers' perceptions of the effects of crisis nursery interventions on their level of stress improved during each of the 3 years studied. For FY 2001, 399 evaluations were completed by adult caregivers who received crisis nursery services. Of the caregivers who completed evaluations of the services they received, 79% reported that their stress level decreased. In FY 2002, 852 adult caregivers completed evaluations for services received. Of those, 91% reported a decrease in stress. In FY 2003, 650 adult caregivers completed evaluations for services received and of those, 90% reported a decrease in stress.

Caregivers' perceptions of the effects of crisis nursery interventions on their parenting skills also improved for each of the 3 years studied. In FY 2001, of the 304 caregivers receiving crisis nursery services who completed evaluations, 77% reported a positive change in their parenting skills. In FY 2002, of the 664 caregivers who completed evaluations, 91% reported a positive change in their parenting skills. Of the 718 caregivers receiving crisis nursery services who completed evaluations in FY 2003, 96% reported a positive change in parenting skills. During the 3 year period studied, the percent of caregivers reporting a positive change in their parenting skills increased by 24%.

Caregiver reported perception of risk of maltreatment improved during each of the 3 years studied. In FY 2001, of the 248 caregivers who completed evaluations, 73% reported that nursery services reduced their risk of maltreatment. Of the 594 caregivers who completed

Table 11
Improvements reported by caregivers

Variables	FY 2001	FY 2002	FY 2003
Decrease in parental stress			
Number reporting decrease	399	852	650
Percentage reporting decrease	79%	91%	90%
Reduced risk of maltreatment			
Number reporting decrease	248	594	745
Percentage reporting decrease	73%	79%	98%
Improvement in parenting skills			
Number reporting improvement	304	664	718
Percentage reporting improvement	77%	91%	96%

evaluations in FY 2002, 79% reported a reduced risk of maltreatment and in FY 2003, 98% of the 745 caregivers completing evaluations reported a reduced risk of maltreatment.

4. Discussion

The crisis nurseries in Illinois used federal start-up money available in the 1980s to initiate their programs. When direct support for the programs was rolled into family support block grants administered by the state in the 1990s, access to funding declined. IDHS saw a value in the preventive services provided by the nurseries and agreed to provide $500,000 to be used by all five nurseries to provide family support services. The five nurseries divided the grant according to the financial needs of the specific crisis nursery programs. As part of the funding agreement, IDHS required the nurseries to report how the money they provided was being used. This study used aggregate data originally collected and reported to IDHS for funding accountability to begin to examine the impact of crisis nurseries for children and families in Illinois. Although limited, the data provide some interesting insights into crisis nursery services and directions for future research.

4.1. Reasons for accessing services

Caregivers' reasons for requesting crisis nursery services changed. Caregivers requesting support for "parental stress" increased by 5%. The increase in caregivers who needed crisis intervention for parental stress required that the nurseries provide additional individual and group counseling to assist parents in ameliorating the stress of the immediate situation. It also required education and coaching to assist caregivers in developing healthy strategies to cope with stressful situations in the future to decrease reliance on crisis nursery services. The response of the nurseries is seen in the increase in individual and group counseling hours as well as educational services provided.

The percentage of parents citing "substance abuse/use" as a reason for requesting crisis nursery services more than doubled during the 3 years studied. The increase noted may have resulted from increased illicit substance production and subsequent use in the crisis nursery service areas. The five crisis nurseries are located in small cities surrounded by large rural farm areas where the production, distribution, sale, and use of crystal methamphetamine increase was reported immediately preceding the 3 year period studied. (U.S. Department of Justice, 2001). The increase in substance use and subsequent treatment needs could account for the increase in those seeking services for "substance use/abuse."

Also, when caregivers enter the child welfare system due to substance use, court orders often require parents of infants and young children to seek treatment to prevent their children from being removed from their care and placed in foster care. Substance abuse treatment rarely includes child care. To respond to the need for child care of caregivers in community based treatment programs, crisis nurseries worked collaboratively with local substance abuse treatment programs and county IDCFS programs to provide child care for infants and young children while caregivers attended treatment sessions.

The percentage of caregivers providing other reasons for requesting crisis nursery services decreased during the study period. The percentage of clients requesting crisis

nursery services for "domestic violence issues" decreased from FY 2001 to FY 2003. In considering the reason for this decline, crisis nursery workers noted that there had been an increase in cooperation among crisis nurseries, law enforcement agencies, and domestic violence shelters in their local communities to work together to meet the needs of families experiencing domestic violence. The decline in those accessing crisis nursery services for "domestic violence" may reflect this change in the service delivery structure.

The percentage of those who provided "medical" as a reason for requesting crisis nursery services also decreased from 2000–2001 through 2002–2003. It is unclear why the proportion of those needing crisis nursery services due to "medical" reasons declined.

4.2. Changes in demand

In reviewing the data with the researchers, the crisis nursery directors and workers saw how the changes in service demands of clients affected their programs during the 3 years studied. The mean number of admissions per child almost doubled during the study period. In fact, the average number of admissions for all children (4.1 per child) was about the same as the average number of admissions for DCFS children co-served by IDCFS and the crisis nurseries (3.9 per child). This rise in the average number of admissions per child for all children reflected the increased severity of problems in families accessing crisis nursery services and the increased need for assistance over time.

The increase in the number of children co-served by IDCFS and crisis nurseries, the number of children from homeless families, and the number of children with developmental disabilities also reflected a change in service demand. The type of children and families served required more intensive services at the point of contact. The need for extended services beyond crisis intervention increased. New intervention skills were required of the crisis nursery work force. The demand in services changed from responding to time limited, short term, acute crises of stable families to focused, ongoing interventions to assist families in developing skills and strategies to meet long term family problems. The change in demand required new staff skills and increased the need for specialized training for staff and volunteers to meet ongoing family needs.

The need for increased ongoing services from the crisis nurseries was also seen in caregivers seeking crisis nursery services for mental health reasons. Although the percentage of caregivers who reported "mental health" as the reason for seeking crisis nursery services decreased, executive directors and staff saw families with adults with severe psychiatric problems accessing crisis nursery and after-crisis services on an ongoing basis. Part of the reason for the need for this increased crisis nursery support was the caregivers' difficulty in obtaining mental health services in a timely manner for non-life threatening situations. In each community, executive directors and staff expressed concerns regarding the lack of access to mental health services for clients who were not in acute psychiatric crisis.

4.3. Service effectiveness

IDHS required that the crisis nurseries report on the effectiveness of crisis nursery services in decreasing the potential for child abuse and neglect, decreasing parental stress,

and improving parenting skills. Over 90% of those caregivers who evaluated the crisis nursery services they received for themselves and their children reported that the crisis nurseries were effective in achieving these three outcomes. The caregivers' reported that their stress decreased. They also reported that their danger of abusing or neglecting their children decreased. In addition, they reported that their skills to effectively parent their children increased.

4.4. Public perception and support of crisis nurseries

Other findings from the study provide insight into how crisis nurseries are viewed by the broader public. During the study period, the crisis nurseries engaged in public education campaigns in their local communities about crisis nursery services. The decrease in the number of clients turned away because they requested services that the nurseries did not offer reflected the success of the crisis nurseries' educational efforts. The dramatic increase of in-kind contribution by local communities also reflects the effectiveness of the crisis nurseries' educational efforts.

5. Future research

This study provides a basis to understand the place crisis nursery services play in services for young children and their families. Because the analysis of crisis nursery services in Illinois used aggregate data reported by the crisis nurseries to IDHS, case level data were unavailable, therefore, only limited analysis could be done. Future research is necessary to ascertain the individual and co-occurring risk factors for specific families and children served by the crisis nurseries. Examination of causal relationships can explain how and who crisis nurseries serve best. Through studies of longitudinal, case level data, future research can determine how effective crisis nursery services are in preventing the long term effects of trauma the infants and young children crisis nurseries serve.

Longitudinal study is also needed to assess the effectiveness of crisis nursery interventions over time in preventing future abuse and neglect or foster care placement for children and families served. Studies that match service recipients with subsequent confirmed cases of child abuse and neglect or entry into foster care overtime could give a better understanding of the long term treatment effects of receiving crisis nursery services. Such studies could clarify if crisis nurseries eliminate the need for expensive foster care placements, if crisis nurseries presently play a role in family reunification for families with children in foster care, or how crisis nurseries fit into the patchwork of services families put together to safely care for their children.

The promising outcomes reported by crisis nursery recipients in reducing their stress, reducing the risk of abuse and neglect of young children, and enhancing their parenting skills also needs further study. Studies that compare outcomes for a matched sample of crisis nursery service recipients with families with similar attributes who have not received crisis nursery services would provide a clearer picture of the effects of crisis nursery intervention.

6. Conclusion

Crisis nurseries have provided effective services for families of young children in five communities in Illinois for over 20 years. The nurseries have had little time or money to evaluate their services or make a case for the important role they play in the continuum of child welfare and mental health services for young children and their families. As access to mental health and family support services decline due to lack of available funding, crisis nurseries provide ongoing after-crisis care to families with these needs. In providing emergency child care for parents with acute medical, mental health, domestic violence, or substance abuse problems, crisis nurseries provide a way for families to stay safe and together through an acute crisis and develop skills to meet new challenges. In providing emergency child care for caregivers whose child care is unexpectedly eliminated, crisis nurseries provide safe, last-minute child care. By providing referrals to other community services, crisis nurseries serve as trusted advisors in linking families to needed care that the crisis nurseries can not provide. In all these ways, crisis nurseries are a vital community resource in the system of care for young children and their families.

References

Andrews, B., Bishop, A. R., & Sussman, M. S. (1999). Emergency child care and overnight respite for children from birth to 5 years of age. In J. A. Silver, B. J. Amster, & T. Haecker (Eds.), *Young children and foster care* (pp. 325–345). Baltimore: Paul H. Brookes.

ARCH National Resource Center for Respite and Crisis Services. (1994). *Factsheet number 31*. http://www.archrespite.org/archfs31.htm. Retrieved 5/6/2004.

Burt, M. R. (1976). Final results of the Nashville comprehensive emergency services project. *Child Welfare*, *LV*(9), 661–664.

Burt, M. R., & Balyeat, R. (1974). A new system for improving the care of neglected and abused children. *Child Welfare*, *LIII*(3), 167–169.

Child Abuse, Domestic Violence, Adoption and Family Services Act, Temporary Child Care for Children with Disabilities and Crisis Nurseries Act Amendments, Pub. L. 102–295 (1992), Clark, Mary K. (1990). *A dream come true: The story of casa de los ninos* (2nd ed.). Tucson, AZ: Casa de Los Ninos.

Clark, M. K. (1990). *A dream come true: The story of Casa de los Ninos* (2nd ed.). Tuczon, AZ: Casa de los Ninos.

Cowen, P. S. (1998). Crisis child care: An intervention for at-risk families. *Issues in Comprehensive Pediatric Nursing*, *21*(3), 147–158.

DeLapp, J., Denniston, J., Kelly, J., & Vivian, P. (1998). *Respite, crisis care, and family resource services: Partners in family support (ARCH Factsheet Number 51)*. Chapel Hill (NC): National Center for Respite and Crisis Care Service.

Dougherty, S., Yu, E., Edgar, M., Day, P., & Wade, C. (2002). *Planned and crisis respite for families with children: Results of a collaborative study*. Chapel Hill (NC): ARCH National Respite Network and Resource Center.

Franz, J. (1980). Being there: A 24 hour emergency crisis care center. *Children Today*, *9*(1), 7–10.

Gaensbauer, T. J. (2004). Telling their stories: Representation and reenactment of traumatic experiences occurring the first year of life. *Zero to Three*, *24*(5), 25–31.

Knitzer, J. (1982). *Unclaimed children: The failure of public responsibility to children and adolescents in need of mental health services*. Washington (DC): Children's Defense Fund.

Knitzer, J. (2000). Early childhood mental health services: A policy and systems perspective. In J. P. Shonkoff, & S. J. Miesels (Eds.), *Handbook of early childhood intervention* (2nd edition). New York: Cambridge University Press.

Osofsky, J. D. (1997). The effects of exposure to violence on young children. In J. M. Notterman (Ed.), *The evolution of psychology: Fifty years of the American Psychologist* (pp. 725–740). Washington, DC: American Psychological Association.

Pynoos, R. S. (1994). Traumatic stress and developmental psychopathology in children and adolescents. In R. S. Pynoos (Ed.), *Posttraumatic stress disorder: A clinical review* (pp. 725–740). Lutherville (MD): The Sidran Press.

Schechter, D. S., Coates, S. W., & First, E. (2001–2002). Observations of acute reactions of young children and their families to the World Trade Center attacks. *Zero to Three*, *22*(3), 9–13.

Schmitt, B. D. (1980). The prevention of child abuse and neglect: A review of the literature with recommendations for application. *Child Abuse and Neglect*, *4*, 171–177.

Stein, T. J. (1985). Projects to prevent out-of-home placement. *Children and Youth Services Review*, *72*, 109–121.

Subramanian, K. (1985). Reducing child abuse through respite center intervention. *Child Welfare*, *64*, 501–509.

Temporary Child Care for Children with Disabilities and Crisis Nurseries Act of 1986, Pub. L. No. 99–101. (1986).

Thomas, J. M. (2001–2002). A long walk together: Children's world learning center—Pentagon. *Zero to Three*, *22*(3), 5–8.

Webb, N. B. (1999). *Play therapy with children in crisis*. New York: The Guilford Press.

Cynthia Stringfellow

Educare Learning Network

What is Educare?

PROGRAM, PLACE, PARTNERSHIP and PLATFORM

Educare is a research-based Program that prepares young, at-risk children for school; a specially designed Place that nurtures early learning and sends a bold message about the value of investing in the first five years; an innovative Partnership between the public and private sectors to create a more efficient, more effective early learning program; and a compelling Platform to drive change among policymakers, business leaders and early childhood providers by showing what quality early learning looks like.

Educare: Attacking the Achievement Gap

Educare Schools are dramatically changing the life trajectories of thousands of children growing up in families facing the greatest obstacles to success—and changing the way America thinks about early education. Each Educare School is a comprehensive early childhood program aimed at preventing the achievement gap that takes root between children in poverty and their middle-income peers long before they enter kindergarten. Independent research shows Educare works. Experience also demonstrates that Educare is a powerful catalyst for improving early childhood practice, informing early childhood policy, and cultivating new private and public investments in the first five years of learning.

Through a growing coast-to-coast network of state-of-the-art, full-day, year-round schools, funded mostly by existing public dollars, Educare serves at-risk children from birth to five years. Each embraces a community's most vulnerable children with programming and instructional support that develop early skills and nurture the strong parent-child relationships that create the foundation for successful learning.

Our Results

Research shows that children who experience Educare for a full five years arrive at elementary school performing on par with average kindergarteners, regardless of socio-economic standing. Educare children have more extensive vocabularies and are better able to recognize letters, numbers and colors than their peers. And children who experience Educare also develop strong social skills, including self-confidence, persistence and methods to manage frustration. All of these abilities are strong predictors of later success in academics—and in life. What's more, early findings indicate the gains Educare children make hold as they move through elementary school.

Program

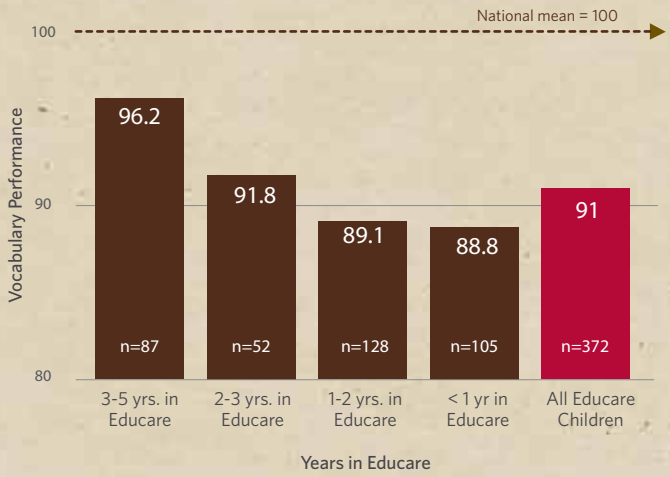
Educare is a **PROGRAM** based on the best early education practices that ensure the school-readiness of children most at risk for academic failure.

Young children who experience the world as predictable and supportive develop strong emotional foundations essential for learning. The Educare model draws from a wide range of research-based practices that foster learning environments that support infants, toddlers and young children who are growing up in stressful, impoverished communities.

Research shows that vocabulary growth among children from low-income homes lags behind that of their middle-income peers. Without intentional intervention, this gap, which is evident at nine months of age, only continues to widen.

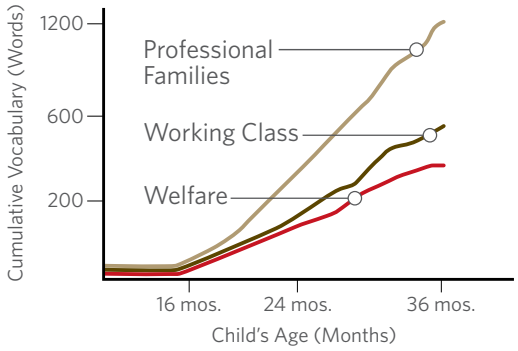
Vocabulary: Children who spend more years in Educare emerge better prepared for kindergarten

Peabody Picture Vocabulary Test



Yazejian, N., & Bryant, D. M. (2010). Promising Results: Educare implementation study data, January 2010. Chapel Hill: FPG Child Development Institute, UNC-CH.

Disparities in Early Vocabulary Growth



Source: Hart, B. and Risley, T.R. (1995). "Meaningful Differences in the Everyday Experiences of Young Children." Baltimore, MD: Brooks Publishing Co.

At Educare Schools, teachers work with children—beginning in infancy and through preschool—and their parents to develop pre-literacy and early math skills such as letter and number recognition, problem solving, and counting. Equal emphasis is given to developing social-emotional skills: the ability to focus on a task, persistence, impulse control and cooperation with peers.

Central to Educare's mission is involving families in their children's development. Activities and interactions are aimed at strengthening parents' abilities to serve as champions for their child's learning after they leave Educare and enter primary and secondary schools.

A unique component of the Educare model is the practice of continuity of care. Each child stays with the same team of teachers from birth to age three. Children then move into a preschool classroom for students ages three to five with a different team of teachers. This continuity creates close bonds among children, teachers and parents, reinforcing the stable relationships essential to learning.

Educare demands high standards. Schools serve 140 to 200 children. Class sizes are kept small and teacher-child ratios are kept low to ensure individualized care. Infant-toddler classes serve eight children. Preschool classrooms serve 17 children. Each room has three teachers. Lead teachers hold bachelor degrees, and every four classrooms are supervised by master-degreed teachers who work as coaches inside classrooms.

Full-time social workers and various consultants (e.g., speech pathologists, nurses, visiting artists) provide additional support to each family. Teachers and social workers regularly review and evaluate their success in helping children grow and learn, and adjust practices accordingly.

This approach is paying off. Independent research by the FPG Child Development Institute at the University of North Carolina-Chapel Hill finds that children who started Educare between birth and age two exceeded national averages on measures of school readiness. Those gains persisted even when controlling for risk factors such as maternal education, race and parents' ages. Kindergartners who spent their early years at Educare arrived at elementary school ready to learn and on par with middle-income peers.

Place

Educare is much more than a successful education model. It is a memorable **PLACE** of early learning that sends a clear message that we must invest in early childhood education because children are born learning.

A Showcase for Quality

Educare Schools are designed and constructed with children's learning in mind. Ample physical space and light allow babies, toddlers, and preschoolers to explore, learn and develop. Classrooms are safe, comfortable places that promote bonds between the teaching staff and young children. Spaces encourage interactive learning so that teachers and children are seen together reading, acting out stories, creating artwork, counting, or conducting simple experiments.

Inside every Educare School, significant space is devoted to family-related activities, including one-on-one counseling and support groups for mothers, fathers and grandparents. There is a room with computers to facilitate parents' efforts in job hunting or in researching elementary schools their children will eventually attend.

The first Educare School opened in Chicago in 2000. Today, Educare Schools are located throughout the country—from Seattle to Tulsa to Miami to Milwaukee—with more on the way. All Educare Schools are in economically disadvantaged communities, and each school is tailored to meet local needs. One Educare School in Tulsa includes an on-site health clinic. Denver Educare stands next to a teacher-training institute on the historic Clayton Early Learning campus. Educare in Waterville, Maine, is the first rural school in the Network.

Partnership

Educare is about **PARTNERSHIP**. Philanthropists, Head Start and Early Head Start providers, and school officials partner to narrow the achievement gap for children in their communities. Each commits to securing the financing, program expertise and public support essential to maintaining Educare's high-quality standards.

Joining Forces

The Ounce of Prevention Fund, with the Irving Harris Foundation, opened the first Educare School in Chicago. In 2003, the Buffett Early Childhood Fund and the Omaha Public Schools opened the second Educare on Omaha's north side. Soon after, the Buffett Early Childhood Fund and Ounce of Prevention Fund joined forces to support other local public-private partnerships in communities across the country to establish Educare Schools. Today, this joint initiative, known as the Educare Learning Network, supports the development of these schools and provides training, assistance and a forum for learning to Educare staff.

The Educare movement has been embraced by other major philanthropic organizations—the George Kaiser Family Foundation, the W.K. Kellogg Foundation and the Bill & Melinda Gates Foundation—that, along with the Buffett and Harris foundations, provide challenge grants through an Educare replication pool to support steady growth in the Network.

In each city where Educare has taken root, new public-private partnerships are created to share governance of each school. Local philanthropists provide private dollars to build the schools and facilitate the flow of public dollars that support day-to-day activities. Federal funds from Early Head Start and Head Start provide critical funding for program operations and often are augmented by state funds for child care and preschool programs that flow to local school districts and programs.

"Public-private partnerships like Educare are the only way we're going to get there. ... It takes adults putting egos aside, putting historical differences aside, and saying, 'Let's figure out a better way to do it.' ... This, Educare, is a better way to do [early education]—and it's starting to become a real national model."

Arne Duncan, Secretary, US Department of Education, speaking at Educare of Oklahoma City

Platform

In cities and states across the nation, Educare is serving as a **PLATFORM** for raising awareness of the value and vital importance of learning during a child's first five years of life. It is changing practice and policies about how early education programs are created and sustained.

At-risk children who do not receive quality early care and education are 50 percent more likely to be placed in special-education classes, 25 percent more likely to drop out of school, 40 percent more likely to become a teen parent, and 70 percent more likely to be arrested for a violent crime.

A Wise Investment

Despite growing scientific evidence that brain growth and development occur most rapidly during the first five years of life, our society's current investment in children's education and care is lowest during those critical early years. Comprehensive learning programs for very young children of low-income parents remain scarce even though they can help prevent more costly interventions later in life.

At-risk children who do not receive quality early care and education are 25 percent more likely to drop out of school, 40 percent more likely to become a teen parent, 50 percent more likely to be placed in special-education classes, and 70 percent more likely to be arrested for a violent crime.

James J. Heckman, Ph.D., the 2000 Nobel Prize winner in economics, has determined that such social problems can be traced to an absence of social and emotional skills, such as perseverance and self-control—skills acquired during a child's earliest learning years. "The best evidence supports the policy prescription: invest in the very young," says Heckman.

Building Better Teachers

Educare Schools also serve as a training ground for thousands of early learning professionals. In addition to visiting our schools, many are coached in the teaching methods and practices that we have implemented over the past decade. Those early childhood professionals bring elements of our high-quality approach to the children they serve, helping to raise standards in teaching and in education outcomes.

Building these communities of learning—and practice—that extend beyond the walls of Educare is a key component of our strategy to work beyond the walls of our schools.

Educare is setting dramatic new standards for high-quality early childhood education so that all American children, including those living in poverty, can share in the American dream of equal opportunity for all.

Compared to peers

- The majority of Educare parents remain involved in their child's learning.
- About half of Educare graduates attend higher-performing institutions such as magnet, charter and gifted schools.
- Teachers report that most Educare parents participate in school activities, pick up their children's report cards and initiate conversations with teachers.

A Catalyst for Change

Educare Schools serve as "showrooms" that demonstrate what high-quality, well-implemented early learning programs can look like and help to convince policymakers, business leaders and others that investments in early learning make a difference in the life outcomes for even the most at-risk children.

Educare Schools also help create new champions for early learning by demonstrating, in real early learning classrooms, what is possible. Educare partners and families have become powerful voices for change.

Educare of Omaha helped advocacy and philanthropic leaders make the case for Nebraska to dramatically increase its investments in early learning programs. The Nebraska state constitution now declares that learning begins at birth, and a $60 million public/private endowment is expanding quality birth-to-three services.

Illinois increased funding of early childhood investments by over $172 million after Educare opened in 2000, and is moving toward full funding of preschool services.

Educare of Tulsa helped to inspire a $25 million pilot program to promote the school readiness of at-risk children. After visiting Educare of Omaha, the Kansas governor supported the establishment of an $11 million early childhood block grant with a set-aside for infants and toddlers.

Even before Educare of Central Maine opened its doors in 2010, it helped to promote expansion of state prekindergarten programs, the redirection of funds to early education and prevention programs and improvements to the state's child care quality standards.

The Educare movement and two related policy initiatives —the Birth to Five Policy Alliance, focused on state policies, and the First Five Years Fund, focused on federal policies— are supported by a group of like-minded philanthropists: the Buffett Early Childhood Fund; the W.K. Kellogg Foundation; the George Kaiser Family Foundation; The Children's Initiative: A Project of the J.B. & M.K. Pritzker Foundation; the Bill & Melinda Gates Foundation; and the Irving Harris Foundation. More partners are welcome.

For more information, visit www.educareschools.org.

EDUCARE
LEARNING NETWORK

Program Core Features

The core features of Educare Schools reflect the best-available, evidence-based strategies for effectively preparing at-risk young children and their families for success in school. The power of the Educare model is derived from these core features working together in a comprehensive, intentional and sustained way to achieve a high-quality early childhood program that helps children ages birth to five grow up safe, healthy and eager to learn.

The Educare Learning Network endorses these core features. Because the Educare network values continuous improvement and innovation, the core features may evolve in response to new research or evidence.

Provide full-day, full-year services

Maintain low staff-child ratios and small class sizes

- Infant-toddler classrooms: 3 adults and 8 children
- Preschool classrooms: 3 adults and 17 children

Use research-based strategies

- Programs engage in a system of reciprocal data feedback and utilization for continuous program improvement and individualized planning for children and families.
- Parents are engaged in ongoing communication about their child's screenings and assessments.
- Programs participate in the national, multi-site Educare Learning Network Implementation Study.
- Programs secure a local evaluation partner to assist in ongoing local program evaluation and the national Implementation Study.

Provide continuity of care

- To minimize transitions and help children develop secure relationships, primary caregiving is in place for all children.
- Each primary caregiver is assigned no more than four infants and toddlers or nine preschoolers.
- Children remain with the same teaching team from birth to age three.
- Children remain with a second set of teachers from age three until they transition to kindergarten.
- Program uses strategies to retain staff and maintain staff group assignments.

Offer on-site family support services

- The program fosters the development of strong, positive relationships among children, families and staff.
- Staff use evidence-based strategies that help parents promote and sustain their children's learning and later success in school:
    - Promote and enhance the parent-child relationship
    - Provide parents with information about their child's growth and development
    - Encourage parents to get involved in their child's education and school
- Family support specialists have small caseloads, averaging 30 or fewer families.
- Staff develop strong relationships with community organizations to facilitate referrals for services not available on site, such as mental health services.

Maintain high staff qualifications and intensive staff development

- In each classroom, there is a:
  - Lead teacher with a bachelor's degree in early childhood education;
  - Assistant teacher with an associate's degree in early childhood education; and
  - Teacher aide with a high school diploma/GED and courses or credential in child development.
- Master teachers have advanced degrees in early childhood education and special training in infancy for birth-to-age-three classrooms.
- If staff credentials above are not fully implemented, the agency clearly defines qualifications and expectations for staff to achieve the requirements.
- Master teachers oversee no more than four classrooms to provide intensive coaching, mentoring and support to teachers and to promote excellent classroom practice and staff retention.
- Family support supervisors have master's degrees in social work or its equivalent.
- Family support specialists have bachelor's or master's degrees in an appropriate field.
- With their supervisors, all staff members develop individual plans for professional development.
- Auxiliary staff (floaters and permanent substitutes) are available to maintain classroom ratios and support participation in professional development activities.
- Program supports all staff pursuing degrees in early childhood education.

Provide enhanced focus on language and literacy

- Intentional emphasis on language and literacy in:
  - age-appropriate assessments
  - curriculum and lesson plans
  - program planning
  - family engagement work
  - teacher supervision
  - adult and peer interaction
- Master teachers review assessment data, observe classrooms and provide direct coaching to teachers on early language and literacy strategies.

Emphasize social-emotional development to promote school readiness

- Social-emotional developmental theory informs all aspects of the program.
- Intentional emphasis on social-emotional development in:
  - age-appropriate screening and assessments
  - curriculum and lesson plans
  - program planning
  - family engagement work
  - teacher supervision
  - program operation
- All staff are trained annually on the discipline and guidance policy, which is based on proactive, positive approaches to discipline.
- The environment and staff behavior emphasize the centrality of relationships.
- All staff are trained on fostering engagement with children and families, with attention to verbal, non-verbal and written communications, as well as conflict resolution and cultural contexts.
- Transition planning for all moves into, within and from the program begins at least six months in advance and involves parents and multi-disciplinary staff teams.

Provide enhanced focus on problem-solving and numeracy

- Curriculum emphasizes problem-solving and numeracy skills development.
- Staff include these skills in individual child strength plans, weekly lesson plans and the design of group interactions.

Integrate the arts

- Programs use the arts to strengthen and support social-emotional, language and literacy development.
- Curriculum includes intentional emphasis on art experiences (drama, dance, music, story-telling and visual arts) to foster development.
- Community artists provide live performances and serve as classroom artists-in-residence.
- Parents, families and staff have opportunities to participate in arts activities.

Start early, with an emphasis on prenatal services

- To promote maternal and child health and well-being, the program or community partners provide Early Head Start services to pregnant women and newborns.
- Programs enroll infants as early as families require.
- Some programs provide doula services (prenatal and childbirth assistance) to build relationships with families and between parent and child as early as possible.

Implement an interdisciplinary approach

- Programs build effective teams among supervisors, teachers, family support, other staff, consultants and families.
- Staff implement and document strategies to ensure that everyone understands the importance of multiple perspectives and has the skills to be successful in their interdisciplinary efforts.
- Education and family support staff meet regularly to discuss and understand the child in the context of his or her family and conduct family/child reviews for each child a minimum of three times a year.
- Parent conferences include teachers, family support and other appropriate staff.
- Staff receive consultation from professionals with specialized information and expertise.

Implement reflective practice and supervision

- All program design and management systems support the integration and infusion of reflective practice and supervision.
- Reflective practice is implemented as the organizational model, including sensitivity to context, commitment to growth and change, shared goals, open communication, commitment to reflecting on the work and clear professional standards.
- Reflective supervision—incorporating the elements of reflection, regularity and collaboration—is implemented as the supervisory model at all staff levels.
- Each supervisor manages six or fewer supervisees.
- All Educare staff participate in individual reflective supervision at least once a month, with an additional group or individual reflective supervision.
- Job descriptions and performance appraisals include reflective practice and supervision.

Session IV

Targeting Parental Substance Abuse:

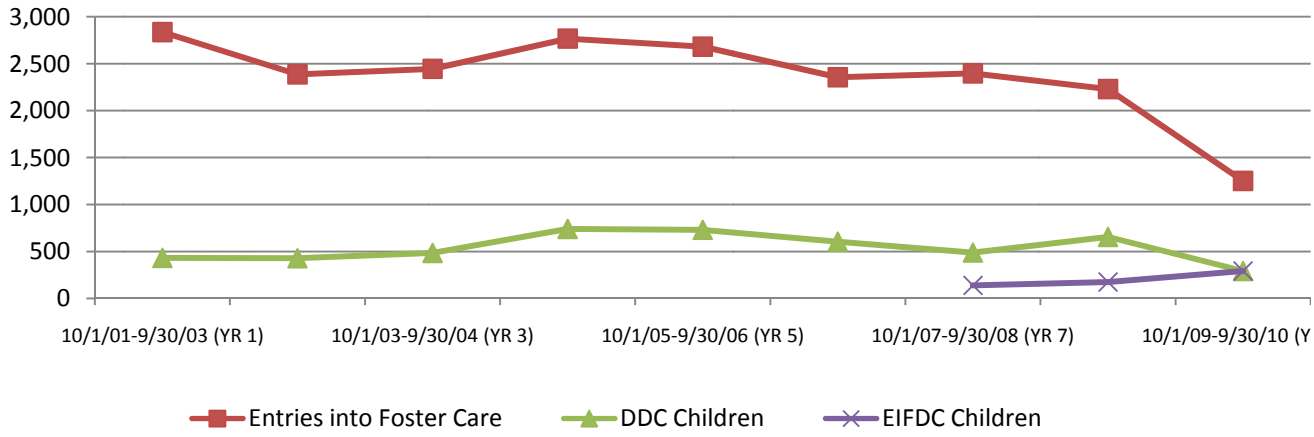
Providing Better Protection and Support for Children, Including Substance-Exposed Infants

Sacramento County Family Related Drug Court Programs
Informational Sheet
April 2012

In December 1998, the Presiding Judge of the Sacramento County Juvenile Court convened a meeting with representatives from multiple agencies to explore the feasibility of establishing a drug court for the dependency system. This priority was based upon the high percentage of court cases in which parental substance abuse was a driving factor in the child abuse/neglect allegations leading to court action. Sacramento County's efforts leading to the implementation of its first family drug court evolved over several years and can be broadly grouped into four primary efforts: (1) improved worker training; (2) system of care implementation; (3) early intervention services; and, (4) intensive recovery management services. The first family court initiated from these efforts was the Dependency Drug Court (DDC) in 2001. In 2007, Sacramento County initiated a preventive program, called the Early Intervention Family Drug Court (EIFDC) which serves families affected by prenatal substance use but where the child is still in the custody of the parents.

From October 1st, 2001 to September 30, 2010, there were 6,049 substantiated reports of child maltreatment with 2,372 of those children entering foster care in Sacramento. Consistent with national trends, the rates of substantiations and entries into foster care have dropped since 2001. Figure 1 presents trends in entries into foster care and number of children in the Sacramento DDC and EIFDC programs since 2001.

Figure 1: Sacramento County Child Welfare and Family Related Drug Court Trends

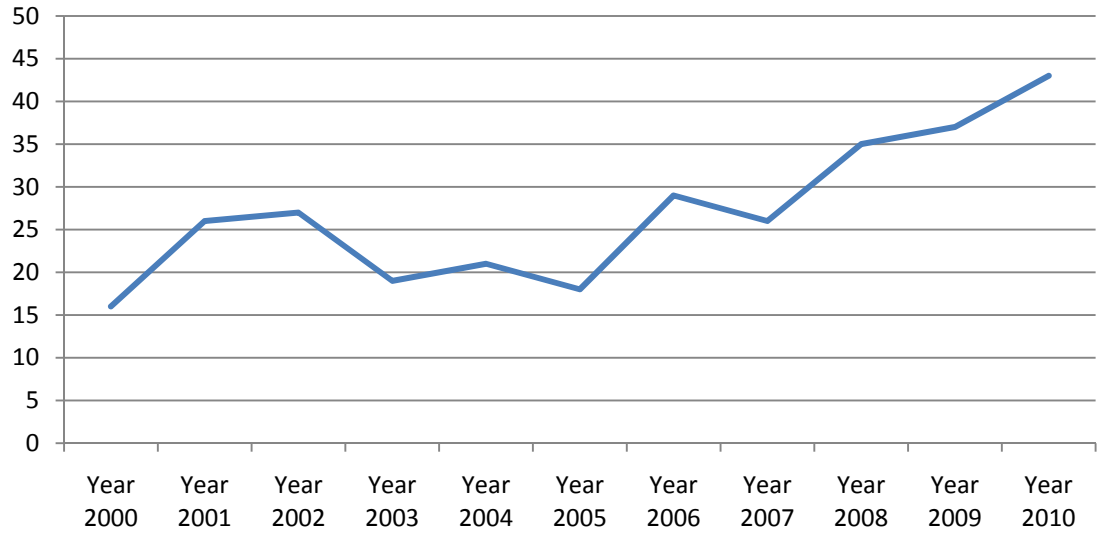


Sacramento County has one of the highest rates of children born substance-exposed to alcohol and drugs in the State of California (see Table 1). In addition, Sacramento County has seen an increase in the rates of substance exposed infants over the past decade (see Figure 2). These data represent only infants who were diagnosed at birth with neonatal withdraw symptoms and do not include those infants who were positive at birth for illicit drugs or were exposed to substances earlier in the pregnancy. These rates also do not include children who were prenatally exposed to maternal alcohol use. Thus, the rates presented are likely undercounts of the true rates of children born prenatally exposed to alcohol, illicit and prescription drugs in Sacramento County and the State.

Table: 1 Rates of Substance-Exposed Infants by California's Largest Counties[1]

County	Total Births in 2010	Diagnosed in 2010	Diagnosis per 1,000 births
Alameda	19,302	37	1.92
Contra Costa	12,352	27	2.19
Fresno	16,281	16	0.98
Los Angeles	133,160	83	0.62
Orange	38,327	45	1.18
Riverside	30,659	41	1.34
Sacramento	20,055	43	2.14
San Bernardino	31,367	30	0.96
San Diego	44,838	58	1.29
Santa Clara	22,936	9	0.39
Statewide	509,979	695	1.36

Figure 2: Number of Infants Diagnosed with Neonatal Withdraw Symptoms in Sacramento County[2]



COURT PROGRAM DESCRIPTIONS

Sacramento County has two programs serving substance abusing families in the child welfare system: the Dependency Drug Court (DDC) and the Early Intervention Family Drug Court (EIFDC). Both programs seek to blend the goals of child safety, permanency (whether reunification, adoption or permanent guardianship) and recovery from substance abuse. The focus of the DDC is in children who have been placed in out-of-home care while the EIFDC focuses on children who are still in the custody of their parents. The DDC and EIFDC program work closely with the Specialized Treatment and Recovery Services (STARS) program, a local non-profit community-based organization that provides case management services designed to assist parents in entering and completing treatment and court requirements. Each parent is matched to a STARS worker referred to as a Recovery Specialist. The primary duty of the Recovery Specialist, who is often in recovery themselves, is to

[1]/[2]Data from Office of Statewide Health Planning and Developed and the Sacramento Bee.

maintain a supportive relationship with the parent(s), with an emphasis on engagement and retention in treatment, while providing recovery and compliance monitoring for the Child Protection Service (CPS) Division and the Dependency Court. The Recovery Specialist monitors urine testing, substance abuse treatment and self-help group compliance. Urine testing is administered on a random basis and is always an observed collection. Compliance reports are sent to CPS, legal counsel and the Court two times each month. Families from court programs also can participate in Celebrating Families (CF) during their time in the court. CF is an evidence-based 16-week curriculum that addresses the needs of children and parents in families that have serious problems with alcohol and other drugs. Early evidence suggests that this program is significantly improving child well-being.

Both court programs use both incentives and sanctions to encourage the client to take responsibility for his or her actions. If the parent is compliant with the court orders, the bench officer encourages further compliance and administers appropriate incentives. The positive incentives valued most highly by participants seems to be the handshake and words of encouragement of the judge, recovery stones with words of encouragement and the accolades of the other participants. Sanctions for non-compliance vary depending upon the client's progress in the program and can range from court reprimands to dismissal from the program. Non-compliance includes: Failure to timely enroll in AOD treatment programs; positive urine test or admission of use; unexcused missed urine test (administrative positive) or refusal to test; failure to participate in required AOD treatment program activities and treatment plan; use/possession of controlled substance without valid prescription; failure to comply with rules of the AOD treatment programs and dependency drug court; use of alcohol when ordered to abstain; failure to appear for a compliance hearing; and failure to cooperate with substance treatment program staff or STARS recovery specialist. Until April 2009, the Sacramento County DDC utilized jail as a sanction. From the onset of the DDC through March 30, 2009, parents in Level I or II could receive up to four days in jail as a sanction. Any parent who agreed to enter residential treatment could receive a "stay" on the jail time once they completed the residential treatment. If they failed to complete residential treatment, the parents were ordered serve the jail time. On March 30, 2009, the Supreme Court of California ruled that "the juvenile court may not use its contempt power to incarcerate a parent solely for the failure to satisfy aspects of a voluntary reunification case plan" (In re Nolan W, March 30, 2009). As a result of this ruling, the Sacramento DDC immediately ceased using jail as a sanction for noncompliance. If a client in the voluntary EIFDC does not comply, there is a possibility depending on the client's child welfare case that they could be referred to the DDC.

The following is a brief description of the goals of each program, the number of parents and children served to date and selective outcomes of each program.

SACRAMENTO DRUG DEPENDENCY COURT (DDC)

The Sacramento DDC is a court-mandated program, which began in 2001, for parents with a child welfare case where parental substance use has been identified as contributing factor to the child maltreatment. Compliance reviews and management of the recovery aspects of the case are heard by the DDC bench officer throughout the life of the parents' participation in the DDC. Parents begin DDC services promptly at their first court hearing to increase compliance of court orders and engagement in substance abuse treatment. The DDC is a collaboration of the Juvenile Court, , Alcohol and Drug Services Division, CPS, Parents' Defense Attorneys, Children's Law Center of Sacramento, County Counsel, , and Bridges, Inc (STARS).

The DDC goals are:

- To increase successful family permanency rates;
- To increase clients' alcohol and other drug treatment compliance rates;
- To decrease the average length of stay of children in out-of-home care;
- To decrease related out-of-home costs;
- To increase the number of children placed with a permanent plan within statutory timeliness;
- To increase the number of parents with substance involvement are screened, assessed, and timely placed in the most appropriate treatment modality; and,
- To increase collaboration between the Court, CPS, and substance abuse treatment agencies.

To graduate from the Sacramento Dependency Drug Court, a parent must complete the following for 180 consecutive days:

- Drug test negative 2-3 times weekly (random tests are employed);
- Attend all treatment groups or individual sessions required;
- Attend all scheduled meetings with their STARS Recovery Specialists;
- Attend three or more support group or 12-step meetings weekly;
- Attend all required DCC appearances; and,
- Complete all requirements of the Court.

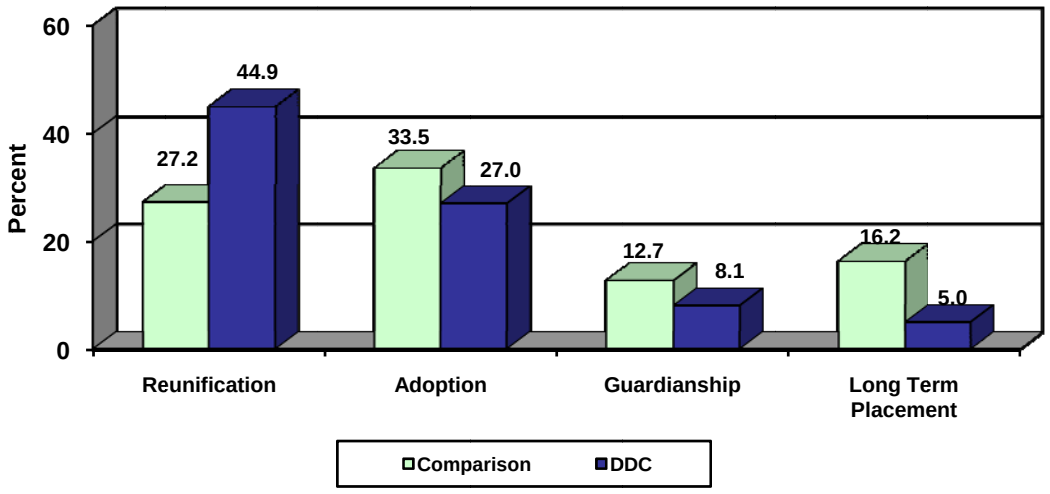
Characteristics of DDC Participants

DDC children have represented an increasingly larger percentage of children who entered foster care in Sacramento County over the past nine years. In 2001, DDC children comprised 15.2% of the entries into foster care in Sacramento County. This peaked at 29.4% in Year 2008 but dropped to only 23.3% in Year 2009. Since 2001, the DDC has served 5,142 children and 3,313 parents.

Child Permanency Outcomes

The primary goal of the DDC is a permanent placement that is in the best interest of the child. One of the longest prospective follow-up studies of a DDC population found that at 60 months-post DDC, Sacramento DDC children were significantly more likely to be reunified with their parents than an equivalent group of comparison children who did not receive DDC services. In contrast, comparison group children were more likely in permanent guardianship or long-term placement than DDC children. There were no significant differences in rates of finalized adoption at 60 months (see Figure 3).

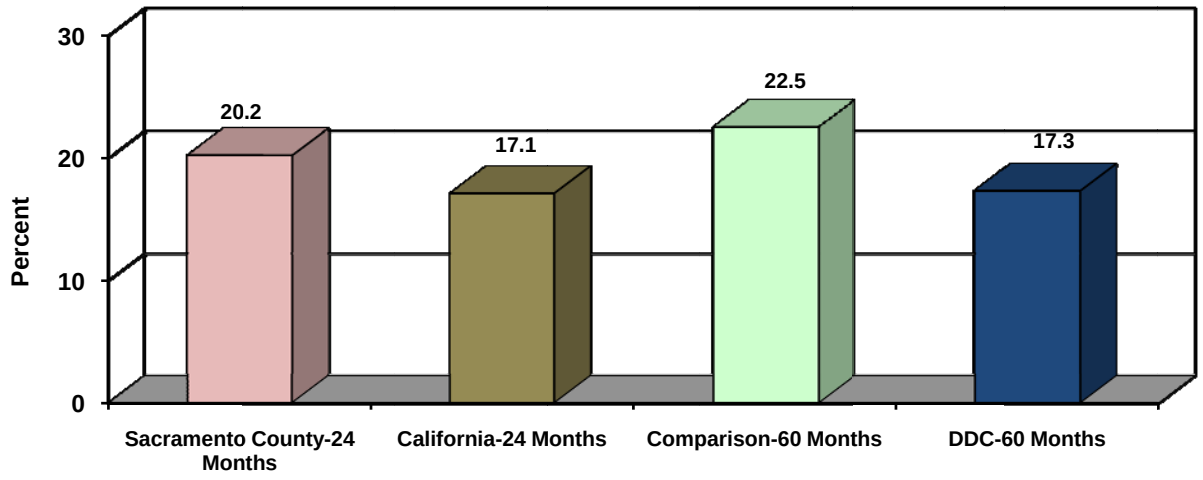
Figure 3: 60 Month Child Permanency Outcomes



Recurrence of Child Maltreatment

The DDC has shown long-term impacts on the reduction recurrence of child maltreatment. Out to 60 months post-DDC entry, DDC children were significantly less like to be the victim on another substantiated child maltreatment report than comparison children (17.3% vs. 22.5%). In addition, DDC children had less recurrence of maltreatment than the overall Sacramento County child welfare population and equivalent rates of a subsequent substantiated maltreatment report as the State child welfare population at 24 months (the farthest time period for which these data are collected), a three year shorter follow-up period (see Figure 4).

Figure 4: 60 Month Recurrence of Maltreatment Rates for DDC and Comparison Children Versus 24 Month Sacramento County and California Recurrence Rates



DDC Cost Analysis

The DDC program has produced substantial cost savings due to increased reunification rates. It is estimated that the DDC has saved $38,960,524 in foster care costs alone, due to the higher 24 month reunification rate of DDC children relative to the comparison group.

EARLY INTERVENTION FAMILY DRUG COURT (EIFDC)

While the success DDC has been well documented in serving families where the child was placed in out-of-home care due to parental substance use, there was a increasing need in Sacramento County for a more preventative program that not only kept children safe but also worked to keep families intact whenever possible. As a result, EIFDC, a voluntary program was implemented in 2007. Participation in EIFDC involves agreement by the parent to participate in Informal Child Welfare Supervision in lieu of filing a court petition for child maltreatment as long as the parent is in compliance with the treatment plan and the child is not placed at significant risk. Initially, this court was focused on infants born substance exposed to illicit drugs and alcohol but due to demand for preventive in-home services, was expanded to include all children ages 0-5 with prenatal or postnatal substance exposure. A central goal of EIFDC is to keep children safely in the home while providing their families the necessary substance abuse treatment and support services.

The EIFDC goals are:

- To increase the number of children at risk of removal, who remain in parent(s) custody;
- To decrease the recurrence of maltreatment;
- To increase the number of children receiving supportive or treatment services;
- To increase the number of infants receiving developmental assessments and interventions, as well as mental health treatment;
- To increase the capacity of service providers to offer substance abuse treatment services; To increase the number of parents in the Informal Supervision program who are screened and engaged in EIFDC;
- To increase the number of parents receiving and participating in substance abuse recovery case management and supportive services;
- To increase the number of parents participating in community-based parenting classes and support services;
- To increase the number of families participating in parent/child resiliency services;
- To increase the number of families receiving individualized supportive and recovery services through Family Resource Centers and faith-based organizations;
- To provide comprehensive assessments to families with substance-exposed infants and work collaboratively to link those families to necessary services;
- To develop and implement the necessary policies and procedures to improve collaboration among agency partners, resulting in improved services for families and children served through the EIFDC; and
- To modify existing evaluation of Informal Supervision families to include data collection and monitoring of outcomes related to parent's participation in the EIFDC.

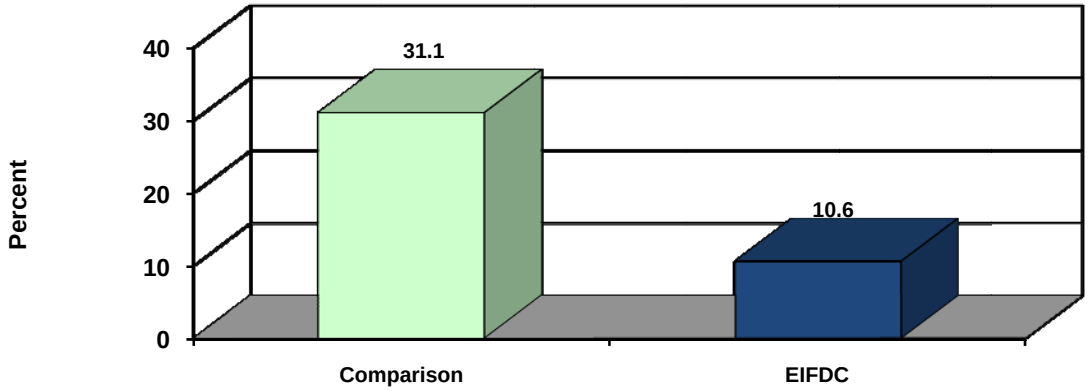
Characteristics of EIFDC Participants

EIFDC children have represented an increasingly larger percentage of Sacramento County children with substantiated allegations. In 2007, EIFDC children comprised 2.4% of all substantiated allegations within Sacramento County. This rose to 3.5% in 2008. Since 2007, the EIFDC has served 1,093 children and 633 parents.

Placement in Out-of-Home Care

Less than 11% of EIFDC children ended up having a child welfare petition filed and being placed in out-of-home care. Comparison children were three times more likely to have a child welfare petition file and be placed in out-of-home care than EIFDC children (see Figure 5).

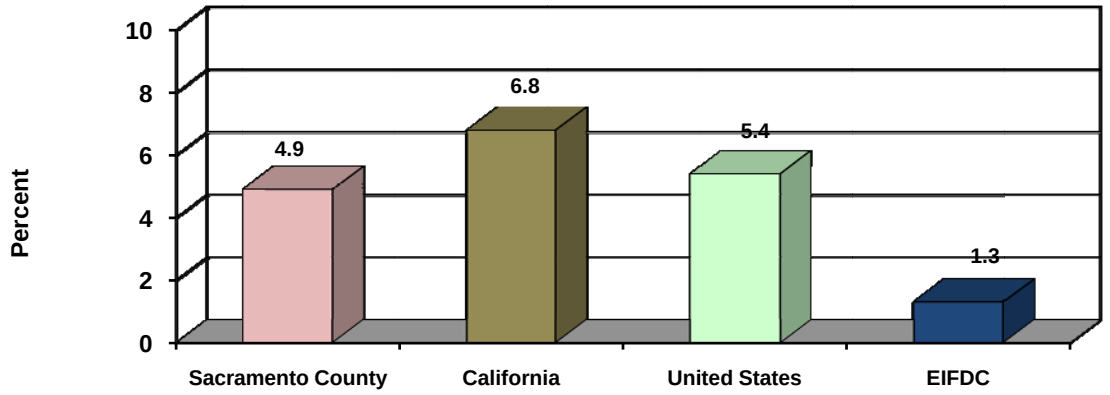
Figure 5: Percentage of EIFDC and Comparison Children Placed in Out-of-Home Care



Recurrence of Child Maltreatment

EIFDC children had significantly lower rates of recurrence of child maltreatment where the child experienced a subsequent substantiated maltreatment within six months of their parent's enrollment into the EIFDC relative to Sacramento County, California and national averages (see Figure 6).

Table 6: Percentage of EIFDC Children who experienced a Recurrence of Maltreatment



EIFDC Cost Analysis

There have been nine children born to mothers participating in EIFDC. None of these children have been born substance exposed, resulting in an estimated savings to Sacramento County of $21,642 per year[2] per child ($194,778 per year total). Other areas of potential cost savings/avoidance include the cost offsets of children not being placed in out-of-home care.

CONCLUSION

- Sacramento County operates two successful, innovative, high capacity programs focused on serving substance abusing parents in the child welfare system whose children have been placed in-out-of home care or are at risk of removal.
- Findings from a decade long evaluation of the Sacramento Dependency Drug Court clearly indicate that Family Drug Courts help parents engage in and successfully complete treatment, leading to significantly higher rates of children achieving permanent placements, lower rates of future substantiated child maltreatment reports and cost savings associated with increased reunification rates
- The Sacramento Early Intervention Family Drug Court has been found to be successful in keeping safely at home while providing their families with much needed preventive and treatment services, reducing rates of future maltreatment and preventing future substance exposed births, all leading to significant cost savings.
- A combination of a comprehensive assessment of treatment need, immediate access to treatment, intensive monitoring and support along with specialized court oversight that includes both incentives and sanctions makes these programs more effective than other traditional approaches for serving substance abusing families in the child welfare system

[2] Stade, B., Ali, A., Bennett, D., Campbell, D., Johnston, M., Lens, C., Tran, S., et al. (2009). The burden of prenatal exposure to alcohol: revised measurement of cost. *The Canadian journal of clinical pharmacology. 16*(1), e91-102. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/19168935

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TIES Transitional Model for Children Adopted from Foster Care

Children adopted from foster care are in need of family interventions to improve their outcomes. Young children need nurturing, positive relationships, save environments, and rich learning opportunities to thrive. Children adopted from foster care are at risk because of prenatal substance abuse and early disruptive, neglectful or abusive environments.TIES Transitional Model promotes secure attachments of high risk children to new families. After completion of the preparation and support of prospective adoptive parents (9 hours of psychoeducation before Resource Parents are matched with individual children), families are offered the following services: (1) pre-placement assessment and consultation, and (2) adoption informed intervention during the first year after placement. In the pre-placement assessment of children and consultation with families, TTM provides a multi-disciplinary review of records (social service, legal, medical, mental health, educational) and evaluation of the child's development, strengths and needs. The prospective parents and child welfare workers meet face-to-face with the TIES team for feedback so parents can make informed decisions and receive individualized recommendations regarding the strengths and needs of the child and management of the transition of the child into the new home. If parents go forward with the match and the child moves into the new home, TTM provides adoption-informed intervention during the first year after placement including developmental assessments and home visiting of infants; monthly transition psychotherapy groups for the Resource Parents and older children, and parent-child groups for families of infants and toddlers; adoption-informed counseling; and/or ongoing interdisciplinary consultations. The treatment protocol is based on interventions that combine development of coping strategies and emotion regulation for the child, and parenting strategies that are adoption-specific and take into account the child's background and foster care history.

TIES model also includes ADAPT is the first intervention model to target older adoptive children, despite the fact that they are over-represented in both drug abuse and mental health settings. Adapt follows the principles of prevention and drug-abuse preventive interventions, but also includes indirect interventions for increasing child resiliency. Our intervention focuses on improving family interactions and attachment to improve resilience of youngsters, as well as developing parental skills at behavioral management and monitoring. We draw from the existent evidence-base of interventions that have been found effective for treating specific mental health issues in children, such as trauma, externalizing behaviors, internalizing behaviors, and anxiety[22-25]. We also draw on preventive interventions for children in foster care and bereaved children[22, 26-28]. We use two broad strategies derived from this literature. First, a positive approach to parenting is important to child outcomes in general and is particularly so for foster families[25, 28-33]. We instruct parents to increase praise, rewards, encouragement, positive events, and family rituals. Second, the strong cognitive behavioral literature in ADAPT includes teaching children coping strategies to manage negative affective states[34] and increase their awareness and identification of emotions in self and others[35], and open lines of communication between children and parents (effective listening and expression skills training with role-play). Finally, we draw on the strong behavioral literature[26] to help families manage difficult child behaviors. We modify these interventions in light of the child's history (see second paragraph below for specifics).

Our intervention is informed by the empirical literature on adoptive families in two ways. Adoption is conceptualized as a significant emotional event in the lives of children. Children understand and deal with their adoption differently depending on their age and developmental stage, and often struggle with issues related to loss, abandonment and rejection. While we do not believe that adoption is traumatic for children, we model our approach in a manner similar to the exposure elements of Trauma-Focused CBT where the child gains an understanding of the adoption, creates a narrative of their adoption story and can discuss it comfortably with his/her adoptive parents and the broader community. These strategies are used to normalize concerns about adoption (psycho-education), increase child and parents' knowledge of and comfort with the child's adoption history (exposure), create a narrative (adoption story) parents and children can share with each other (including difficult topics such as birth parent histories of abuse/neglect, mental illness, incarceration, substance abuse, etc.), help parents view children's behavior problems from the perspective of their history, and increase awareness of the effects of adoption history on the child's sense of self, identity development, emotion regulation patterns, and family interactions. The importance of this approach was exemplified by the words of a pilot participant who said in the first session, "Adoption is the nightmare of my life. How can I listen in school when I'm wondering who is my real mom?" Our exposure approach was very helpful for him.

Second, we modify the evidence-based interventions (described above in ADAPT Approach to Increasing Child Resiliency) in ADAPT in light of the child's history. For example, a typical time out or time in intervention for controlling difficult behaviors may need to be modified for adoptive children. In a pilot case treated by our team, a young boy firmly believed that he would stay in his adoptive home only until he got into enough trouble to be sent away, since he had been rejected by several previous families. To control his tantrums, the parents were taught to walk him to a chair for time in, but to say, "No matter how many tantrums you throw, we are your parents; we love you; and we will always be your parents. You need to sit quietly on your chair for the next minute to help you calm down." Previous time ins alone had been ineffective for controlling the tantrums, but adding the reassurance quickly decreased them. Similarly, many children adopted from foster care have very deprived backgrounds and often steal after they enter their new homes. Typical

advice would be to apply a negative consequence to this behavior. This is also useful for adoptive children, but understanding the previous deprivation is also important. We have found it useful to advise parents to explain to the child that they understand that they still feel they need to take things for themselves. We recommend that they hide a box in a closet with objects similar to those the child is tempted to steal. The child is then told that when they feel like stealing something, it is okay to go to the box and take an object. A negative consequence is applied to instances when the child steals objects not in the box. A child who has been neglected and deprived may steal food from his/her adoptive family. Within our treatment, we might suggest that the family provide readily available food, such as a bowl of fruit or other appropriate snacks, so that the child always has access to food. Finally, both national and international studies have found that socioeconomic status is negatively related to child outcomes in adoptive families. In ADAPT, we teach families to recognize that their children often are aware that they were born into less well functioning families than their adoptive families. Many families, particularly middle class and above, focus much of their positive attention of their child's intellectual achievements. ADAPT teaches families to increase positive reinforcement for their adoptive children who often have very poor self esteem and feel even worse when adoptive families find many of their behaviors unacceptable. We encourage positive rewards for a range of behaviors, making sure the child feels loved and valued apart from achievement. We work with families to help their children feel loved and cared for, apart from academic achievement, so that they do not feel devalued if they prove to have academic problems later in school. We help them appreciate the child's own unique strengths and talents.

Adoptive children experience divided loyalties to birth and adoptive families and experience unique identity formation issues relative to integrating their biological background, the influence of their adoptive families, and their own unique qualities. Children adopted transracially have particularly unique experiences in integrating their cultural background with their adoptive background, as well as developing skills to manage societal responses to their appearance that is different from their adoptive family. ADAPT includes opportunities for adoptive families to discuss these issues and help build resilience in youth through strengthening family relations and child identity formation.

Brief Report on DDC Dependents Placement and Permanency.
These findings represent the first two years of the current grant cycle, from January 1, 2010 to December 31, 2011

Number of out-of-home placements and length of time in out-of-home placement (does not include placements "with parent" or "with other parent")

During Years 1 and 2 of the current grant cycle, from January 1, 2010 through December 31, 2011, the total number of children, who are dependents of DDC participants, was 239 and the total number of out-of-home placements for those children was 301. Per child, the mean number of out-of-home placements was 1.26 (Standard Deviation = 0.89). For each child, the mean number of days in out-of-home placement was 152.97 (Standard Deviation = 107.8). See Table 1 for types of out-of-home placements, the percentage of how much each placement was utilized out of the total out-of-home placements, the number of times a child was placed in a particular placement, the number of children assigned to each placement, and the mean number of days spent in each placement.

Table 1
Frequency and Mean Number of Out-of-Home Placements for Dependents of DDC Participants

Placement	Percentage of overall out-of-home placements	Frequency of placement (# of times placed out of total out-of-home placements)	Number of children per placement	Mean number of days for each child per placement	Standard Deviation
With Relative	43.9%	132	119	249.2	186
With Non-relative	7.3%	22	21	176.9	133
Joint Custody-Parent/Relative	4.3%	13	13	128.4	148.3
Joint Custody-Parent Treatment	7.6%	23	23	138.7	92.9
Shelter	7.6%	23	23	76.3	159.1
Foster Home	27.6%	83	76	177.6	149.6
Hospital	1%	3	3	46.7	67.1
Incarcerated	.3%	1	1	74	
Aged Out	.3%	1	1	513	

Time from dependency petition filing to permanency

Since January 1, 2010, a total of 34 out of 145 participants (23.4%) have successfully completed the DDC program. Of those 34 participants, data on time from dependency petition filing to permanency was available for 20 participants with a total of 45 dependents. Of those 45 dependents, the mean length of time from dependency petition filing to permanency is 286.4 days, (Standard Deviation=130.1).

Child welfare outcome (i.e., TPR in foster care/group home; TPR to relatives; perm. guardianship with relatives without TPR; perm. guardianship with relatives with TPR; joint custody; sole custody)

Of the 45 total dependents, whose parents successfully completed DDC, 31 (68.9%) were placed in sole custody, 3 (6.7%) were placed in joint custody, 8 (17.8%) were placed in permanent guardianship with relative, 2 (4.4%) were placed with other parent (no TPR or signed surrenders) and 1 (2.2%) aged out.

OJJDP FY 09 Family
Drug Courts Program

U.S. Department of Justice Office of Justice Programs Office of Juvenile Justice and Delinquency Prevention
Miami-Dade Dependency Drug Court Expansion and Enhancement Initiative

Program Report # 5
July 1 to December 31, 2011

1. *Indicate status of each goal that was due for completion during a previous reporting period but carried over due to implementation of other problems*. **N/A**

2. *State the status of each goal which was scheduled to be achieved during the report period.*

Goal	**Responsible Staff**	**Achievement**
Train Staff on DDC Protocol and data collection/evaluation	Eliette Duarte, Dr. James Pann, Dr. Angela Yehl	Staff training with supervision and follow-up occurred throughout the reporting period.
Engaging Moms Project	Dr. Gayle Dakof , Eliette Duarte	Consultation on measures and work plan for the evaluation, ongoing consultation with the DDC Judge (Cohen) and program coordinator (Duarte) on implementation of EMP in the DDC; preparation of PowerPoint presentations for Cohen & Duarte; refinement of DDC-EMP intervention protocols.
Program Evaluation Services and Data Collection	Dr. James Pann, Dr. Angela Yehl	Evaluation activities are ongoing and include support to the DDC staff on data collection, alterations to the MIS; development of stakeholder and participant survey; data analysis and report for additional variables tracked by the evaluation team, and GPRA Data Collection and Reporting to OJJDP. Results are discussed in #6 below.
Hand-N-Hand parenting program	Eliette Duarte, Linda Ray Intervention Center, Dr. Lynne Katz	The Project Hand-N-Hand parenting program was delivered to the participating DDC clients with children in the 0-3 age range.13 parents completed the pre-and post assessment protocol and received certificates of participation. Results are discussed in #6 below.
Increase # of Enrollments by 3 per	Eliette Duarte	A total of 26 new

month		participants have been enrolled in Dependency Drug Court (DDC) from July 1, 2011 through December 31, 2011 for a total of 145 participants exceeding our annual goal of 40 per year.
Advisory Group Meetings	AOC and DDC staff Participating community partners	Meetings occurred as needed throughout the reporting period.

3. *State the corrective action planned to resolve implementation problems and state the effect of these problems on the remaining schedule for achieving the project remaining goals.* N/A

4. *If appropriate, identify changes that are needed in the implementation plan specified in the grant application to overcome problems. Changes that alter plans and/or goals set forth in the application require prior grantor agency approval and issuance of a Grant Adjustment Notice (GAN).* No changes in this reporting period.

5. *State what technical assistance the grantor agency might provide during the next six month period help resolve implementation problems. If any technical assistance has been provided to resolve implementation problems, state the problems (or tasks) addressed and the results (or impact) of the assistance provided.* No technical assistance identified in this reporting period.

6. *Based on the Performance Measures set forth in the grant application (implementation plan), indicate in quantitative terms the results (of the project) achieving both during the project period and cumulative-to-date. Explanatory and qualifying statements will be helpful here, especially if project objectives have changed.*

Number of family drug court participants

A total of 26 new participants have been enrolled in Dependency Drug Court (DDC) from July 1, 2011 through December 31, 2011 for a total of 145 participants exceeding our annual goal of 40 per year.

Percentage of participants who successfully complete the program

Nine participants graduated successfully from the DDC program between July 1, 2011 and December 31, 2011. Since January 1, 2010, a total of 31 out of 145 participants (21.4%) have successfully completed the DDC program.

Since January 1, 2010, a total of 38 out of 145 participants (26.2%) did not successfully complete DDC, since they have exited the program prematurely. Seventy- Six (76) are still active. One participant arrested on a previous warrant, one participant who was noncompliant due to significant medical needs, participants who were not deemed appropriate for DDC, and all parents who opted to sign surrenders and actively participated in the permanency process of his/her child were not included since these are not thought to be "unsuccessful" DDC cases. Of these 38 participants, 11 exited the DDC program prematurely between July 1, 2011 and December 31, 2011. Of the eleven participants, 100 percent exited due to noncompliance with the program.

Improved Parenting Skills

Project Hand N Hand

For the Project Hand N Hand parenting program group (11 sessions in length) delivered from April 2011 to June 2011, data collection included the Adult-Adolescent Parenting Inventory-2 (AAPI-2) and the Knowledge of Infant Development Inventory (KIDI). Out of the initial 18, 13 parents entered into the Hand N Hand program. Of the 13 who participated in Hand N Hand, 10 completed the program successfully (76.9%). During the period from July 1 to December 31, 2011 the Project Hand-N-Hand team worked on matching the pre/posttest results for each of the clients and begin to analyze the progress over time. This data will be available in the next reporting period. Additionally, the Project Hand-N-Hand staff worked on reviewing the curriculum for the next cohort and making any modifications or adjustments to meet the clients' needs. The team also began identifying additional developmentally appropriate materials that will be needed for implementation with the next cohort.

Since January 1, 2010, a total of 19 out of 145 DDC participants (13.1%) participated in the Hand N Hand parenting program. Of those 19 participants, 15 (78.9%) completed the Hand N Hand program successfully.

Other Parenting Programs

A total of 8 out of the 145 DDC participants (5.5%) completed one or more parenting programs aside from Hand N Hand between July 1, 2011 and December 31, 2011. Of those 8 participants, 5 (62.5%) completed the program(s) successfully. Matching AAPI-2 pretests and posttests were completed and entered into the program MIS for 4 participants. Of those individuals, 4 out of 4 (100%) demonstrated improved scores on 2 out of 5 AAPI-2 constructs, one of which was Construct B, which suggests improved attitudes toward parenting and improved ability to be empathically aware of children's needs. On Construct B, participants' level of improvement indicated an effect size consistent with what would be expected given the intervention and target population (d=1.91).

Since January 1, 2010, a total of 56 out of 145 DDC participants (38.6%) completed one, or more, parenting programs that were not Hand N Hand. Of those 56 participants, 50 (89.3%) completed one, or more, program(s) successfully.

Reduction in Substance Abuse

A change in substance abuse behavior was assessed for all 26 participants who enrolled in the DDC program between July 1, 2011 and December 31, 2011, via a series of random drug screen tests. A 90-day baseline percentage of drug screens was established for each participant and was then compared to subsequent drug screens from the time the baseline was completed. Fifteen out of 26 participants were administered drug screens to establish a 90-day baseline period and were also administered drug screens over an additional minimum of 30 days post baseline (i.e., a minimum of 120 days in total). Of those 15 participants, 80% exhibited a desired change in substance abuse (i.e., a reduction in the rate of positive screens from baseline, or all negative screens).

Since January 1, 2010 a total of 89 out of 145 participants (61.4%) were administered drug screens to establish a 90-day baseline period and were also administered drug screens over an additional minimum of 30 days post baseline (i.e., a minimum of 120 days in total). Of those 89 participants, 75.3% exhibited a desired change in substance abuse and 24.7% did not evidence the desired change in their behavior. As indicated above, participants were classified as exhibiting a reduction in substance abuse behavior if the participants demonstrated a reduction in positive screens for a minimum of 30 days from the first 90 days (baseline period), or all negative drug screens from the first day of enrollment.

Percent of participants with a new drug related offense (arrest or referral to court)
The percentage of new drug related offenses includes participants who have been arrested or referred to court for a drug related offense, which has occurred subsequent to the participant's enrollment in DDC. None of the 145 participants (0%) had a new drug related offense, between July 1, 2011 and December 31, 2011.

Since January 1, 2010, a total of 3 of the 145 participants (2.07%) were arrested or referred to court for a new drug related offense since beginning the DDC program. More specifically, one participant was arrested for Marijuana possession, one participant was arrested for Cocaine Purchase, and one participant was arrested for Petit Theft.

Percent of participants who have a new DCF referral
Between July 1, 2011 and December 31, 2011 three of the 145 total participants (2.07%) had a new DCF referral. Since January 1, 2010, a total of 8 of the 145 participants (5.52%) had a new DCF referral. Two participants had a DCF referral for child abuse/neglect, four participants had a DCF referral for substance abuse, and two had a DCF referral for the birth of a child while in the program.

Percent of participants who have a new substantiated child protection case
One of the 145 participants (.07%) had a new substantiated child protection case between July 1, 2011 and December 31, 2011.

Since January 1, 2010, a total of 4 of the 145 participants (2.76%) had a new substantiated child protection case.

TECHNICAL ASSISTANCE BRIEF

PERMANENCY PLANNING FOR CHILDREN DEPARTMENT
DECEMBER 2003

Development of the Miami-Dade County Dependency Drug Court

NATIONAL COUNCIL OF
JUVENILE AND FAMILY COURT JUDGES

DEVELOPMENT OF THE MIAMI-DADE COUNTY DEPENDENCY DRUG COURT

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NATIONAL COUNCIL OF
JUVENILE AND FAMILY COURT JUDGES

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DEVELOPMENT OF THE MIAMI-DADE COUNTY DEPENDENCY DRUG COURT

Since the mid-1980s, the nation has seen a marked increase in cases involving child abuse and neglect. These cases have overwhelmed our nation's dependency courts and child welfare systems. In September of 2000, the foster care system held approximately 556,000 children.[1] There are many factors which have contributed to the increase in dependency cases, but the primary cause has been identified as parental substance abuse. According to *Linking Child Welfare and Substance Abuse Treatment: A Guide for Legislators*, National Conference of State Legislatures, August 2000, "A large percentage of parents who abuse, neglect or abandon their children have drug and alcohol problems...Although national data are incomplete, it is estimated that substance abuse is a factor in three-fourths of all foster care placements."[2]

Adult Drug Court

Although specialized drug courts operated in the 1950s and 1970s in Chicago and New York City as "Narcotics Courts," they provided limited access to drug treatment for offenders. The criminal justice system continued to be overwhelmed and overburdened with criminal cases involving substances. During the 1980s, it became apparent that the criminal justice system needed to be re-examined and processing of cases dealing with substance abuse had to be dealt with differently. Thus, the criminal justice system took an in-depth look at the relationship between substance abuse and criminal activity and realized that treatment was a necessary and vital component in treating offenders and in reducing the crimes related to substance abuse.

In response to this need, Miami-Dade County, Florida opened the nation's first modern drug court in 1989 and became a pioneer in the national drug court movement of today. Its success provided a model for courts across the nation to implement an adult drug court in their jurisdictions. The ultimate goal of drug courts is "to achieve a fundamental change in the lifestyle of the litigants that will...substantially reduce the likelihood of their further involvement with the justice system, increase public safety, and significantly enhance the likelihood that the parties and their families will function as productive community members."[3]

Family Drug Court

The success of the Miami-Dade adult drug court provided a concrete model and inspired those courts dealing with child abuse and neglect cases involving substance abusing parents to create a "family drug court." While the traditional adult drug court handles criminal cases, the family drug court handles domestic relations cases and child abuse and neglect or dependency cases. These cases involve the threat of loss or restriction of parental rights due to parental substance abuse. While parents are the "clients" or "participants" in the family drug court, the goal of the family drug court is to provide for the safety and well-being of children while providing parents resources and a mechanism to become sober and responsible.

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[1] Administration for Children and Families, U.S. Department of Health and Human Services (2002). *Fact Sheets, Child Welfare*. Retrieved December 11, 2003 from www.acf.hhs.gov/news/facts/chilwelf.html.

[2] Christian, S., Edwards, K. (2000). *Linking Child Welfare and Substance Abuse Treatment: A Guide for Legislators*. National Conference of State Legislators.

[3] McGee, C.M., Parham, J., Merrigan, T. T., Smith, M. (1998). *Applying Drug Court Concepts in the Juvenile and Family Court Environment: A Primer for Judges*. C.S. Cooper (ed.). Prepared by American University for State Justice Institute. Washington, D.C.: American University.

"The family drug courts are exponentially more complex than adult drug courts because more aspects of the clients' lives and relationships are examined."[4]

A contributing factor in 80 percent of dependency cases in Miami-Dade County is alcohol and drug use by parents.[5] Despite a relatively rich treatment environment in Miami-Dade County, treatment providers and the dependency court were not sharing information about parents. Nor were they working together to provide the necessary array of integrative therapeutic services in order to ensure positive outcomes for reunifying families. Poor participation of substance abusing parents in recovery programs led to the creation of "family treatment courts" to specifically address these problems. As a key component of the family treatment court model, a Dependency Drug Court (DDC) provides a structured therapeutic approach to assist primary custodians to live a drug-free life, to assume the full responsibilities of parenthood, and to achieve reunification within statutory timeframes.

Family drug courts involve a collaborative effort among various components of justice, child welfare, and public health treatment systems which include early identification of eligible participants; assessment and evaluation; access to appropriate treatment services for parents; services for children; frequent drug testing and court appearances; judicial intervention; incentives and sanctions; and collaborative efforts among courts, child welfare agencies, treatment providers, public agencies, and community based organizations.

The Adoption and Safe Families Act

Notwithstanding the widely accepted theory that children are resilient and can bounce back from adversity, children's perception of the passage of time is different than adults. Adults can wait indefinitely for uncertain situations to resolve, but children's sense of time is immediate. In recognition of this, and to prevent children from languishing in foster care, the Adoption and Safe Families Act of 1997 (ASFA) was passed. ASFA set fourth—among other mandates—time-sensitive guidelines for the court to follow in the processing of child abuse and neglect cases.

ASFA requires that a permanency hearing to determine a child's permanent placement be held 12 months after a child is considered to have entered foster care (starting from the date of the first judicial finding of abuse or neglect, or 14 months after the date the child has entered placement, whichever is earlier). At the 12-month permanency hearing the court must determine whether the child will be:

- returned to the parent;
- placed for adoption;
- placed in a legal guardianship;
- placed in kinship care; or
- placed in another permanent living arrangement.

A Termination of Parental Rights (TPR) proceeding will be initiated under ASFA if:

- a child has been in foster care for 15 of the most recent 22 months;
- it is determined that the child has been abandoned; or
- no reasonable efforts are required to preserve or reunite the family.

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[4] *Ibid.*

[5] Dependency Drug Court Protocol—Miami, Florida.

Exceptions to the TPR requirements are:

- the child is in relative care;
- compelling reasons have been documented that TPR is not in the child's best interest; or
- the agency has not provided the necessary services as outlined in the case plan if reasonable efforts are required.

Definition and Goals of Family Drug Court

In a family or dependency drug court, focus is on meeting the treatment needs of the substance abusing parent, as well as meeting the safety, permanency, and well-being needs of the child.

The goals of the family drug court include:

- providing permanency planning and placement for children as outlined in the *RESOURCE GUIDELINES*[6] and the *ADOPTION AND PERMANENCY GUIDELINES;*[7]
- addressing intergenerational issues of abuse and neglect in families;
- providing children and parents with access to support services to assist them in becoming productive individuals;
- providing appropriate and timely treatment services;
- providing a safe nurturing environment for children to grow and flourish;
- expediting the handling of cases in order to avoid delays in case processing;
- working collaboratively with courts, child welfare, treatment, and other community agencies to address holistic needs of families (e.g., parenting skills training, housing needs, vocational training, health and mental health services); and
- working with families from a strength-based perspective.

Miami-Dade County's Dependency Drug Court

Spearheaded and conceived by Judge Jeri Beth Cohen, the Administrative Office of the Courts (AOC) of the Eleventh Judicial District implemented the Miami-Dade County Dependency Drug Court (DDC) in March 1999.[8] Initial planning for the DDC was conducted by the Planning Committee which consisted of Judge Jeri Beth Cohen; Sharon Abrams, Chief Information Officer for Miami-Dade County Juvenile Division; Paul Indelicato, Director, Juvenile Court Operations, Juvenile Justice Center; Lynne Katz, Ph.D., Program Administrator, Linda Ray Intervention Center; members of the AOC; representatives of the Department of Children and Families (DCF); community substance abuse treatment providers; and community mental health treatment providers. Judge Cohen presided over the drug court from its inception in March 1999 through January 2003. There are presently four juvenile courtrooms in the Miami-Dade juvenile division, each of which handles about 300 dependency cases a year.

Judge Cohen joined the Dependency Court system in 1996 after having spent four years in the criminal division of the court. As part of her tenure in criminal court, Judge Cohen sat in the Driving Under the Influence (DUI) division, where she began an informal DUI drug court. Based on her success with this drug court, she was able to obtain a grant from the Florida Department of Transportation for a program that monitors repeat DUI offenders. This program has now become part of DUI probation. As a result of this work, Judge Cohen developed relationships with

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[6] *RESOURCE GUIDELINES: Improving Court Practice in Child Abuse & Neglect Cases* (1995). National Council of Juvenile and Family Court Judges, Reno, Nevada.

[7] *ADOPTION AND PERMANENCY GUIDELINES: Improving Court Practice in Child Abuse and Neglect Cases* (2000). National Council of Juvenile and Family Court Judges, Reno, Nevada.

[8] The DDC project was funded through the Office of the State Courts Administrator.

community mental health and substance abuse treatment providers. She drew on her experience over the eight years that she had presided over the DUI and dependency courts to build the foundation for the DDC program.

The DDC Program Goals

The primary goal of the DDC is to provide integrated services to primary custodians and their children, so that the parents can maintain sobriety long term and the children can improve their social, emotional, and intellectual functioning. Through intensive services, monitoring, and case work, the DDC ensures that all children remaining with custodians in drug court will experience safe and nurturing permanent homes. To achieve this goal, parents are expected to comply not only with drug-related treatment, but with mental health treatment, targeted parenting programs, vocational training, and other relevant services. A hallmark of the DDC is its provision of intensive early interventions for children, including interactive parenting protocols and regular developmental assessments. These protocols continue to be funded through the Substance Abuse and Mental Health Services Administration (SAMHSA). The interventions are provided by the Linda Ray Early Intervention Center at the University of Miami (Linda Ray Center). Equally important to the program are the therapeutic relationships fostered between specialized case workers attached to the court and the presiding judge, who interacts with parents and children on a regular basis.

Role of the Judge

The DDC judge seeks to establish a rehabilitative relationship with the parent, children, and extended family through frequent interactions during court appearances. The DDC judge supervises and reinforces treatment by reviewing reports from DDC specialists and DCF counselors and discussing treatment obstacles with parents during their frequent court appearances.[9] The DDC judge exercises a flexible and a consciously therapeutic rapport with the drug-using parent. Crucial to this approach is the presence of a representative from all agency providers at the hearings. Judge Cohen believes that, "Only a system that provides intensive monitoring and a holistic approach to services has a chance of successfully reunifying children under ASFA time lines." Although it is the parent that appears before the court, the Judge looks to the larger family unit and the needs and best interests of the child(ren). The DDC understands that participants in the program live in families and communities, not in treatment facilities and courts. Accordingly, the rehabilitative process must necessarily involve all significant family members, and the court must constantly take into account the strengths and weaknesses within the family and seek to heal the family unit as a whole.

Services Provided

The DDC's primary focus is identifying and treating the underlying issues that may have contributed to substance abuse. The Miami DDC's services not only include substance abuse counseling and intensive and interactive parenting classes, but also competent psychological and psychiatric evaluations, trauma counseling, psychotropic medication management (if required), housing, vocational training, medical services, and family planning counseling. This program also includes developmental assessments and interventions for infants and children, including substance abuse and counseling classes for older children. Women and men in the DDC are encouraged to seek family planning as part of their case plan. Furthermore, the DDC refers all adolescent girls and boys whose parents are participating in DDC to family planning and AIDS counseling. Thus, the DDC treats the entire family as a cohesive unit and seeks to address all treatment needs. As a result, parents understand that the courts expect a complete lifestyle change that promotes health

[9] DDC Protocol October 12, 2000, pg. 13.

and safety for their children. Moreover, the DDC evaluates and treats co-occurring mental health problems as well, out of a conviction that sobriety cannot be maintained in co-morbid individuals who are not simultaneously treated for substance abuse and mental health disorders. Judge Cohen strongly believes that without true collaboration, integration, and commitment among all the system players involved with the family, services and treatment are fragmented and do not contribute to the rehabilitation of the impaired family structure.

> ***"If we have learned one thing from Dependency Drug Court, it is that substance abuse is only one aspect of the psycho-pathology that impairs families in the dependency system."***[10]
> -Judge Cohen

DDC Team

Due to the overwhelming number of child welfare cases that enter the system, Judge Cohen emphasizes the need for a dedicated and well trained staff to be assigned to the DDC. The ratio of parents to caseworkers must be kept low. Through the Judge's concerted efforts in negotiating with DCF, three protective services caseworkers have been dedicated to the DDC. These DCF counselors are responsible for developing and managing all aspects of the case plan. The DCF is represented by counsel who provides support and direction in the dependency case process.

Additional funding has been obtained from the Florida State Legislature to fund three positions for addiction specialists, including a program administrator. DCF also contributes funding through Temporary Assistance for Needy Families (TANF) for two additional specialists. As the legislative monies were terminated, future funding for the specialists is provided jointly through DCF and a National Institute of Health grant awarded to DDC. DDC specialists are a major factor in the success of the DDC efforts. The DDC currently employs five specialists who provide a critical link between the parent, treatment provider, and the court. DDC specialists are responsible for alcohol, drug abuse, and mental health screenings and assessments; referrals to and enrollment in treatment services; alcohol and other drug testing; progress monitoring; and crisis and therapeutic intervention. DDC specialists carry beepers, so that they can be available to parents for emergencies. They work not only with the targeted parents, but also provide therapeutic interventions for the extended family. They convene weekly staffings at the treatment facilities and at the Linda Ray Center in order to continually update and reassess the treatment plan. The specialists understand their job as not only providing case management, but also retaining and engaging the parent in the dependency court process by advocating for the parent and keeping the parent motivated in treatment and recovery. The DDC specialists receive weekly clinical supervision and therapeutic training from a consultant team from the University of Miami which enhances their service provision. This collaboration between the DDC and the University of Miami was a precursor to a National Institute of Health (NIH) grant obtained by Dr. Gayle Dakof at the University of Miami, Department of Epidemiology, to study the effects of therapeutic gender-specific case management on family reunification and permanency.

Other key participants involved in the DDC program are community substance abuse treatment and methadone providers, mental health providers, and victim services. As mentioned above, while the DDC is called a drug court, it is more appropriately a court that addresses co-occurring mental health and trauma-related pathology in conjunction with substance abuse problems. Somewhere between 75-90 percent of DDC participants, primarily women, have suffered physical

[10] "Miami's Dependency Drug Court." *Navigating the Pathways*. pg. 89.

or sexual abuse. These women also suffer from mental health problems at approximately the same rate. These percentages comport with the literature on co-occurring disorders for women.[11] DDC seeks to treat the parent in an integrated manner by emphasizing that mental health counseling and medication compliance are equally as important as sobriety. Judge Cohen believes that there can be no sustained sobriety unless all significant mental health problems are addressed simultaneously with substance abuse treatment. Moreover, therapy must be provided using gender-sensitive protocols that take into account the specialized needs of women. The court in Miami has been influential in compelling treatment facilities to provide more integrative and gender-sensitive therapies. In addition, the court has influenced traditional treatment facilities to be more receptive to methadone maintenance as a legitimate form of treatment for opiate dependency. Through an environment of trust and mutual respect, the DDC has built a strong, mutually-reinforcing collaboration between itself and treatment providers in order to provide efficient, immediate, and comprehensive services to parents.

Miami is fortunate to have an early childhood intervention center that specializes in providing case management and developmental services for substance-exposed children ages 0-3. Through a series of grants from SAMHSA, the DDC through the Linda Ray Center provides parenting skills training to DDC parents through their Nurturing and Strengthening Families curricula. In addition, all DDC children ages 0-3 are assessed at six-month intervals for developmental problems using the Ages and Stages protocol. Children with deficits are referred for further testing and services. All older children receive comprehensive psychological evaluations through the Court Evaluation Unit, funded by the Administrative Office of the Courts. Although funding has not been constant, DDC has maintained a certified family nurse practitioner on-site at the courthouse on drug court days. The nurse meets with parents individually throughout the week to provide a wide variety of health services, including family planning.

The DDC promotes a non-adversarial approach to processing cases through the system. Therefore, it is important that defense attorneys representing parents in DDC be non-adversarial and believe in the drug court mission. While defense attorneys need not be present at every review hearing, unless notified by the DDC specialist that there is a problem, they should be present at the initial stages to explain DDC protocol and assist in finalizing the case plan and to help the parent sign all DDC paperwork. Of course, no decisions are made that affect the parent's due process unless the attorney is present. While DCF attorneys are present at all reviews, the interaction is between the court, the parent, and the DDC specialist. Rarely is there a need for the attorneys to get involved, especially once all the legal and procedural aspects of the case are accomplished.

Forging Partnerships

Judge Cohen has provided leadership for the team and has played a significant role in emphasizing a need for a collaborative effort and forging partnerships among the key players in the dependency process. Substance abuse and mental health treatment providers, attorneys, the court, DCF caseworkers, and DDC specialists are all held accountable through this process. This facilitates the development of a clear policy and protocol for communication between these agencies and enables the courts to be well informed of the ongoing progress of the participants - which was greatly lacking in the past. Requiring that weekly substantive progress reports be submitted by providers has increased accountability on the part of providers and consequently led to enhanced quality of services and outcomes. Collaborative efforts have been maintained as the level and

[11] "Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse." *Treatment Improvement Protocol (TIP) Series 9.* (1994). U.S. Department of Health and Human Services, Center for Substance Abuse Treatment.

modality of treatment are negotiated and agreed upon with the DDC staff and no one is released from residential treatment without a discharge and safety plan approved by the court.

Referral Process

Participation in the DDC is voluntary and is at the discretion of the DDC judge. A Judicial Eligibility Checklist is completed by court staff to refer a parent for consideration.[12] The judge determines eligibility and makes referrals to DDC based on availability of space and complexity of the case. The court tries to choose the most difficult cases that will require the most intensive services and monitoring, including those cases where the mother has given birth to several drug or alcohol-exposed babies. The court will not accept a parent accused of sexual or severe physical abuse, or a parent with severe mental health issues that are not well controlled. Although rare, in appropriate circumstances, the DDC will accept a parent who has already lost one child through a TPR proceeding. Difficult cases for the court are those that involve spousal batterers with addictions. In special circumstances, the court has accepted male participants who have been accused or convicted of domestic violence.

Program Phases

The length of the DDC program is one year commencing with the parents' voluntary agreement to participate. The court intensively monitors parents though five phases during which time they appear before the court on a regular basis. Random and/or tri-weekly urine tests are a part of the monitoring. Judge Cohen believes that it is essential to have on-site urine screening at the court in order to develop a relationship of trust with the screener and prevent urine tampering. A final "self-reliance" phase was added to break the codependency that can develop between the client and the court and to prevent a relapse immediately before graduation.

Recently, the DDC formed a partnership with "Project Safe" though the Children's Home Society. Project Safe has agreed to monitor DDC graduates for up to one year to ensure continued sobriety and safety for the children, as well as to assist with additional services. In addition, the DDC ensures that all graduating parents have a close tie to an Alcoholic Anonymous or Narcotics Anonymous (AA/NA) "home" group and sponsor. In addition, in most cases, steady employment is required. The DDC encourages graduating parents who stay clean for at least six months to become mentors and sponsors for other parents in the program. An additional safeguard for parents is placement at a transitional facility run by Camillus House (the Homeless Trust). This facility, "Sommerville," offers housing for up to two years for parents and their children, and is largely populated by DDC families. The facility provides parenting, childcare, and AA/NA meetings on site. DDC is collaborating with Camillus House to build transitional housing for DDC families with on-site comprehensive services.

Incentives and Sanctions

The court seeks safe permanent homes for children who do not remain with parents in residential treatment or at home as soon as they enter the DDC system. It should be stressed that Judge Cohen believes, and the literature supports, that parents do best in recovery when they remain with their children. Although the court recognizes that addiction is a relapsing disease, the court is diligent and applies a graded system of rewards such as decreased court appearances and urinalysis, increased unsupervised visitation with children, phase advancement for compliance, and reunification with children.

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[12] DDC Protocol October 12, 2000, pg. 13.

The court implements sanctions for non-compliance with the program or case plan (e.g., missed hearings, counseling sessions, and drug tests). The sanctions are specifically enumerated in the DDC protocol and in the contract that the parents sign prior to entering drug court. Sanctions are immediate, certain, graduated, and designed to fit the infraction. The DDC has incorporated the research on the efficacy of rewards and sanctions in designing its approach. These sanctions include increased court appearances, more frequent urine tests, community service hours at a homeless center or thrift shop catering to recovering addicts, phase demotion, short periods of incarceration (usually on the weekends), and ultimately, termination of parental rights. Judge Cohen used the jail sanction only 5 percent of the time in the last year in which she presided over the DDC and only in situations where the court had already tried less severe sanctions. The jail sanction has never been used as a punishment, but only as a method to change behavior. Interestingly, the sanction has succeeded in changing non-compliant behavior in only one instance.[13] Although the court is aware that the statutory 12-15 months to permanency provided for in ASFA and Florida law is not always an adequate amount of time for rehabilitation from addiction, the need to achieve permanency within that timeframe has mandated that DDC's time line be designed to serve the best interests of the child(ren) and not the adult(s).

Some DDC Statistics

During the first year (1999) the DDC referred 92 parents. Of the 92 referrals to DDC, 15 refused to participate. Seventy-seven parents agreed to participate in the DDC and of the 77 that agreed, 10 dropped out and their cases went to TPR. The remaining 67 cases involved 212 children, with 84 of the children under the age of four.

Table 1: Number of People Accepted into the DDC by Year

Year	Number Accepted into the Program
1999	67
2000	23
2001	36
2002	40
2003 (through 10/31/03)	28

About 80 percent of the cases referred to DDC were women. Miami DDC program specialists' experience has shown that it is difficult to engage men in the DDC process. Unless they are significantly bonded to a woman participating in DDC or a woman who is not a substance abuser and have extremely strong family support, men do not tend to participate in DDC

In May 2000, DDC graduated its first class. Of the 13 graduates, one was male. As of October 31, 2003, 72 people with 234 children have graduated from the DDC. The case outcomes of the people entering the program but not graduating are not specifically tracked. However, these cases most likely proceed to TPR, a custodial agreement, custody with a relative, surrender, etc.

DDC Success

Graduation is not the only measure of success in the family drug court. Success is also measured by achieving permanency for the children. Judge Cohen points out that "failure to comply with DDC is also a success, if lack of commitment and dedication is determined early then children can be moved to permanency expeditiously."

[13] "Miami's Dependency Drug Court." *Navigating the Pathways*. pg. 92.

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ABSTRACT

The Eleventh Judicial Circuit Administrative Office of the Courts (AOC) implemented Dependency Drug Court (DDC) in March 1999. Building on the existing DDC, we propose to expand and enhance DDC through implementation of two evidence-based intervention approaches that have been successfully piloted. This Initiative includes a case management intervention model for mothers and a parenting program for families with children ages 0-3. Activities include: screening, assessment, treatment plans and enhanced case management for an additional 120 dependency abuse/neglect cases and parenting sessions 40 parent-child dyads. The goals are: increase positive permanency outcomes (sole custody, joint custody, or permanent guardianship with family members with termination of parental rights when appropriate) which will be measured by outcomes upon completion of drug court; reduce likelihood of negative outcomes for children by addressing the substance abuse of parents and providing services for their children, which will be measured by re-entry. The evaluation will provide feedback regarding the implementation; present findings relative to data collected and outcome variables (including the performance measures); address the extent to which program implementation was consistent with the plans for implementation; identify the program's impact and effectiveness; and delineate lessons learned from the evaluation.

PROGRAM NARRATIVE

Statement of the Problem

Effects on Target Population and Community

Drug abuse among women with children is a serious public health problem that not only is damaging to the mothers but also places their children at risk of abuse, neglect, and other problem behaviors. Women drug users are at high risk of becoming HIV infected and

developing AIDS, being victims of abuse and crime (Dansky, Byrne & Brady, 1999; Tardiff et al. 1994), and neglecting or abusing their own children (Sagatun-Edwards, Saylor, & Shifflett, 1995).

Local Data

The DDC is a part of the Juvenile Division of the Eleventh Judicial Circuit of Florida, the fourth largest trial court in the nation. In 2008, 744 dependency abuse/neglect cases were filed (Criminal Justice Information System-CJIS) with 523 verified substance abuse allegations (Department of Children and Families-DCF Florida Safe Families Network-FSFN). Currently 54% of those offered DDC accept for a potential of 282 DDC eligible parents (DDC data).

One notable problem (locally and nationally) in the treatment of adults is high dropout rates among both male and female patients, and there are indications that female patients, especially those involved in the child welfare system, have exceptionally high dropout rates (Gregoire & Schultz, 2001; Morgenstern et al, 2006). Three studies were funded by the National Institute on Drug Abuse (NIDA), for the University of Miami Center for Treatment Research on Adolescent Drug Abuse (CTRADA) to work in partnership with the Eleventh Judicial Circuit Juvenile Division. These three studies focused on the Engaging Moms enhanced case management intervention to increase drug abuse treatment enrollment and retention among mothers in DDC and found that a higher proportion of mothers receiving the Engaging Moms intervention successfully graduated from dependency drug court (68% vs 53%).

Participants were all DDC mothers whose children were adjudicated dependent; the mothers voluntarily enrolled in drug court, and were randomized into the study immediately upon their enrollment in drug court. Participants were African-American (37%), Hispanic (35%), White, Non-Hispanic (22%), and 6% self-identified as other ethnicities. They averaged

30.7 years of age; had extremely low incomes, reporting an annual median family income of approximately $7,000; and were not well educated (43% high school graduates or GED). Participants primarily abused cocaine and alcohol, and they had considerable mental health problems with a high percentage of mothers showing symptoms of serious depression (52%) and anxiety (49%), with 12% reporting current suicidal ideation.

Results overall demonstrated significant promise. Sixty-eight percent of mothers had positive permanency outcomes (sole custody, joint custody, and permanent guardianship with family members without termination of parental rights). In all outcomes examined, significant time effects from intake through the 18 month follow-up period were found. Mothers decreased their self reported alcohol and drug use, and over time were increasingly less likely to produce a positive drug test. They showed improvement in their mental health and family functions, and decreased their risk for child abuse. Finally, the children of mothers enrolled in the study significantly decreased their internalizing, and externalizing behaviors between intake and 18 month follow-up. Participation was also associated with significantly better outcomes over time. For child welfare outcomes, almost twice as many mothers assigned to the control group in comparison to those randomized to the experimental group had their cases filed for termination of parental rights (43%vs. 23%) (Dakof, et al (2004).

Research/Evaluation Studies

Research and evaluation studies that relate to the problem and contribute to the understanding of causes and potential solutions show that dependency drug courts address complex family systems and family needs. Females comprise more than 85% of those served by dependency drug courts (Cooper 2001; Edwards & Ray, 2005). Because these courts are more likely to serve women, programs collaborating with the DDC, and the DDC program itself, are

inherently concerned with the specific issues that women face, including barriers to treatment entry and retention (Ingersoll, Lu, & Haller 1995; Rockhill, Green, & Newton-Curtis, in press), and the need for gender-specific treatment approaches that address such issues as parenting and domestic violence (Finkelstein, 1995; Grella, 1996; Dakof, 2000; Dakof et al 2004). Given that children's permanency, safety and well-being are the key concern of the DDC cases, it is important to note the overlay that exists in these cases that connects the mother's road to sobriety with child outcomes. Infants and toddlers make up one third of all admissions into the child welfare system and once they are in care, young children remain longer and are more likely to be abused and neglected (Wulczyn, Hislop, & Harden, (2002). Despite considerable scientific and research evidence (Shonkoff and Phillips, 2000), discussions on children's mental health during their time within the dependency system have consistently excluded babies and toddlers, focusing instead on school-age children and adolescents. Unfortunately within the public mental health system, the majority of mental health professionals who provide services for children know relatively little about those under the age of six years or how to serve them. Thus, the DDC Planning Team identified a need to expand capacity from 60 to 100 participants with focus on the mothers and to provide differential, developmentally appropriate services to their children.

Although the DDC has made great strides in innovating drug court procedures and methods, it has never received federal operational funding and has struggled with limited resources that have hampered attempts to fully sustain innovations and expand reach. The *Expansion and Enhancement Initiative*, if funded, will allow the DDC to increase capacity to serve clients who need services but are currently not able to access the program due to funding limitations, and also will allow the program to implement the enhanced program services for mothers and their children.

IMPACT/OUTCOMES AND EVALUATION/PERFORMANCE MEASURE DATA COLLECTION PLAN

The mandatory performance measures identified by OJJDP will be collected and submitted to the OJJDP online system (Data Collection and Technical Assistance Tool) on a regular basis by the evaluation team. The performance measures, the data that the *Expansion and Enhancement Initiative* will provide, and the method for collecting the data are indicated in the table below.

Performance Measures	Data Provided by DDC *Expansion And Enhancement Initiative*	Data Collection Methods (Data will be provided to evaluator electronically)
1. Number of family drug court participants. 2. Percent of participants who successfully complete the program. 3. Percent of participants who exhibit a desired change in the targeted behavior (e.g., a reduction in substance abuse, improved parenting skills). 4. Percent of participants with a new drug-related offense (arrest or referral to court). 5. Percent of participants who have a new CPS referral. 6. Percent of participants who have a new substantiated child protection case.	1. Number of family drug court participants. 2. Number of participants who exited the program; Number of participants who successfully complete the program. 3. Number of participants who exhibit a desired change in the targeted behavior (i.e., parenting knowledge and behavior; parental substance abuse). 4. Number of participants with a new drug-related offense. 5. Number of participants who have a new CPS referral. 6. Number of participants who have a new substantiated child protection case.	1. DDC Specialists collect the data in an Excel file. 2. DDC Specialists collect the data in the Excel file. 3. AAPI-2, KIDI will be administered pre and post-intervention. Clinicians will score the instruments. All drug screen results are collected in the Excel file or Eleventh Circuit Drug Court Application. 4. CJIS data checks at intake, and every 3 months until closing. 5. DCF Reports to the Court. 6. DCF Reports to the Court.

PROJECT/PROGRAM DESIGN AND IMPLEMENTATION

1. Collaborative Planning

Stakeholders, Planning Process/Participants, Cross-Training,

The DDC is a partnership among key stakeholders in the dependency court, including: the DDC Judge; the South Florida Provider Coalition (SFPC); the managing agency for the substance abuse and mental health providers; Our Kids of Miami Dade/Monroe, Inc., the

managing agency for child welfare providers; the Department of Children and Families (DCF) Substance Abuse/Mental Health Division; the Child Welfare Regional Legal Counsel; University of Miami CTRADA and UM Linda Ray Intervention Center (LRIC); defense counsel; DDC Alumni; and AOC staff (Juvenile Operations Director, Chief Deputy Court Administrator, Grants Administrator, DDC Program Coordinator).

In an effort to reach permanency (with reunification when possible) for the children within the 12 month timeframe required by Adoption and Safe Families Act (ASFA, Public Law 105-89), the collaborative group supports the DDC program which provides maximum support to the parents as they move towards sobriety. All stakeholders (above) have collaborated since the inception of DDC, and have provided input for this proposal to enhance and expand the DDC so that higher quality services can be offered to more mothers and children. If funded, the group is ready to begin detailed implementation of the proposed *Expansion and Enhancement Initiative.* During the first quarter, monthly meetings will be held. Following that, meetings will be held quarterly. Cross-trainings and staffing meetings prior to hearings occur regularly. These cross discipline events involve drug court partners, drug court staff, child welfare case managers and treatment providers and are elaborated upon in sections below.

Major milestones

1997	Collaborative DDC planning initiated.
1999	One of 3 family drug courts in SAMHSA CSAT Family Drug Court Initiative. Team of 13 attended and presented.
2000	"Beyond Dependency and Substance Abuse" training for all circuit dependency staff.
2000	Team of 13 attended and presented at Family Drug Court National Conference.
2002	Created child friendly, accredited daycare and children's programs in treatment facilities.
2002	Strengthening Families Parenting Initiative for DDC funded by SAMHSA.
2003	Engaging Moms Intervention for Family Drug Court funded by NIDA.

2007	*Seeking Safety* trauma model implemented at treatment centers.
2007	On-site psychiatrist at treatment centers.
2008	Expansion of DDC case referrals from all judicial sections.

2. Target Population, Screening, and Eligibility

Target Population and Eligibility Criteria

The population eligible for DDC and this project are parents named in new dependency petitions with substance abuse allegations who enter drug court voluntarily. Parents alleged to be sexual perpetrators, or mentally incompetent, or diagnosed with an un-stabilized, severe mental disorder (e.g., paranoia, hallucinations, delusions, mania, lack of stabilization on psychotropic medication, failure to follow medical regime, or other functional impairment that would inhibit effective program participation), or have an advanced terminal illness are excluded. Parents with a history of violent or criminal offenses or who are on methadone maintenance programs will be considered on a case by case basis. Drugs of choice for this population are cocaine, marijuana, alcohol, benzodiazepines and opiates in that order. Most parents are poly-substance abusers. Parents under dependency court supervision for child abuse and/or neglect will be screened and ordered to provide urine specimens on a regular basis. At the judge's discretion, any family member who desires custody or contact with children under the court's jurisdiction, and or significant others of drug court participants, may also be required to provide urine specimens.

Identifying and Screening Eligible Clients for Dependency Drug Court

Parents are identified in all 5 dependency courtrooms. Initial screening is based on the judges' or courtroom staff identifying parents who want to be the primary custodian and have allegations of substance abuse in the petition or stated to the court. If the possibility of reunification exists, these parents can be offered DDC services. The Judge ultimately determines

eligibility to be referred to the DDC program. The *Judicial Eligibility Checklist* (Attachment VIII) is completed by court staff to refer a parent to DDC for consideration.

Stage in Process Parents are Screened

After the initial screening at the first hearing, the DDC Program Coordinator conducts the intake assessment and then refers the client to the DDC Specialist and treatment provider with recommended services based upon the expressed and assessed needs of the participant.

Length of Time Between Child Welfare, Filing of Petition, First Appearance, Treatment

Parents are identified at the shelter hearing which occurs within 24 hours of filing of the detention petition. Assessment of the parent's status occurs within 7 days after screening and treatment begins within 7 days of the assessment, if it has not already commenced. In summary, the client's first appearance in DDC and enrollment in treatment occurs within the first month of the case and sometimes occurs within days of the first hearing.

Determine and Maintain Targeted Capacity

The current capacity of the basic DDC model is 60 participants per year, which is based on available funding. That capacity is ensured through an Administrative Memorandum requiring all judges across the dependency division to send potentially eligible cases to DDC for screening.

3. Clinical Assessment and Service Delivery

Clinical Assessment

DDC Intake, clinical screen and assessment of parents is conducted by the DDC Program Coordinator upon referral, identification, eligibility confirmation, and approval of the Judge. The intake consists of: an overview of the program components; completion of releases of

information and the client file information sheet; assessment of the client's mental status, suicide and homicide risk, and treatment motivation.

Instruments

The assessment protocol of the parent administered by the DDC Program Coordinator includes: the Mini International Neuropsychiatric Interview (MINI), the Addictions Severity Index-Female Version (ASI-F), and the ASAM Patient Placement Criteria. Intake and assessment measures were chosen to obtain the following information: assessment of physical health; alcohol and drug use history; evaluation of current alcohol and drug use; current degree of psychopathology; exposure to abuse or violence; and psychosocial history including family of origin information, employment history and capability, and history of involvement in the criminal or juvenile justice systems. The information is used to develop treatment plans and match treatment needs with services.

Treatment Plans and Service Delivery

In most cases, within 8-10 hours after intake and assessment the parent is referred to a DDC Specialist and a SFPC treatment provider. The dependent child(ren) whose parent(s) agree to participate in DDC are assigned to Family Resource Center (FRC), a full-case management agency within the community-based system of care, led by Our Kids of Miami Dade/Monroe, Inc. FRC has a drug court unit specific to DDC participants (see Services for details). The report from the screening and assessment with treatment recommendations is provided to the court, and the substance abuse treatment provider, and the FRC case manager. Medical referrals may be made to screen for infectious diseases, life threatening illnesses, birth control history, and health maintenance history. These referrals may come from the treatment provider or FRC case manager.

The FRC case manager conducts intake for the dependent child applying clinical standards to evaluate the nature of children's needs as they enter the child welfare system. Within 30 days of a case entering the system all children in out of home care receive Level of Care Assessments (LOCA) which evaluate all systems of a child's life and from which recommendations for needed services are made. The LOCA includes: Ages and Stages, Part C evaluations at the Early Steps Part C provider sites at the University of Miami or South Miami Hospital and the Florida Diagnostic and Learning Resources System for children.

The South Florida Provider Coalition (SFPC), composed of most of the substance abuse and mental health treatment providers in Miami-Dade County, provides services for co-occurring disorders. SFPC has the single Florida Department of Children and Families' (DCF) contract for managing the provision of substance abuse treatment services for the entire county which they do through sub-contracts with 29 service provider organizations. To ensure quality and effectiveness of treatment services, the DCF contract for managing the provision of substance abuse treatment services requires SFPC to subcontract with network providers who, together, provide community-based substance abuse and/or mental health services statutorily authorized for adults and children. SFPC provides oversight so that all network providers comply with all client-related and other requirements. (Attachment III)

Treatment Interventions

The specific treatment interventions are provided according to DCF protocols. Residential: Level 2 - 24 hour supervision, 20 hours of clinical service weekly and 20 hours of activities; Level 3 - 24 hour supervision, 10 hours clinical service and 10 hours activities; Level 4 – supervised housing with Outpatient Level of Care (individual and group), individual, trauma HIV +, therapy groups counseling. Workshops - 12-steps, relapse prevention, anger

management, problem-solving, parenting, developmental education, HIV prevention, child care, vocational training, case management, family therapy, psychiatric evaluation, medication management, mental health counseling, nutritional consults, bio-psychosocial and needs assessment, and Fellowship Meetings. Outpatient: 2, 3 hours weekly groups or continuing care which includes: parenting group, substance abuse group, weekly in-home case management, weekly individual counseling (some designed specifically for parents with children).

DDC seeks to keep children with their parents in treatment whenever possible. Four DDC treatment providers provide residential treatment for mothers and their children, and one facility provides residential treatment for children with fathers or with both parents. The court is involved with these providers in assuring quality services for children residing in the facilities.

Integration of Treatment Services with DDC

As mentioned previously, cross-trainings and weekly staffing occur both formally and informally on a regular basis.

Individual Needs of the Client, Gender Appropriate, Culturally Competent

Treatment plans are developed based on the intake interviews, results of assessments, and the individual needs of the client. Miami-Dade County is an extremely diverse community, with a kaleidoscope of cultures and languages. All service and treatment providers have bi- and many have multi-lingual staff. The DDC, service and treatment providers inquire of participants whether they have norms, beliefs and values that might either contraindicate placement in treatment *per se* or require that placements be made selectively in these regards. All services are provided in both English and Spanish.

Monitoring Quality and Effectiveness of Treatment Services

The court is very involved in monitoring the quality of services and demands that services are evidence based. For example, the court was integral in the inclusion of trauma informed services such as Seeking Safety, quality early childhood intervention programs and -- most importantly-- identifying and treating co-occurring disorders (also see SFPC above).

Through written or oral communication the treatment provider must report progress to the DDC. DDC Specialists and treatment providers report progress of the parent to the court at hearings and additional drug testing is also conducted at hearings to enhance monitoring (Attachment IV).

Methods of Drug Testing and Analysis

Parents can drop urine specimens at treatment centers or on-site at the courthouse free of charge, even on days when they are not mandated to be in court. If alcohol is the drug of choice, then parents are placed on SCRAM bracelets. These devices cannot be removed and detect any amount of alcohol intake through a scientifically based alcohol detection system. In addition to tests at the treatment center, health technicians conduct the urinalysis test on site at the Juvenile Court. A 5-panel test is used. Urine is dropped at least twice monthly randomly or upon suspicion. Clients are observed by a same-sex staff member during the urine drop. Urine is analyzed in the presence of the client. Turnaround time for results at the hearing is within minutes. At treatment centers the test is sent to a lab, and it takes 48 hours to obtain the results (also see Component 6)

Continuum of Care for Children, Parents, and Families

There are long standing Linkage Agreements and Memoranda of Understanding between the DDC, SFPC, and Our Kids to meet the children, parents' and families' needs for additional services (Attachment IV).

The Family Resource Center of South Florida (FRC) is the Our Kids, Inc. subcontracted agency to provide service for children whose parent(s) are participating in DDC (Attachment V). The FRC provides a full continuum of services aimed at strengthening families. Services (available in English, Spanish and Creole) include family support, crisis intervention, housing location, family preservation, parent education and counseling. Referrals are made to other community providers for substance abuse, mental health, health, child care, educational, and/or social service needs of the children. Case management is provided for the entire case, meaning the parents, children, and entire familial system and includes: weekly meetings which transition to bi-monthly and monthly depending on the case progress, involvement of family members/support systems, urine analysis testing, monitoring of effectiveness of services, and weekly case staffings prior to court. Services provided by case management staff include: referral to program and services, monitoring case progress, coordination of system of care services, detailed case reports and recommendations to the court. The average caseload per case manager reflects best practice and does not exceed 15 families.

Strategies include involving family members/significant others in the treatment process. Family and collateral counseling is provided by recognized state/local authorities to provide such counseling. Parenting skills development classes are required for both fathers and mothers of school age children, and child care provision at the treatment facility is provided. Clients' family members are engaged to help motivate and support the client through successful completion of DDC. Clients in need are provided assistance with funding for use of public transportation. Coordination of treatment and recovery continuum with other services, such as vocational rehabilitation, education, legal aid, and transportation is provided through DDC, FRC and treatment providers.

4. Program Design and Length:

DDC Structure, Requirements

The Administrative Office of the Courts (AOC) of the Eleventh Judicial Circuit, Juvenile Division, implemented the Dependency Drug Court (DDC) in March 1999. There are 5 dependency judicial sections within the Juvenile Division, one of which is designated as the drug court.

Dependency Drug Court Protocol:

DDC participants progress through five phases for completion of the DDC program.

Phase I

Goals	Expectations	Advancement Requirements
* Screening and assessments * Assessment and referral for additional services (based upon individual needs) * Assessment of children's special needs * Placement in community-based treatment * Identification of treatment barriers * Decrease alcohol/drug use as evidenced by negative Urinalysis * Urinalysis Schedule * Resolve legal issues in Dependency Court * Acquire consistent visitation	* Weekly court appearances * Urinalysis testing 3x weekly or random * Enter substance abuse treatment * Compliance with court orders * Engage with Specialist * Visitation with children (establish schedule) * Attend AA/NA meetings * Plea to Dependency Allegations	* Regular court appearances * Team recommendation * Participation in substance abuse treatment program * Negative urinalysis for at least one week. * Completion of sanctions

Phase II

Goals	Expectations	Advancement Requirements
* Continued Abstinence * Enroll and participate in ancillary services * Attend family planning appointment * Identify home group for AA/NA meetings * Attend AA/NA meetings regularly * Maintain negative urinalysis results * Maintain safe, adequate, visitation with children based on the developmental needs of the children	* Every 2 weeks Court appearances * Urinalysis testing 3x weekly or random * Engagement in substance abuse treatment * Begin ancillary services * Continued attendance in AA/NA meetings and identification of home group. * Work toward service plan goals * Consistent visitation with children	* Regular court appearances * Team recommendation * Progress towards treatment plan goals * Negative urinalysis results for a minimum of two months * Compliance with sanctions * Express commitment to participation in services

* Medication compliance	* Begin to identify a sponsor * Cooperate with DDC Specialist/FRC case manager	

Phase III

Goals	Expectations	Advancement Requirements
* Continued abstinence * Internalization of recovery tools * Educational and vocational training * Attend parenting course(s) * Demonstration of effective parenting skills * Negative urinalysis results * Successfully complete treatment program and ancillary services. * Begin aftercare program * Obtain sponsor * Begin working 12 step program	* Monthly court appearances * Urinalysis testing as ordered * Completion of substance abuse treatment and other services * Demonstrate good parenting skills with children * Educational or vocational training * Cooperate with case manager * Remain self sufficient * Attend AA/NA meetings 3-4 times per week * Involvement with 12 step program	* Regular court appearances * Progress toward treatment plan goals * Team recommendation * Negative urinalysis for 4 months * Compliance with sanctions * Obtain sponsor

Phase IV

Goals	Expectations	Advancement Requirements
* Continued abstinence and recovery * Develop aftercare plan (client to complete with treatment counselor, inclusive of relapse plan) * No positive urinalysis * Maintain regular contact with sponsor * Behavior consistent with recovery lifestyle	* Every other month court appearances * Urinalysis testing as ordered * Complete treatment * Reunification with children and demonstration of good parenting skills * Remain self sufficient * Cooperate with DDC Specialist/FRC case manager	* Regular court appearances * Reunification with child (ren). * Completion of treatment programs as court ordered * Team recommendation * No positive urinalysis

Self Reliance Phase

Goals	Expectations	Advancement Requirements
* Continued abstinence and recovery * Participate in aftercare program (e.g. Project Safe) when available * Maintain stable housing * Maintain stable employment * Court approved permanency plan * Reintegration into community * No positive urinalysis	* Aftercare participants: court appearance at end of third month or as needed * Non-aftercare participants: monthly court appearances * Weekly urinalysis testing * Attend treatment * Compliance with court order * Court approved permanency plan * Stable employment * Stable Housing * Remain self sufficient * Cooperate with DDC Specialist/FRC case manager	* Completion of all graduation requirements (e.g. completion of services, employment, reunification, etc.) * Custody of children * Completion of parenting skills training * Completion of treatment program as court ordered * Maintain stable employment * Maintain safe and stable housing * Completion of all court

		conditions * No positive urinalysis results prior to graduation * Graduation

Termination

Termination from the program occurs if the goal for the child (ren) changes from reunification to termination of parental rights because parent has been consistently non-compliant or there are findings of egregious child abuse or neglect, or if the parent is not engaging over time, or the parent chooses not to seek reunification.

5. Judicial Supervision (also see Phases Chart above and Incentives and Sanctions below)

The DDC Judge seeks to establish a unique, therapeutic relationship with the parent through interactions during court appearances. The Judge supervises and reinforces treatment by reviewing reports from DDC Specialists, FRC Case Managers, and treatment providers and discussing recovery obstacles with the parent(s). Both positive and negative incentives (i.e. rewards and sanctions) are used to encourage compliance. The judge assumes the role of both task master and cheerleader. In this setting, the judge is able to reward successes, and provide additional motivation. Conversely, the judge can sanction noncompliance, thereby discouraging failure.

The DDC Program Coordinator facilitates a team staffing two days prior to court hearings which includes: FRC Case Managers, DDC Specialists, DCF attorney, treatment providers, defense attorney, and others as appropriate. Progress reports are shared and are discussed and recommendations regarding rewards and sanctions recommendations are prepared to present to the judge. The judge does not attend the staffings, however the DDC Specialist

provides a written report to the judge summarizing all the reports from providers prior to the hearing and provides copies to all appropriate parties at the court hearing.

Participant's progress in recovery is monitored by the DDC Specialist, who submits progress reports to the court, FRC, DCF and treatment providers. The progress reports contain: the results of every alcohol/drug test; attendance at required meetings and/or counseling sessions; participation in required treatment program activities; adherence to the rules of the DCF Case Plan and the rules of the treatment program; and compliance with the FRC Case Plan.

6. **Drug Testing**

Method, Frequency and Randomization

Urinalysis testing occurs 3 times weekly or randomly in Phases I and II; as ordered in Phases III and IV; and weekly in the Self Reliance Phases (also see chart above). Clients have a weekday call in schedule and from a preset calendar DDC staff tells them if they have testing that day, if they do then they go to court or a treatment center for urinalysis. If they do not comply it is considered a positive. Testing at DDC is conducted by Behavioral Health Technicians from The Village, a treatment provider. Typically, a 5-panel test is used. Clients are observed by a same-sex staff member during the urine drop. Urine is analyzed in the presence of the client, there is also the capability of testing if adulterants are suspected. Turn around time for results at a DDC hearing is immediate. At treatment facilities it may be immediate or, if sent to a lab, it may take 48 hours. Family members may be tested if they are seeking contact with or custody of the child.

7. Incentives and Sanctions:

Guidelines for Applying, Consideration of Demonstrated Effectiveness

The incentives and sanctions utilized in DDC are based on the Ten Key Components for drug courts produced by a diverse group of drug court practitioners and other experts from across the country and brought together by the National Association of Drug Court Professionals. Key Component #6 requires a coordinated strategy governing drug court responses to participants' compliance' through Performance Benchmarks http://www.nadcp.org/whatis/. (see chart below)

At each court hearing parents are subject to a range of sanctions or rewards based on their program compliance for the report period. The table below summarizes compliant and non-compliant behaviors and the corresponding rewards and sanctions.

ACHIEVEMENTS	**REWARDS**
* Attending Court Appearances * Negative Urinalysis Results * Attendance/Participation in Treatment * Attendance/Participation in AA/NA meetings * Attending Approved Visitation with Child(ren) consistently * Compliance with Case Plan * Phase Promotion	* Acknowledgment by Judge * Applause * Decreased Court Appearances * Decreased Urinalysis Testing * Phase Advancement * Phase Advancement Certificate * Case Called Early in Court * Gift Cards/Tokens/Vouchers (when available)
INFRACTIONS	**SANCTIONS**
* Violation of Order * Dishonest Statement * Failure to Perform Sanctions * Failure to Comply with Case Plan * Establishment of New Neglect * Failure to attend Visitation * Unauthorized Visitation * Leaving Treatment * Treatment Non-Attendance * Treatment Termination for Infractions * Positive Urinalysis * Missed Urinalysis * Tampering with Urine	* Reprimand from Court * Increased Court Appearances * Essay * Community Service Hours * Phase Demotion * Increased Urinalysis Monitoring * Recommendation for TPR * Good bye Letter to the Children

SANCTIONS SCHEDULE	
PHASE I	1st : Non-Compliant Event: 4 Community Service Hours 2nd : 8 Community Service Hours 3rd : 1 Page Essay / Speech

PHASE II	1st : 15 Community Service Hours 2nd : 20 Community Service Hours/Phase Reduction 3rd : 3 Page Essay / Speech
PHASE III	1st : 15 Community Service Hours 2nd : 20 Community Service Hours/Phase Reduction 3rd : 5 Page Essay / Speech, Reduction in Phase 4th : Program Discharge
PHASE IV	1st : 25 Community Service Hours 2nd: Good bye Letter to Children 3rd : Program Discharge
SELF RELIANCE PHASE *No Positive Urinalysis Results Allowed During Self Reliance Phase	1st : Phase Reduction, Increased Court appearances 2nd : Re-assessment of Needs

Proposed *Expansion and Enhancement Initiative*

This proposal is requesting funding for expansion to increase capacity from 60 to 100 per year, and enhancement of the current DDC primarily through implementation of two evidence-based intervention approaches that have been successfully piloted in the context of DDC, the Engaging Moms Project (EMP), an expanded case management model which enhances the work of the DDC Specialists, and a parenting program specifically targeting the families with children ages 0-3, *Project Hand-N-Hand.*

DDC functioning will be enhanced by integrating the EMP with the established court-based case management services. EMP is a science-based program that was adapted for use in a family drug court context and has shown particular promise in that setting. The model is a gender-specific and family-based intervention designed to help mothers succeed in drug court by complying with court orders such as attending and benefiting from substance abuse and other intervention programs (e.g., domestic violence counseling, parenting classes, etc), attending court sessions, remaining drug free, and demonstrating capacity to parent her children.

EMP was initially conceived as a brief, family-oriented intervention aimed at facilitating treatment entry and retention among mothers of substance-exposed infants. An initial study of this approach (Dakof, Quille, Tejeda, Alberga, Bandstra, & Szapocznik, 2004) showed that it successfully facilitated entry and initial retention of non-treatment seeking drug abusing mothers into drug treatment. Given the promising results of the initial EMP study, the model was adapted for use in DDC, and 2 pilot studies have been completed (see Statement of Need)

The three studies of the EMP are consistent in that each study shows promise for the EMP in (a) enrolling and retaining mothers in substance abuse treatment, (b) promoting positive child welfare outcomes, and (c) improving family functioning and parenting practice.

DDC Specialists will conduct individual and conjoint sessions with the mother and her family, focusing on six core areas of change: (1) motivation and commitment to succeed in drug court and to change her life, (2) the emotional attachment between the mother and her children, (3) relationships between the mother and her family of origin, (4) parenting skills, (5) mothers' romantic relationships, and (6) emotional regulation, problem solving, and communication skills. The EMP theory of change supposes that change in the core six areas are essential if the drug using mother is to achieve sobriety and be able to adequately care for her children.

The intervention is organized in 3 stages: Stage 1: Alliance and Motivation, a)Building a strong therapeutic alliance with the mother and her family, and enhancing mother and family motivation to change including total support to both the mother and her family; empowering validating, highlighting strengths and competence; and building confidence in the program. b) Enhancing motivation by acknowledging the pain, guilt and shame the mother and her family have experienced, and the high stakes involved (e.g., losing child to the child welfare system)

while simultaneously creating positive expectations and hope. Stage 2: Behavioral Change, a) Recognizing behavioral change in both the mother and her family/spouse. b) Exploring the emotional attachment between the mother and her children by helping her explore her maternal role. c) Facilitating the mother's relationship with court personnel (judge, child welfare workers, and attorneys) and treatment or other service providers. Stage 3: Launch to an Independent Life, a) Preparing the mother for an independent life by developing a practical and workable routine for everyday life. b) Addressing how the mother will balance self care, children and work. c) out-lining a plan for dealing with common emergencies with children and families, d) developing a detailed relapse prevention plan; and addressing how the mother will deal with potential problems, mistakes, slips, and relapses.

Dr. Gayle Dakof, the developer of the EMP model will provide a 3 day introductory training to the DDC Specialists who will be implementing the EMP as well as cross-training to all members of the DDC team. Intensive training will be provided to the DDC Specialists consisting of didactic instruction, case consultation, and intensive videotape and live supervision of Specialist's sessions with mothers enrolled in drug court. Dr. Dakof will meet weekly with the DDC Specialists team to include case review and planning, supervision of videotaped EMP sessions, as well as live supervision. Once initial training is completed, Dr Dakof will provide sustainability training on a monthly basis to the specialists. A 1 day cross-training of the EMP approach will be provided to all DDC partners, including the Judge, child welfare case managers, attorneys, and substance abuse treatment providers. Thereafter, booster sessions, updates, and opportunities to train new DDC partners will be scheduled in quarterly half-day sessions (See Timeline).

The University of Miami Linda Ray Intervention Center will implement *Project Hand-N-Hand* (see Statement of Need Effect on Target Population and Community) for three cohorts of families with a child 0-3. Parenting groups will meet for 12 weeks for a 90 minute session that includes two segments. The first will be a 60-minute parent-only session for the facilitator to present sessions on the topics related to parenting young children that have been found to optimize child development (See Timeline). The topics include child development, developmentally appropriate expectations, how to create a home environment that is safe and stimulating, the connection between early experiences and brain development, establishing trust between parents and children, self-esteem, establishing routines, responsive parenting, facilitating language development and emerging literacy, guiding child behaviors, managing stress, and learning and having fun with art, music and movement. This segment will be followed by the second with parent-child interactive learning activities, which will help solidify the information that has been previously presented during the parent only session. During the parent-only session, qualified early-childhood caregivers will care for the children.

In this second segment, parents and their young children will engage in guided, structured play activities for 30-45 minutes. These opportunities will allow the parent and child to interact together using age-appropriate curriculum activities that focus on the development of language) building, social-emotional skills and self-help abilities and dealing with attachment issues that may be observed. The activities will: 1) add to the knowledge and skills-building information gained in the parent only component, 2) provide an opportunity for participants to practice being sensitive and responsive, to facilitate language, and to play appropriately with their children with modeling and guidance from facilitators, and 3) help establish a support network among the participants. Moreover, developmentally appropriate learning materials will be provided for each

family to take home weekly. This will allow parents to practice the skills gained in the intervention. Participant's incentives for on time participation are provided.

Three data elements will be collected pre/post:

1. The AAPI-2 Adult-Adolescent Parenting Inventory Form A (Bavolek & Keene, 1999) is used to measure improved parent knowledge and application of effective parenting practices, as indicated by increased awareness and application/demonstration of positive disciplinary practices. Project Hand-n-Hand has administered the AAPI-2 to 41 participants in 2008 and 90% of the participants improved their AAPI-2 scores from pre to post.

2. KIDI- Knowledge of Infant Development Inventory- (MacPhee, 1996). The KIDI measures parents' knowledge of child behavior and growth. This is administered on a pre and post test basis. The KIDI has been administered to 182 Project Hand-n-Hand participants to date and statistically significant improvements have been noted from pre to post ($t=2.17$; $p<.05$).

3. Behavioral observations will be conducted pre/post. These are coded videotapes of child/parent interactions including free play, guidance of a structured task and separation and reunion coding. This will also help determine what the relationship looks like from pre to post period while parent is in the DDC program.

8. **Management Information System and Evaluation**:

The evaluation team will employ various procedures to determine if the proposed strategies, systems, and activities utilized have a positive effect. The evaluation of the *Expansion and Enhancement Initiative* will be guided by the Context, Input, Process, and Product (CIPP) theory-based evaluation model (Stufflebeam, 2003). The evaluation will focus on the process and product dimensions of the model; specifically, "is the program being [conducted] properly" and "is it succeeding"? (Stufflebeam, 2003, p. 3). The CIPP model will be used to assess and report

the program's merit, worth, and significance as well as to present the lessons learned from its implementation.

The CIPP model will be utilized to examine and provide guidance in relation to the use of resources, quality of implementation, and supervision and training of staff (process evaluation). In addition, the following questions will be addressed:

(a) How closely did project implementation match the plan?
(b) What types of deviation from the plan occurred?
(c) What led to any deviations?
(d) What effect did any deviations have on the planned intervention and performance assessment?
(e) Who provided (program staff) what services (modality, type, intensity, duration), to whom (individual characteristics)?

The program Logic Model (Attachment I) will be used to guide the evaluation. All of the performance measures noted in the chart above, which are important program process and outcome variables, will be collected and incorporated into the evaluation. In addition, to address the process evaluation questions noted above qualitative data will be obtained from interviews with project administration and staff and other key stakeholders every six months. Furthermore, the evaluation team will be represented at all relevant Advisory Committee meetings to remain apprised of the status of project implementation. Satisfaction surveys will also be administered to all participants to obtain their perspective on various aspects of program quality upon discharge from the program. Additionally, surveys will be developed and utilized with project staff to obtain feedback relative to program trainings (administered after all trainings) and to the quality of staff clinical supervision (given every 6 months). Moreover, semi-structured interviews will be conducted with a sample of 6 to 8 participants annually to gain in-depth insight into their experiences in relation to the project. Qualitative content analysis techniques (Denzin & Lincoln,

2000) will be used to interpret the data obtained from interviews and focus groups and the NVivo qualitative research computer application will be used to facilitate this process.

The CIPP model will also be utilized to determine the impact, effectiveness, and sustainability of the *Expansion and Enhancement Initiative* program to affect continuation and expansion decisions (product evaluation). Questions addressed will include the following:

(a) What was the effect of the intervention on participants?
(b) What program or contextual factors were associated with outcomes?
(c) What individual factors were associated with outcomes?
(d) How lasting were the effects?

These questions will be addressed through examination of client demographics and pre/posttest results on the Adult-Adolescent Parenting Inventory-2 (addressing parenting knowledge and behavior) and the Knowledge of Infant Development Inventory (measuring knowledge of child behavior and growth) as well as drug screen results that will be administered on an ongoing basis. The assessment data noted above will be provided to the evaluation team on an ongoing basis in a secure de-identified manner. Additionally, dependency cases are processed by the court using the Criminal Justice Information System (CJIS) and by the Department of Children and Families (DCF) using FSFN. Currently the DDC uses an Excel spreadsheet to track additional data regarding drug court clients; however, a web-based application developed by the Eleventh Judicial Circuit for the Adult Drug Court will be made available to the DDC. The application allows treatment providers to submit reports to the court electronically. Reports from this application will be provided to the evaluator to track several of the process and outcome variables (see Performance Measures Table). The Statistical Program for the Social Sciences (SPSS) will be utilized by the evaluator to maintain a client database (including demographic and assessment instrument data). It will also be used to analyze the quantitative

data to determine the effects of program participation. Given the nature of the data that will be collected the repeated measures analysis of variance statistical procedure will be used to determine the extent of change on the outcomes variables.

Formative program evaluation will have a central role in this project. A quality improvement process will be implemented and will involve the: (1) ongoing assessment of salient process and outcome variables; (2) identification of program needs; (3) redirection of resources to make necessary changes to the program implementation; and (4) assessment to determine the appropriateness and effectiveness of programmatic changes. Formative evaluation reports will be prepared every 6 months to provide feedback regarding the implementation of the program and will include several key components. The reports will present findings relative to data collected on the process and outcome variables (including the performance measures). The evaluation reports will also address the extent to which program implementation was consistent with the plans developed for its implementation and will identify the program's impact and effectiveness. Finally, lessons learned from the program evaluation will be delineated. Prior to the issuance of the reports a feedback workshop with stakeholders will be scheduled (Stufflebeam, 2003). Draft reports will be sent to stakeholders about 10 days prior to scheduled feedback workshops. During the workshops the evaluator will use PowerPoint to present a summary of findings and recommendations and will seek input and suggestions from those present. At the conclusion of the workshops the evaluator will report on next steps, future reports, proposed revisions to the reports, and needs from the project staff especially in relation to data collection. Stakeholder input from the feedback workshops will be incorporated into the final draft of the reports. As indicated previously, the mandatory performance measures will be

reported to OJJDP by the evaluator on a regular basis using the Data Collection and Technical Assistance Tool.

The evaluation team will be represented at all required OJJDP grantee meetings. In addition, it is important to note that the evaluation team will work to participate fully in any cross-site evaluation of the program that may be implemented by OJJDP or one of its contractors.

For information on data-sharing agreements with treatment service providers, child protection services, the court, and other agencies, and how applicable local, state, and federal confidentiality guidelines and requirements will be met, see Memorandum of Understanding Attachment IV.

CAPABILITIES/COMPETENCIES

Organizational Structure

Miami-Dade County (MDC) is submitting this proposal as the applicant on behalf of the Eleventh Judicial Circuit of Florida Administrative Office of the Courts (AOC) as court funds are fiscally administered by the county. The AOC will serve as the lead partner for the *Expansion and Enhancement Initiative*, providing administrative oversight, maintaining AOC policies and procedures, and contracting with: Gayle Dakof, Ph.D; the University of Miami Linda Ray Intervention Center; Research & Evaluation Network on behalf of Marcelo Castro, Ph.D, and James Pann Ph.D., co-evaluators; DDC Specialists and Intake Specialist. The AOC will also manage the program and financial reporting to grantor.

Roles and Responsibilities of Current Project Staff

Current staff consists of a DDC Coordinator and four DDC specialists (Attachment VII) who focus on the parent(s) and are funded at the local level. These staff provide the critical link

between the parent, the child, the treatment provider, other services, and the court. The Coordinator is responsible for the alcohol and drug abuse screenings and assessments, and supervision of specialists and case managers, and facilitation of staffing meetings. The DDC Specialists are responsible for referral and enrollment in treatment services, alcohol and other drug testing, progress monitoring, crisis and therapeutic intervention, to engage and retain the parent in the dependency court process, advocating for the parent, and keeping the parent motivated to treatment and recovery throughout the long DDC process.

Contracted Staff for the *Expansion and Enhancement Initiative*

The two DDC Specialists will have the same responsibilities as the current specialists described above and the Intake Specialist will assist the DDC Coordinator by conducting alcohol and drug abuse screenings and assessments (Attachment VI).

Gayle Dakof, Ph.D is Research Associate Professor of Epidemiology and Public Health, Director of CTRADA, and the developer of the EMP intervention. Dr. Dakof has trained clinicians in EMP for several randomized clinical trials. For over 20 years, Dr. Dakof has been central to designing and implementing CTRADA's controlled trials and process studies is the creator of the EMP model. She will provide training and supervision for the EMP implementation (Attachment VII).

Lynne Katz, Ed.D is Director of the University of Miami's Linda Ray Intervention Center and a Research Assistant Professor in the Departments of Applied Psychology and Pediatrics. As Director of the Center since 1993, an early intervention service and research project for children at-risk due to prenatal cocaine exposure, she has maintained a leadership role from the early intervention perspective to create linkages with the community stakeholders of all on-going projects. Dr. Katz and her staff will implement and supervise Project Hand-n-Hand

(Attachment VII).

The program evaluation will be conducted by Drs. James Pann and Marcelo Castro of the Research & Evaluation Network. In addition, a research assistant will be utilized to assist with the evaluation. Drs. Pann and Castro have expertise, demonstrated by research and teaching, in the following areas: program evaluation, qualitative and quantitative research, survey methods, substance abuse, homelessness, and problem solving courts. In addition, particularly relevant to this program, they have conducted program evaluations of several federal initiatives including projects funded by OJJDP, Substance Abuse and Mental Health Services Administration, and the Department of Labor (Attachment VII).

Family Drug Court Team

Judge Jeri B. Cohen, DDC judge, has been a Circuit Court Judge for the State of Florida Eleventh Judicial Circuit for over twelve years. Judge Cohen founded the DDC in Miami which has become a national drug court model. She will provide leadership to the *Expansion and Enhancement Initiative* (Attachment VII). Members of the DDC team include SFPC as managing agency of the 29 treatment providers, Child Welfare Legal Services, an alumni of DDC, Defense Counsel, DCF supervisor for SA/MH Division, DCF attorney supervisor, DCF attorney on behalf of the child, Gayle Dakof Ph.D., Lynne Katz, Ed.D, (Attachment VI) AOC staff: Grants Administrator, Juvenile Division Operations Director, DDC Coordinator, and the Chief Deputy Court Administrator/CIO.

Interdisciplinary, Non-Adversarial Work Team

Most of the above members of the DDC have worked together since the inception with only a few changes and there are long standing MOUs between DDC and each treatment provider and between SFPC and Our Kids (Attachment IV).

SUSTAINABILITY PLAN

The Eleventh Judicial Circuit of Florida Administrative Office of the Courts (AOC) Grants Administration Office has worked collaboratively with justice system partners since 1995. Extensive work has been done with the Juvenile Division and the community to obtain funding for services for those who come in contact with the dependency system. The AOC's Grants Administration and Administrative Service Division (finance) have managed and administered many of these grants. The AOC is one of the project's primary stakeholders and will continue to serve on the Advisory Committee providing administrative support and liaison services for the EMP Initiative. There are high levels of commitment in appropriate places at the State level that the drug treatment courts now operating will be sustained. Similar expressions of intent are being expressed in the halls of local county government and by the Chief Judge and Administrative Judge of the Circuit's juvenile division. The Obama/Biden Administration's support for drug courts bodes well for the future and the AOC's past success in obtaining funding for individuals involved in the justice system provides a strong base for continued funding.

The DDC team already has many of the components necessary for successful sustainability: judicial leadership; committed team of drug court partners; strong institutional support from the AOC and Our Kids; and the recent establishment of a community based non-profit organization (Dependency Drug Court Angels) devoted to raising funds and community support for the DDC.

Session V

CPS System Reform to Better Serve Prevention & Protection Goals

Strengthening CPS Ability to Protect Infants and Young Children against Maltreatment
(A few thoughts based on data – not yet published – from California…please do not quote or cite without author's permission)

Emily Putnam-Hornstein[1]

In 2010, referrals involving approximately 6 million children believed to have been harmed or at risk of harm were made to child protective service (CPS) agencies in the United States. Roughly 3 million children received an investigation and nearly 700,000 were identified as victims of abuse or neglect. Yet, these numbers likely underestimate the true public health burden of child maltreatment. The Fourth National Incidence Study (NIS-4), which estimates the number of children abused and neglected in the United States based on both formal reports made to CPS, as well as knowledge of maltreated children gleaned through other sources, determined that more than 1.2 million (1 in 58) children are demonstrably harmed or injured by child abuse or neglect annually. If a more inclusive "endangerment" standard for defining child maltreatment injuries is applied, the NIS-4 suggests that nearly 3 million (1 in 25) children are endangered by maltreatment each year.

While it is incredibly tragic that rates of child maltreatment in the U.S. may be two to three times higher than the actual number of identified victims, it is not clear if, where, or how this nation's surveillance system is falling short. Certainly, CPS cannot be faulted for failing to protect children never referred. Yet for those children known to CPS, high rates of re-reporting and maltreatment recurrence highlight widespread system failures to adequately and appropriately respond to child abuse and neglect

Nationally, the age distribution of children reported for maltreatment continues to shift downward, with the highest rates of alleged maltreatment occurring during infancy. Given the physical vulnerability that defines the first year of life, as well as a growing body of research linking early childhood adversities to developmental deficiencies into adulthood, there is perhaps no greater or more important opportunity for CPS and other systems to positively intervene than during infancy. An improved understanding of maltreatment referral and re-referral patterns for children first identified as possible victims during infancy may translate into simple and impactful methods for tailoring and targeting secondary and tertiary prevention responses following an initial report of maltreatment.

The purpose of this research was to generate knowledge concerning the recurrence of maltreatment among those children reported to CPS during infancy, the group that stands to benefit the most from efforts that successfully reduce maltreatment recurrence, both

[1] Co-authors on this manuscript include James Simon, LCSW (University of Southern California), John Joseph Magruder, PhD (University of California at Berkeley), and Barbara Needell, PhD (University of California at Berkeley).

because maltreatment that begins during infancy is likely to be quite chronic in duration and because its timing is quite developmentally consequential.

What does birth/CPS data from California indicate?

- Among the 563,871 children in California's 2006 birth cohort, 5.3% (29,889) were referred for maltreatment before their first birthday.
- Over one-quarter of these referrals were made within 3-days of the infant's birth
    - Not surprisingly, among these 3-day referrals, 98% involved an allegation of neglect or substantial risk of maltreatment. Unfortunately, we do not have data as to how many of these allegations involved maternal substance abuse.
- 70% of these infants had older siblings. And among those with older siblings, 50% had an older sibling who had been referred for maltreatment on an earlier date. In other words, many of these infants came from families who had current or prior CPS involvement.

What happened to the nearly 30,000 children first identified as possible victims of maltreatment during infancy?

- 12% (3,569) of these initial infant referrals were evaluated out without any investigation.
- 50% (15,092) led to an investigation in which the allegation was determined to be "unfounded" or "inconclusive".
- 38% (11,228) were investigated and substantiated.
    - Among substantiated cases, 47% of infants were placed in out-of-home foster care, 22% received home-based services, and 31% received no formal CPS services/no case was opened (there may have been a referral to a community agency).

Stepping back to the full cohort of children referred during infancy, this means that 82% of these babies remained in the home following the initial referral of abuse or neglect. How did those infants who remained in the home fare through the age of five? Was the initial referral a chance event, with no further safety or well-being concerns raised in follow-up allegations?

- 56% of these infants were referred again before the age of five.
- The rate of re-referral was equivalent among infants with allegations initially evaluated out and those who received an investigation that was unfounded/inconclusive (54%).
    - Among those remaining in the home following an initial allegation that was substantiated, 58% of those receiving no formal services were re-referred, while 65% of those who received services were re-referred.

Were there unique characteristics of infants who were at increased/reduced risk of being re-reported?

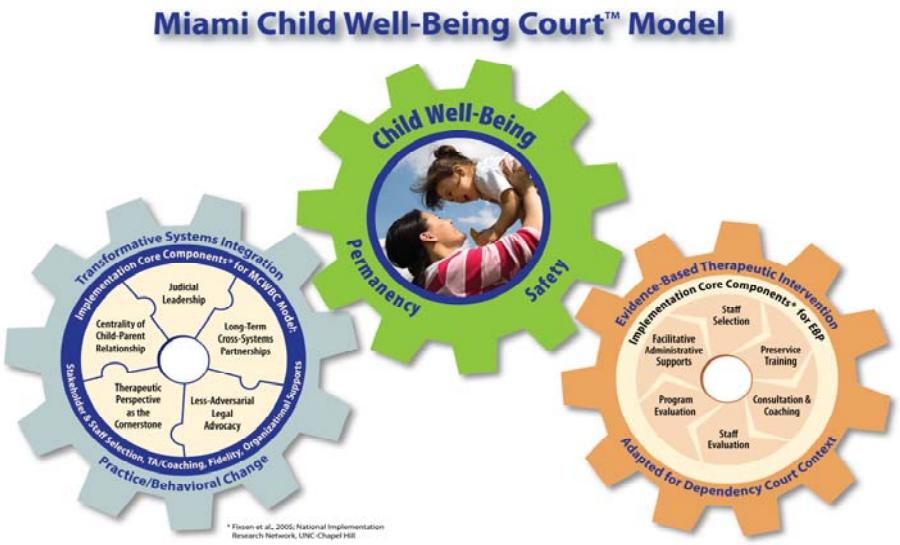
- At least in California, the population of infants referred for maltreatment amounts to a distinct subset of children in the overall birth cohort, defined not by any one single risk factor, but by the presence of multiple risk factors. The profile of these infants is one of cumulative disadvantage.
- Yet among referred infants, risk factors strongly predictive of a future referral did not emerge.

Questions raised (although not answered) by these data[2]

- *The majority (82%) of referred infants remain at home, yet over half (56%) of these infants are re-referred before they enter kindergarten. This seems unacceptably high to me. What (if anything) should we be doing differently?*

- *Equally disconcerting is that the highest rate of re-referrals is observed for infants who are substantiated and receive services (64%). While these infants are likely being triaged for formal services because they come from families facing the greatest risk burden, a 64% re-referral rate would seem to indicate that services offered are inadequate (either in dosage or substance). If there is an insufficient evidence-base from which to deliver effective services, how should that influence current CPS practices and policies?*

[2] These reflections represent my thoughts, not necessarily those of my co-authors!



The **Miami Child Well-Being Court™** model is a pioneering court-initiated systems-integration approach to promote healing and recovery from trauma in maltreated young children and to break the intergenerational transmission of child abuse and neglect. In this model, the dependency court is a platform for increasing the reach and effectiveness of therapeutic evidence based interventions for maltreated children and their caregivers. The model focuses on (1) centering the attention of the court on the developmental, emotional, relational, and mental health needs of the young child in judicial decision-making, case planning, and permanency determination; (2) timely referral to and judicial monitoring of services for adjudicated children and their parents, and (3) cross-disciplinary, sustainable practice change at the case level. The model has generated a groundswell of interest, with communities across the country and internationally seeking technical assistance to explore adoption and assist with implementation of the model. As the original developers of the model, the Miami team has continued on a steady course to build the training resources that will guide effective and sustainable implementation of their complex model.

Training, Planning and Evaluation – Accomplishments to Date:

- Qualitative study of the essential elements in the Miami model, which yielded a set of **replicable core components** comprising professional behavioral changes and implementation practice necessary for effective dissemination of the model.
- Development and piloting of a **cross-systems training and coaching curriculum** focused on behavioral practice change across professionals (judge, attorneys, caseworker, child/parent therapeutic service providers) to support full integration of the therapeutic perspective in the dependency court proceedings and to keep the child as the central focus.
- Development (in progress) of an implementation **manual** and training/coaching **curriculum** that provides step-by-step concrete guidance for jurisdictions seeking to implement the model.
- Development and piloting of fidelity **tools** for evaluating the effectiveness of training and degree of implementation of behavioral changes in newly adopting sites: (1) court observational tool, (2) out-of-court self-assessment tools (by discipline), and (3) child/parent therapeutic service tool to capture adaptations for court.
- **Planning for technical assistance** to sites exploring adoption of the model to support effective implementation, including site readiness, staff selection, performance assessment, and capacity building for evidence-based services.

The ***MCWBC Training & Evaluation Team*** is led by Judge Cindy Lederman, Miami-Dade Juvenile Court (11th Judicial Circuit, FL),and Dr. Lynne Katz, University of Miami Linda Ray Intervention Center, in collaboration with researchers at RTI International, Dr. Jenifer Goldman Fraser and Dr. Cecilia Casanueva. This effort is currently being funded by a generous grant from the National Center for Injury Prevention and Control at the Centers for Disease Control (No. R18 CE001714). The model began as an innovative collaboration between the judiciary and infant mental health, led by Judge Lederman in partnership with trauma expert, Dr. Joy Osofsky, of the Louisiana State University Health Sciences Center, and Dr. Katz.

The Miami Child Well-Being Court™ Model

We are at a critical juncture for funding to further develop and test the effectiveness of the training manual, curriculum, and fidelity tools. This next step is urgently needed to move closer to better meeting the needs of maltreated children, their caregivers, and the professionals who represent and support them. The urgency is also driven by the looming reality that the originating judge will not be on the bench forever.

Short-Term Goals (2-3 years) for Training Planning and Evaluation:

- "Seeing is Believing" – Our training experiences to date make clear that observations in the Miami court are a crucial training component, for new sites to observe first-hand how different the Miami court is from traditional court .We are seeking to produce **training DVDs** presenting real and simulated court dependency proceedings demonstrating the behavioral practices inherent to the model, enacted by the judge and other professionals from the Miami team who have been engaged in the model for the past decade.
- To finalize and produce copies of the training manual for distribution.
- To further develop the training curriculum to incorporate multiple case studies, redacted court transcripts, cross-discipline role plays and mock-court exercises to ensure training methods incorporate varied modalities for different adult learning styles.
- To further develop training evaluation tools.
- To test the effectiveness of the training approach in new jurisdiction(s).

Long-Term Goals (3 years +) for Training, Implementation, and Outcomes Research:

- Work with the Children's Bureau T & TA Network to carve out a national learning collaborative to support effective diffusion of the Miami model and related best practices in court, child welfare, and child mental health. The collaborative will foster shared knowledge and strategies related to funding challenges, organizational barriers and solutions, and discipline-specific leadership.
- Collaborate with the purveyors of relevant evidence-based programs to identify and study adaptations for court-involved young children and their caregivers.
- Conduct rigorous research on implementation.
- Conduct rigorous research on child mental and behavioral health, parent-child relationship, and child resilience outcomes associated with adaptation of an EBP embedded in the Miami practice and systems-change model.

The Miami Child Well-Being Court™ Model
Evidence-Based Therapeutic Intervention adapted for the Court Context

The field is at a critical juncture. Evidence-based interventions for maltreated infants and young children and their caregivers need to be more widely available and adequately funded to assure intervention fidelity and to expand and concretize the provider's role in working with court-involved families. Without funding, effectiveness research on adaptations of EB approaches for this population cannot be carried out. Without funding, judges who are seeking to implement the MCWBC model cannot expect their partnering agencies to have the resources to pay for out-of-session activities not necessarily covered by existing entitlement funding. Below we list a subset of the 14 additional core activities essential to the treatment providers work within the court settings and across the professionals working on the case::

1. **Collection of all referral and eligibility criteria documentation from caseworkers**

   Collection of all documents to begin the intake process, including, but not limited to: therapeutic treatment's referral form, eligibility form, Verified Petition for Dependency or Shelter Petition (Dependency Petition), Adjudicatory Order; and any other documentation on risk and safety.

2. **Child-parent assessment**

   Completion of all components of the assessment: Individual session(s) with parent, including but not limited to; clinical observation(s) of the child-parent relationship; child's caregiver home visit; parent home visit; child care visit/observation; review with caseworkers of Verified Petition for Dependency; review of risk and safety issues additional to allegation; review of case plan and service provider reports (collateral information from all providers) provided by case worker.

3. **Collaboration with other professionals working with the court**

   Discussions with lawyers and caseworker re: a) gathering of collateral information, including ongoing risk and safety issues, b) child and parent service needs (e.g., substance-abuse treatment, domestic violence services, adult mental health; PT, OT, Speech/Language), c) review of case plan, and d) discussion of therapeutic provider's narrative to be presented at next court hearing and recommendations of services in reference to parent/child needs.

4. **Protecting therapeutic relationship with court client: Preparation for hearing**

   In preparation for hearing a) remind parent that therapists are required to inform the Judge of their client's status in therapeutic treatment; b) Share critical aspects of what is to be reported in court with emphasis on risk and safety issues, and c) Provide opportunities for client to ask questions in order to insure that parent understands the reporting process and implications of what will be reported by therapist.

5. **Participation in the dependency court hearings**

   Provide verbal report of: Status of therapeutic treatment including the quality of the parent-child relationship; Status of insight into the allegations of removal; Parent's degree of compliance; Status of risk factors; Safety issues; Status of child's developmental functioning and extent to which the developmental needs of the child are being met through the referral and support services of the case plan; Information on how developmentally appropriate concurrent planning is being maintained; Recommendations that address current interventions needed.

6. **Reflective supervision of court case**

   Review of assessment instruments and therapeutic progress notes including parent-child quality of the relationship, risks factors, safety, dependency petition, other legal and collateral documents; review court related process and reflect with supervisor about legal implications impacting client progress or therapeutic relationship and clinical meaning of client behavior; reflect on therapist's emotional experience with court process, parallel timeliness and activities in court process and therapy.

Building bridges across the judiciary, child welfare, and child mental health: The Miami Child Well-Being Court™ model

Presented by:
The Hon. Cindy Lederman , 11th Circuit Juvenile Court, Miami
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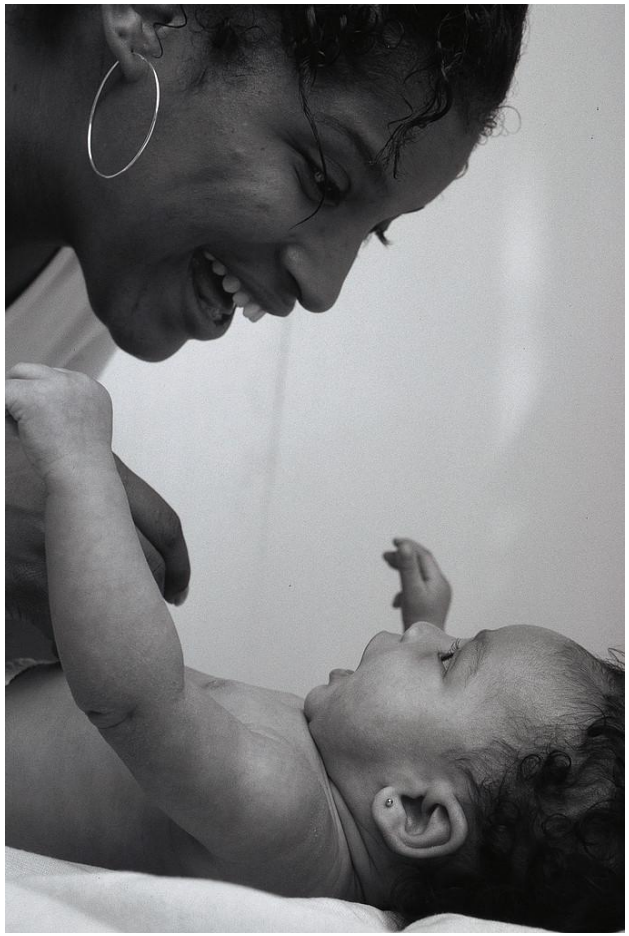
Presented at
National Child Welfare Evaluation Summit, Washington, DC • August 30, 2011

MCWBC Model: Preliminary Research on Child-Caregiver Relationship Outcomes

Child Outcomes (pre-post treatment comparisons, Crowell)	Effect Sizes
Positive Affect	1.1
Enthusiasm	0.95
Emotional and Behavioral Responsiveness	0.64
Caregiver Outcomes	
Behavioral Responsiveness	0.70
Emotional Responsiveness	0.70
Less Intrusive	0.85



MCWBC Model: Safety Outcomes

Miami MCWBC Cases:

- 0% substantiated or indicated recurrence after 12 or 24+ months for samples of parent/child dyads who reached therapeutic goals

Florida:

- 2009: By 6 months, 7% of all children had a recurrence
- 1998-1999: By 24 months, 30% of children under 4 years old had a recurrence (Lipien & Forthofer, 2004)

NATIONAL FAMILY PRESERVATION NETWORK

Developing Strong Families by Supporting Preservation, Reunification, and Fatherhood Initiatives

An Effective Child Welfare System & Evidence-Based Practice for the Child Welfare System

Priscilla Martens, Executive Director
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Introduction

The National Family Preservation Network (NFPN) was established in 1992 to serve as the primary national voice for the preservation of families through Intensive Family Preservation Services (IFPS). Since its inception, NFPN has advocated incorporating IFPS into the continuum of child welfare services available to families. In recent years NFPN has been at the forefront of promoting intensive reunification services and father involvement, as well as IFPS, in the child welfare system.

All of the models of service that NFPN promotes are built on research. Public child welfare systems are increasingly called upon to institute research-based or evidence-based practice (EBP) but must do so within the constraints of high caseloads, high turnover of caseworkers, a nationwide federal audit which no state child welfare agency has passed, highly publicized child deaths, and intense scrutiny by public officials and the media. Having to constantly react and respond leaves child welfare administrators with little time to reflect and to create a proactive and truly effective child welfare system.

NFPN offers tools, training, assistance, and resources to the child welfare system. As part of its advocacy role in preserving families, NFPN decided to study effective agencies and evidence-based practice in the child welfare system. In this monograph, NFPN describes one of the most effective child welfare agencies in the United States and presents 21 programs that have been found effective, or show promise of being effective, in the child welfare system.

The description of an effective agency, the Allegheny County Department of Human Services in Pittsburgh, Pennsylvania, is presented here as a guide that may be adapted for use in other agencies. It is an overview, not a comprehensive procedures manual. Some of the system's components are much simpler and easier to implement than others. NFPN's desire is for agencies to continually move their child welfare systems toward improved outcomes for children and families. The best outcome is for children to remain with their parents, whenever it is safe to do so, and this monograph is one way that NFPN can express its commitment and support to that outcome and to all of those involved in the child welfare system.

Priscilla Martens
Executive Director
October, 2006

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Part 1: Allegheny County's Effective Child Welfare System

What makes it effective?

All child welfare agencies do a good job in some areas. But, to be truly effective, a child welfare agency must excel at strengthening families and avoiding unnecessary out of home placements.

The Allegheny County Department of Human Services Agency in Pittsburgh, Penn., is a model of excellence for the child welfare system. By comparing key measures of effectiveness with the average of all child welfare systems, Allegheny County surpasses the average, often by a factor of two or three times. The following chart compares Allegheny County with the national average on some of the measures tracked by the federal government:

Measure of Effectiveness	National Average	Allegheny County
Reduction in foster care placements	8% (1998–2003)	24% (1996–2005)
Children reunified with family	55% (FY 2003)	79% (2004)
Children placed with relatives	23% (FY 2003)	62% (2005)
Child deaths from abuse/neglect	2.1/100,000 (2003–2004)	0 (2003–2006)

While it is difficult to find data that correspond to exactly the same time frame in order to compare Allegheny County with national averages, it is apparent that Allegheny County outperforms the national average in all the categories listed. Allegheny County has reduced its foster care placements, there have been no child deaths from abuse or neglect in the past three years, families stay together or are reunited in less than one year (335 days), and placements, when necessary, are most frequently made with other family members. In order to find out the underlying reasons why this is so, we need to look at the pieces that form Allegheny County's child welfare system, beginning with philosophy.

The Philosophy of an Effective Child Welfare System

Within minutes of meeting the top administrators in Allegheny County's human services and child welfare system, a visitor will begin

to hear the philosophy of this system. "Treat people the way you want to be treated." "Don't view child welfare as just a job—go the extra mile." "Try to keep kids in the home whenever possible." "Involve the community—create opportunities for partnerships." "Be visible in the community as a friend, not a foe." None of this is new to child welfare systems, but later on a visitor hears stronger language: "Foster care is stranger care." "Adoption is a failure." Yet, administrators are not being derogatory towards foster or adoptive parents but are simply reinforcing the system's foundation. What exactly is that foundation?

Keeping children safely in the home whenever possible is the foundation and underlying philosophy of Allegheny County's child welfare system. In order to create this shared philosophy, everyone who works in the system needs to learn and understand the language. Thus, it's imperative that everyone speaks in a way that makes the goal of keeping children in the home obvious and achievable. No one wants to fail or to see children raised by strangers, so language itself becomes an incentive to direct efforts and resources to keeping families safely together.

To adhere to any philosophy over time requires constant maintenance, and begins with intensive training. The state of Pennsylvania requires 120 hours of training for new caseworkers. Family empowerment models and strength-based approaches are ingrained in caseworkers throughout this training in Allegheny County. Senior caseworkers (Caseworker III) mentor trainees through job shadowing, thus sharing both philosophy and best practice. Caseworkers who don't share the philosophy are weeded out in the six months probationary period.

Allegheny County's child welfare system demonstrates that effective child welfare administrators do not straddle the fence of keeping families together vs. placing children in substitute care. Trying to do so likely means falling off on the side of substitute care. Fence straddling also leaves caseworkers confused, frustrated, overwhelmed, and not knowing when to place or when not to place. Keeping children out of substitute care whenever safely possible begins with a conviction, not a preference, to maintain the family. This conviction then permeates the entire child welfare agency, resulting in a united culture focused on doing the work that is necessary to keep families together.

Implementing an ironclad philosophy requires a system to direct funds to support that philosophy, as has been done in Allegheny County.

Budgeting for an Effective Child Welfare System

Allegheny County has 1.3 million people and is the 29th most populous county (out of 3,100) in the United States. The child welfare system in Pennsylvania is state supervised and county administered. The county has an integrated human services agency offering all services except for TAN-F. This integrated system permits centralized control over 84 funding streams.

The Department of Human Services (DHS) has an annual budget of about $850 million with the child welfare system, the Office of Children, Youth, and Families, receiving $165 million annually. The DHS director, Marc Cherna, makes all fiscal decisions. Central control over funding and decision-making allows the agency to consider an individual's or family's needs first and then design a program or service to meet those needs.

The private sector also contributes: foundations have assisted in funding a data warehouse that contains data on families served and a description of services provided by the child welfare agency along with information on other county and contracted services including housing, public welfare, and family support centers. Foundation funds were also used to hire additional court hearing officers in order to get rid of the backlog of cases and to hold hearings on child welfare cases more frequently. Perhaps most telling, during his decade of tenure, the agency director has been aggressive about investing in the front of the system, using dollars freed up by reducing placements.

Control over the budget is key to Allegheny County's successful philosophy: just over 50% of the child welfare budget is devoted to prevention and in-home services. Spending at the front end of the system to keep families intact prevents the trauma associated with removal, reduces the need for more costly out-of-home placements, permits a choice of placements when an out-of-home placement is necessary, and holds caseloads to a manageable level.

The effort begins with preventing families from entering the system.

Prevention

Allegheny County invests heavily in prevention with almost one-fifth of the child welfare budget dedicated to that. The County contracts with about 170 other human services agencies. The following are some examples of these services:

The Department of Human Services funds 27 of the 33 Family Support Centers in the county. The agency funds First Steps at four

locations. First Steps is a voluntary program for new mothers that provides a home visitor for moms of children ages birth to five years. The agency also funds after-school and summer programs for high-risk children in public housing communities. It spearheaded a mentoring program, P.O.W.E.R, for early substance abuse identification and rehabilitation for pregnant women and mothers. Women are mentored for 12–18 months with wraparound services provided for the first 60 days. The success rate for women completing the program is 90%.

One unique prevention program funded by the county, called Mother to Son, is run by a church. Boys ages 9–13 have activity groups and "manhood training." Meanwhile, the single mothers of these boys participate in support groups to receive assistance with raising boys and with personal issues.

Another county funded program, Gwen's Girls, is a program for at-risk girls ages 8–18. It offers after-school programs, peer groups, and mother-daughter programs. It also includes a mentoring component to match at-risk girls with women who guide and support the girls in finding and reaching their goals.

Allegheny County enlists the entire community to assist with prevention efforts. Approximately $500,000 is raised annually to provide gifts to children receiving any services through the county. A music festival provides a venue to solicit funding to provide art, music or sports lessons, memberships to museums, and travel money for children. Project Prom helps high school seniors by acquiring prom gowns for girls and tuxedos for boys.

By taking the lead in establishing prevention services and putting a significant amount of its own funds into prevention, Allegheny County's child welfare agency ensures that high-quality preventive services are available and leverages community support and funding to provide even more preventive services. Keeping families out of the system is the first goal. We look next at Allegheny County's approach to the families who enter the system.

In-Home Services

Allegheny County investigates over 10,600 abuse/neglect complaints annually. Approximately one-third of the families, consisting of 8,500 children, receive services. The focus on families receiving services is "family unification" or keeping the family together. The agency spends over one-third of its budget on in-home services.

Following investigation of a complaint, a determination is made about the level of intervention needed to keep the family safely together. A crisis worker can provide or arrange for 12–24 hours of service weekly for up to 30 days. A staffing is then held to determine the level of service needed for an additional 60 days. In-home services are generally provided for a maximum of 90 days with up to 15 hours of aftercare available for an additional six months. The county allocates $500 per family for concrete needs.

In addition to in-home counseling, many other services are also available to families. The agency locates resource specialists at its field offices to assist in linking families with needed services. There are specialists for housing, substance abuse, mental health, resources, and transportation. A high number of referrals, as with most child welfare agencies, involve substance abuse. A substance abuse counselor may accompany a caseworker to see the family and arrange for immediate services. The agency also provides Family Group Decision Making conferences for families.

Parents receive a Parent's Handbook on the first visit from a caseworker. The handbook lists parental rights and responsibilities, and the responsibilities of the agency and the court. Also available to parents is the Director's Action Line, a toll-free phone number that parents can call to request a second opinion on casework decisions. The Action Line now covers the entire Department of Human Services and over 1600 complaints are investigated annually.

What if, despite the services and resources available to keep children in their own homes, the caseworker believes that out-of-home placement is indicated?

Placement

If placement is indicated, a pre-placement conference is held. The conference team, consisting of an administrator, supervisor, and caseworker (minimum) makes the decision as to whether or not placement is necessary. A caseworker is never left with making that decision on her own.

The decision of where to place a child is also critical. Kinship care is the top priority and must be ruled out before a child is placed with non-relatives. Allegheny County places two-thirds of children in out-of-home care with relatives.

All relative placements are licensed. Because the goal is to immediately place the child with relatives, the licensing process also begins

immediately. A special unit conducts the background check on the kin. Workers often take a kit with them when they inspect the home in order to help the kin meet safety standards; the kit contains items such as smoke alarms, safety covers for electrical outlets, etc. With minimum standards being met, including an expedited background check, a preliminary certificate can be issued to allow for immediate placement while other licensing issues are dealt with later. Relatives receive the same board rate for children as foster parents.

If a kinship placement is ruled out, there are 10 contracted providers for non-relative placement. A needs assessment of the child determines the level of care required, and this level and other information about the child are posted on the Internet and in each local office. The providers respond with details about specific foster homes that are available, and the caseworker then selects the home that best fits the child's needs.

Every effort is made to return children to their parents with a wide variety of services provided. Allegheny County returns about 80% of children to their parents each year. An annual Reunification Celebration is held to acknowledge the importance of keeping families together.

In order to quickly move children out of the system, Allegheny County pays close attention to permanency planning.

Permanency Planning

At the first meeting with parents when a child is being removed, the caseworker explains ASFA, what the parents need to do, and the consequences for failing to do so.

A permanency planning conference is held for all cases where children are removed and the plan of reunification will not be completed within 30 days. The caseworker, supervisor, resource coordinator, parents, children over 14, relative caretakers or foster parents, legal advocates, school personnel, and others involved with the child or family are invited to attend. The caseworker provides a summary of the case and current issues, and the group discusses existing goals and any barriers to their achievement, resources, tasks, and the action plan. Goals are developed and agreed upon by all participants, and the action plan becomes part of the case record. Conferences are held at three-month intervals, twice the frequency required by the state. Court reviews are also held every three months.

If the parents have not made sufficient progress by 12 months following placement, alternatives to reunification are considered. Agency officials and the court do question whether 15 months is sufficient to determine a permanent plan for the child, especially where parental substance abuse is involved. The court will waive the 15-month Termination of Parental Rights (TPR) requirement if the family is making progress.

If every effort to reunify the family fails, then termination of parental rights and adoption are the final options. However, Allegheny County judges are reluctant to grant TPRs if adoptive parents have not been identified. They believe that creating legal orphans is not in children's best interests. So the county focuses on speedily identifying adoptive parents.

Adoption

The reluctance of judges to grant TPRs where no adoptive placement has been identified means that the Adoption Unit seeks to identify adoptive families for children who are not yet legally free. The Adoption Unit begins looking for an adoptive family as soon as the court identifies the permanent plan as adoption.

In discussing adoption procedures with the agency's manager for adoptions, her first words are "adoption is a failure." However, when there is no other alternative to an adoptive placement, the adoption unit moves quickly to complete the task. A case averages seven weeks in the adoption unit. The first job is to establish a relationship with the child and find out what type of family the child wants. Every effort is made to maintain the child's ties to biological family, including siblings. Open adoptions are unenforceable in Pennsylvania, so adoptive parents must voluntarily agree to preserve the child's ties to biological family.

Child Deaths

Every child welfare system has to deal with the emotionally wrenching issue of child deaths due to abuse and neglect, especially with those children known to the system.

Allegheny County has had no child deaths of this nature for the past three years (July, 2003–July, 2006). The last child who died was under age 6 and had been "screened out" for services.

Following that death, the director made a decision to investigate all complaints involving children under age 6 even if the complaint did not involve abuse or neglect. The agency responds within two hours

to this type of complaint and makes use of all staff, including administrators, to go out on investigations. The director believes that immediate response to complaints involving young children is the key to preventing child deaths.

Director's Perspective

There are many pieces that fit together to form an effective child welfare system, and it takes time to build an effective system. To get started, Allegheny County's administrator recommends establishing manageable caseloads. Each caseworker in the county averages 17 families. Supervision is also critical, as caseworkers are never asked or expected to make critical decisions about families on their own. Cases are not kept open for monitoring. The agency believes that it is better to close the case, and then reopen if needed, rather than distort caseload and workload by keeping cases open only for monitoring.

Administrators in Allegheny County view themselves as partners with supervisors and caseworkers. They go out on investigations involving children under age six, participate in pre-placement conferences, and do not ask workers to do anything that they themselves are not willing to do. Administrators demonstrate through words and action, "we're all in this together."

System Issues

No child welfare system is perfect and neither is Allegheny County's. The agency faces the nationwide problem of having a disproportionate number of African-American families in its child welfare system—over half of the county's caseload is African-American compared to 13% of the county's child population being African American. The large number of children placed with relatives raises the issue of permanency as relatives may be reluctant to adopt or assume legal guardianship. Relatives may also object to becoming licensed as foster homes.

The philosophy of Allegheny County requires constant tending in order to be accepted and adhered to by all of those working in the system. Everyone has to support the philosophy, and this requires a great deal of time and effort, especially at the beginning.

Summary

Allegheny County has an effective child welfare system because it focuses first on limited entry and second, on quick exits. The philosophy is to keep families together whenever it is safe to do so, and

that message is reinforced in all policies, procedures, and budgeting. By directing a good deal of its own funds to prevention, and working with the community to leverage other funding, many families who otherwise might enter the child welfare system receive a wide variety of community services instead. If a family does enter the system, one-third of the resources are directed to keeping the children with their parents and working with the family in the home environment. Resource specialists are stationed in every child welfare office.

If placement is indicated, the decision is made by a team in a pre-placement conference, never by an individual caseworker. Kin placements are given priority, with two-thirds of children placed with relatives. Relatives are screened, licensed, and paid the same as foster parents. Expedited background checks and kits to help relatives meet safety standards allow for preliminary certification and immediate placement. If the child cannot be placed with relatives, a level of care based on the child's needs is posted, and providers respond with a placement offer. The caseworker then selects the best placement that fits the child's needs. Every effort is made to reunify children with parents, with nearly 80% achieving that goal annually.

A permanency planning conference is held for children who will not be reunified within one month. Case and court reviews are scheduled every three months. Adoption is viewed as a failure or last option. But when the decision is made to place a child for adoption, the adoption unit completes that task within an average of seven weeks.

The child welfare agency has not had a child death in the past three years. The agency takes a proactive approach by investigating every complaint involving a child under the age of six.

Administrators participate in investigations of complaints involving young children and also help out with pre-placement conferences. They work with the community to address needs of families and identify sources of funding. The goal is for the child welfare agency to be viewed in the community as a friend, not a foe. The child welfare agency is an essential member of the community that takes the lead in working with all other members of the community to keep children safe.

Notes

The information on Allegheny County's child welfare system was gathered through phone calls, email, and review of documents. In addition, a site visit was conducted on May 23–24, 2006. The bulk of the information was supplied by Marc Cherna, the director of Allegheny County Department of Human Services, and Marcia Sturdivant, Deputy Director of the Office of Children, Youth, and Families.

Sources for references to data collected by the federal government include the 2004 Child Maltreatment manual produced by the Children's Bureau and the AFCARS Report for 2003.

The National Family Preservation Network assumes sole responsibility for the contents of this paper. Allegheny County administrators welcome visitors who are interested in or would like to replicate their child welfare system. Please contact Marc Cherna (412-350-5705) or Marcia Sturdivant (412-350-5701).

Part 2: Evidence-Based Practice for the Child Welfare System

Introduction

Within recent years, child welfare agencies nationwide have begun to embrace evidence-based practice (EBP) and programs. A growing body of research literature, pressure from policy makers and funders, and federal audits of child welfare agencies have contributed to the mandate and subsequent demand for EBPs.

EBPs are based on best practice as substantiated through research with the gold standard being random assignment control group studies that support the specific program. In actuality, it is very difficult and expensive to conduct randomized controlled studies, so other types of studies may also considered. There is no generally accepted definition of evidence-based practice. The National Family Preservation Network (NFPN) endorses the guidelines and classification system published by the National Association of Public Child Welfare Administrators (NAPCWA). NAPCWA is an affiliate of the American Public Human Services Association; please visit their Web site at http://www.aphsa.org/napcwa/ to view the Guide for Child Welfare Administrators on Evidence Based Practice. NAPWCWA's classification system has six categories with the highest level being well-supported, efficacious practice and the lowest level, concerning practice.

While there are numerous EBP programs, a significant number of the programs, including highly recognizable ones, have studies that support their efficacy in other fields, not the child welfare system. The list provided here includes only research-based practices and programs researched within the child welfare system. The list is not exhaustive but provides examples along a continuum from prevention to post-adoption. Some programs were included in areas in which the research is still in the very early stages (domestic violence, matching children with adoptive parents) but the need for EBP models is great.

NFPN offers this list with the hope that it will inspire child welfare administrators to continue moving towards evidence-based practice by testing some of these practices and programs in their own system.

Evidence-Based Practice and Programs for a Child Welfare Continuum of Services

Parenting Programs

Service	Description	Outcomes	Research Status
1. Nurse-Family Partnership nursefamilypartnership.org	Nurse conducts home visits with family from child's birth to two years of age	79% reduction in child abuse/neglect	Randomized control group studies support outcome listed
2. The Incredible Years www.incredibleyears.com	Parent and child training for children ages 4–8 to prevent, reduce, and treat child aggression and conduct problems	Increases in effective parenting, positive problemsolving and communication; reduced conduct problems/aggression in children	Randomized control group studies support outcomes listed
3. Positive Parenting Program www.triplep-america.com	Behavioral family intervention to prevent severe behavioral and emotional disturbances in children	Improved parenting ability and more positive attitude toward children; children experience fewer problems, are more cooperative, and better behaved at school	Over a dozen comparison group studies support outcomes listed
4. Parent-Child Interaction Therapy (PCIT) www.pcit.org	Coaching physically abusive parents on safe and effective ways to discipline children ages 4–12	Reduced recurrence of maltreatment	Reduced recurrence of maltreatment
5. Project SafeCare Contact: Marcus Institute, Dr. John Lutzker, 404-419-4000	Ecobehavioral parent training model	Reduced recurrence of maltreatment	Comparison group studies support the stated outcome
6. Participation Enhancement Intervention (PEI) http://www.wjh.harvard.edu/~nock/nocklab/publications.html 2005: PEI Manual and Change Plan Worksheet	Intervention to motivate parents to attend and complete treatment sessions for children with aggressive and anti-social behavior	Parents receiving PEI had greater motivation, attended more sessions, and had greater adherence to treatment	Randomized control group study supports outcomes listed

School-Based Programs

Service	Description	Outcomes	Research Status
7. CASASTART http://www.casacolumbia.org/absolutenm/templates/AboutCASA.aspx?articleid=203&zoneid=26	School-centered program to keep 8- to 13-year-olds drug/crime free	Children less likely to use drugs, lower levels of association with delinquent peers, lower levels of violent offenses, more likely to be promoted to next grade	Urban Institute study including random assignment supports positive outcomes listed

Assessment Tools

Service	Description	Outcomes	Research Status
8. Child Abuse Potential (CAP) Inventory Contact: Joel S. Milner, Northern Illinois University tj0jsm1@wpo.cso.niu.edu	Child abuse risk assessment tool (*not* intended for risk assessment of neglect)	Used as predictive tool for risk of concurrent and future abuse and used to evaluate prevention and treatment programs	Valid and reliable tool with numerous studies demonstrating relationship of the tool to risk factors and prevention/treatment programs
9. Family Assessment Tools: North Carolina Family Assessment Scale—NCFAS (for intact families) and NCFAS-R (for use with reunifying families) http://www.nfpn.org/tools/	NCFAS and NCFAS-R measure family functioning	Used with Intensive Family Preservation (IFPS) and Intensive Family Reunification Services (IFRS) and other services to identify goals/treatment and measure pre-post level of family functioning	Tools are valid and reliable with IFPS/IFRS; study underway with differential response program; tools ranked top for child welfare system in study by Berkeley research group
10. Risk Assessment for Foster Care Providers http://www.nccd-crc.org/crc/pubs/fcrp_support_assmnt_sept05.pdf	Assessment tool to determine likelihood of maltreatment or inadequate care of a child by foster care providers	Prediction of future substantiated complaints on foster care providers	Retrospective study supports outcome indicated

In-Home Services

Service	Description	Outcomes	Research Status
11. Differential Response Services http://www.americanhumane.org/site/PageServer?pagename=pb_home#pc	Assessment and services for low risk families	Increased family engagement and cooperation; more services provided; families less likely to have another maltreatment complaint; overall costs lower than traditional CPS investigation	Pilot project in Minnesota with comparison group supports outcomes listed
12. Intensive Family Preservation Services (IFPS) HOMEBUILDERS® model http://www.institutefamily.org/programs_IFPS.asp	Intensive, in-home services include behavioral/cognitive therapy and skill-building	Prevents placement; saves out-of-home care costs; improves family functioning; may reduce disproportionality	Three random assignment, two comparison group, and one retrospective study demonstrate effectiveness; two studies indicate IFPS reduces disproportionality
13. Father engagement and involvement; *Fatherhood Training Curriculum* http://www.nfpn.org/fatherhood/ http://aspe.hhs.gov/_/topic/subtopic.cfm?subtopic=Fatherhood	Motivate and train child welfare workers to engage and involve fathers in their children's lives	Non-custodial fathers and their families become involved in case planning and placement	Outcome evaluation of three-year project demonstrated that training on father involvement for child welfare workers results in changes in practice, including viewing fathers as a resource and involving fathers in case planning; separate Urban Institute study found similar results

Mediation

Service	Description	Outcomes	Research Status
14. Court Mediation Project of the National Council of Juvenile and Family Court Judges http://www.ncjfcj.org/content/view/563/424/	Mediated discussions with attorneys, social worker, and parents to reach mutual agreement regarding child	Adjudication, disposition, case closure reached more quickly; more placements with non-custodial parent/kin; more services provided; lower re-entry rates	Random assignment study in Washington, D.C., supports outcomes listed. Study underway in Cook County, IL.

Substance Abuse

Service	Description	Outcomes	Research Status
15. Involve substance abuse counselors in home visits and treatment plan for substance-abusing parents referred for CPS investigation http://www.financeprojectinfo.org/publications/developingandsupportingIN.pdf (p. 11)	Substance abuse counselors accompany child welfare workers to assess families and refer parents to treatment	Reduced out-of-home placements and length of time children are in foster care	Comparison group study in Delaware supports outcomes listed
16. Relapse Prevention Program for Substance Abusers Contact: Dr. George Parks, Addictive Behaviors Research Ctr., University of Washington, 206-930-1949	Coping strategies to reduce relapses	Effective in preventing relapse with alcohol or polysubstance users	Meta-analysis of 26 studies supports outcome listed

Foster Care

Service	Description	Outcomes	Research Status
17. Visitation Guidelines for Children in Foster Care http://www.co.olmsted.mn.us/departments/services/child_and_family_services_division.asp	Visitation Guide developed by Olmsted County Children and Family Services Division in Minnesota. The Guide is based on research linking frequency of visits between children and parents to successful reunification.	Olmsted County had strengths ratings of 89% and above on federal CFSR ratings for visitation and reunification	CFSR data used for verification of outcomes. No independent evaluation.
18. Multidimensional Treatment Foster Care www.mtfc.com	Intensive training and support for birth/foster parents; family therapy and daily monitoring and intervention for the child placed in care	Fewer placement disruptions, more frequent reunification with birth families, and lower rates of child behavior problems	Large random assignment control group study supports outcomes listed

Domestic Violence

Service	Description	Outcomes	Research Status
19. Domestic Violence Intervention www.thegreenbook.info	Six counties nationwide funded by the federal government to improve services to families threatened by both domestic violence and child maltreatment	Interim Study report available on progress in six communities	Report on five-year study pending

Adoption

Service	Description	Outcomes	Research Status
20. Connecting Adoptive Families with Waiting Children www.adoptuskids.org *A Guide to Connecting Families with Waiting Children*	Best Practice in Matching Waiting Children with Adoptive Families	Lists child and family characteristics associated with adoption stability and adoption disruption	Most of the research is based on adoption disruption/dissolution
21. Post-Adoption Services (in-home) http://www.nfpn.org/tools/articles/ifpsadopt.php	Services to prevent adoption disruption/dissolution	IFPS is effective in preventing disruption/dissolution	Study showed IFPS and a less intensive service were effective in preventing disruption/dissolution for 80% of families

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Transforming Lives through System Integration: The "Improving Outcomes for Children and Families" Initiative

by Bruce Barron

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Transforming Lives through System Integration: The "Improving Outcomes for Children and Families" Initiative

Already good, wanting to be better

As of fall 2007 the Allegheny County Department of Human Services (DHS) had already gained wide recognition for both its structural reorganization and its performance outcomes. The county's child welfare system, known for its poor performance in the early 1990s, had turned around since the arrival of Marc Cherna as director in 1996. Coordination of child services had greatly improved following a 1997 decision to combine several previously separate county agencies into a single Department of Human Services under Cherna's leadership.

DHS had committed itself relentlessly to a progressive child welfare agenda that gave families a greater voice in decisions affecting them, recognized the value of maintaining or reuniting families where possible, and gave preference to placement with relatives ("kinship care") where children had to be removed from their immediate family. Statistical outcomes documented the fruit of these efforts: in the 10 years from 1997 to 2007, the number of children removed from their home had dropped by 28 percent and the average length of an out-of-home stay had fallen from 21 to 14 months. Media coverage of Allegheny County child services had changed from the embarrassing exposés of the early 1990s to positive national recognition for DHS's successes in family preservation.

DHS had effectively leveraged strong support from Pittsburgh's ample philanthropic community toward achieving these goals. Shortly after the establishment of DHS, 17 local foundations created a Human Services Integration Fund, coordinating their response to the department's financial needs as it integrated its operations. This fund provided an invaluable source of private support for a wide range of innovative undertakings, such as the development of DHS's agencywide Data Warehouse and the county's exemplary rehabilitation programs for jail and prison inmates, for which available public dollars would not have been sufficient.

DHS's conviction that better integration of the many programs that serve children should lead to better outcomes had received a strong boost from state government in 2004, when the Pennsylvania Department of Public Welfare (DPW) began requiring counties to prepare an Integrated Children's Services Plan reflecting coordination of early intervention, child welfare, mental retardation, behavior health, and juvenile justice programs. But now, in 2007, Cherna and other DHS executive staff were looking to achieve still better outcomes with children and families by further integrating services, to a degree not attempted in any major U.S. metropolitan area.

"More helpers than clients can remember"

Processes such as the Integrated Children's Services Plan had encouraged the coordination of multiple child-serving systems—for example, by causing staff from various programs to communicate with each other and understand when to refer clients to each other's offices. But the visionaries at DHS had something larger in mind—not just getting programs to talk with each other, but actually making them a unified team from client intake to completion of service delivery. They believed this was the most fruitful and financially sustainable way to attain an additional, safe reduction in out-of-home placement statistics.

Though pleased with the improvements they had already made, Allegheny County DHS staff had also been noting the systemic issues they still wanted to change. Jacki Hoover, a county child welfare worker since 1995 who had joined DHS's executive staff in 2006, became committed to the value of service integration when she discovered that families with multiple needs—behavioral health, child welfare, probation, school counseling—couldn't keep track of who was working with them. "If you can't remember the name of the person who comes to your house every Tuesday and works on a plan for your child, it's probably not a good service," she said.

Robin Orlando, now a key contributor to system integration activities in DHS's executive office, had come to similar conclusions through her work in quality assurance. "I have worked closely with families in evaluating the programs serving them," Orlando stated, "and it is striking to hear them talk about having five people coming into their homes and working on five different plans. Sometimes the plans don't jell and the families are frustrated. I know the intent of each system is to provide supportive services and protect children, but there must be a way to do it without setting the family back a few steps."

Former DHS Office of Information Management Deputy Director John Pierce was another strong advocate for further integration. In his previous work at Hershey Medical Center, he had seen outcomes for youths in residential placement improve after the treatment facilities became more holistic in approach, integrating preventive and aftercare services with their residential programs. "We are trying to achieve the same thing here," Pierce explained, "except that we are integrating all aspects of youth services, not just the child welfare system."

A plan emerges

The ideas coming together at DHS were not all new. The philosophical underpinnings were already in place. Two prior initiatives aimed at children with behavioral health issues had emphasized the importance of bringing child-serving professionals together as a coordinated team and of giving the youths and families being served a greater voice in decisions on their service plan.

One of them, the federally funded System of Care Initiative, had been operating in Allegheny County since 2000, with support from three federal grants. System of Care's focus on team-based planning, community partnerships, and consumer empowerment ("family voice and choice") had improved both client outcomes and DHS's reputation in lower-income, often distrusting communities.

Through the establishment of joint planning teams, System of Care had made progress in coordinating services more effectively for children with multiple needs. The other initiative, known as Family Group Decision-Making, introduces the use of an independent facilitator to ensure that families are empowered to participate as partners in formulating a plan that meets their needs.

But those previous efforts, being pilot projects, had reached only a modest number of clients. DHS leadership now wanted to take these practices "to scale"—that is, to make them the normal way of doing business across the department—and to combine them with several additional innovative steps. Of course, implementing best practices systemwide, not just with a selected subset of staff, would be a more imposing task.

Indeed, many internal discussions would take place over the next two years on how best to expand best practices to scale—for example, whether to focus on certain client target groups first, or to gradually include additional staff who showed interest in new initiatives, or to try to reach everyone at once.

The emerging ideas were articulated formally in September 2007 as part of a three-page concept paper, modestly titled "Improving Outcomes for Children and Families in Allegheny County" and prepared for circulation to Human Services Integration Fund members. The concept paper expressed DHS's belief that more thorough and widespread service integration could further reduce the number and length of out-of-home placements, and it enumerated a series of specific project objectives that could enable this integration.

These objectives included:

- Developing the tools for a common, systemwide intake process, assessment instrument, and service plan
- The incorporation of "System of Care values" throughout the whole child-serving system
- Development and implementation of a change management strategy among staff, contracted providers, and service recipients
- Training front-line workers in skills relevant to the functioning of an integrated system
- Restructuring financial incentives and performance indicators in provider contracts to align with the goal of integration and the desired service outcomes

Attracting funds

This daunting project, unprecedented for a system as large as Allegheny County's, would require considerable expertise to implement. But DHS's ambitious vision received an early, crucial vote of confidence from a major, strategically congruent organization: Casey Family Programs, the nation's largest operating foundation focused entirely on foster care and on improving the child welfare system. Casey Family Programs had established a goal of safely reducing the number of out-of-home child placements nationally by half—from about 500,000 to 250,000—between 2005 and 2020.

The foundation, which is working in more than 40 states, was attracted to Allegheny County because it had a competent, highly motivated child service agency that had already demonstrated a significant reduction in out-of-home placements and was capable of initiating further advances that could serve to inspire change nationally.

Cherna presented the concept to Casey Family Programs senior management, with whom he already had a strong professional relationship, and found them receptive. "They liked the idea of strengthening a system that was already working well and then replicating it," Cherna recalled.

As a result, between October 2007 and February 2008 the three-page "Improving Outcomes" concept paper grew into a 20-page submission. Casey Family Programs agreed to fund the involvement of two nationally prominent leaders in the field: Fred Wulczyn, a research fellow at the University of Chicago's Chapin Hall Center for Children, and John VanDenBerg, an expert in guiding implementation of the client service approach known as High Fidelity Wraparound. In addition, Casey Family Programs' in-house experts would take a hands-on approach, coming to Pittsburgh for quarterly meetings at which they would receive detailed program updates and offer suggestions.

The interest shown by Casey Family Programs further encouraged local foundations whose assistance was needed to fill other funding gaps. Most significantly, the Richard King Mellon Foundation provided a $1.5 million grant to upgrade DHS's information technology infrastructure so that the agency could implement a new behavioral health assessment tool known as the CANS (Child and Adolescent Needs and Strengths) and improve its capacity to track and analyze client outcomes. The Grable Foundation and the Heinz Endowments also awarded grants.

Community Care Behavioral Health, the managed care organization directing Medical Assistance funds for behavioral health services in Allegheny County, became another valued partner in finding ways to provide reimbursement for DHS's systemic innovations.

Bringing in more players

To garner staff feedback and buy-in, DHS formed seven multisystem work groups, composed of 10 to 14 members each, in April 2008. The topics for these work groups flowed from years of observing the systemic barriers that needed attention.

They included:

- common registration and intake
- common assessment and service planning
- a team-based service approach with one staff member as the facilitator or "single point of accountability"
- inclusion/recruitment of youths and family members with personal experience of the system to become members of the service team
- workforce development to implement new service approaches effectively
- performance-based contracting
- development of neighborhood centers

Rather than simply asking each deputy director to assign staff, DHS "looked for people whose interest had been sparked and who wanted to do something different," As a result, the teams performed energetically, sometimes generating more ideas than could be pursued right away. For example, the neighborhood centers group's suggestions on strengthening DHS's community presence have had to wait while other changes more directly related to the Improving Outcomes goals have taken priority.

The work group on common registration and intake proved to have the easiest assignment, largely because of the considerable investment in data integration and management that had already taken place since the creation of DHS in 1997. Information technology director John Pierce had spearheaded unification of the data from DHS's five predecessor agencies, each of which had its own recordkeeping system incompatible with all the others. "My goal was to remove barriers that would keep people from getting integrated information and providing better service," Pierce stated

DHS's status as a super-agency was crucial to achieving this goal, because if the agencies were still separate they would face greater regulatory obstacles in sharing client information with each other. Since Cherna, as head of DHS, is officially recognized as responsible for all the records, he could more easily direct their combination in a single database.

Finalizing the agreements on how a Master Client Index would collect data and make it available across systems took six months. But Pierce's experience—dating back to his Ph.D. research in 1971 on the benefits of removing barriers to information sharing—has made him a firm believer in integration. "Where we have been able to measure the difference in outcomes between single-focus agencies and a multiservice agency, the outcomes have been dramatically different," he indicated.

DHS's Master Client Index now contains about 15 million records on 600,000 individuals, greatly enhancing Allegheny County's capacity to implement an Improving Outcomes initiative.

Can we agree on a CANS?

Meanwhile, the work group developing a common assessment and service plan worked through sensitive negotiations, seeking agreement on a form of the CANS assessment that could be shared by all child-serving agencies.

The CANS, developed by John Lyons of the University of Ottawa, is designed to help child-serving staff obtain information on clients and families through conversation, rather than in the ponderous and intrusive style of survey questionnaires.

"The CANS enables the individual and family to use their voice to guide the process," DHS's Robin Orlando explained. According to Orlando, caseworkers trained in using the CANS have found it invaluable in building a partnership with families. Comments like "I didn't know that much about this family and I had been working with them for two years" have been common.

Orlando and others had seen the CANS's value in behavioral health settings. But before it could become a common assessment, work group members had to align their varied perspectives on what information they are required to collect, what additional information would be helpful, and any disclosure limitations. The new tool would have to bridge the differences in treatment approaches and statutory obligations between child welfare, mental health, substance abuse, and juvenile justice providers. Lyons himself communicated with work group members regarding issues of information gathering and confidentiality.

Gradually the objections were addressed. Some of them turned out to be false alarms—cases where, as Hoover put it, "there are certain myths that something is a legal requirement, whereas actually it's just the way you've always done it." Behavioral health staff discovered that they could request a waiver to use the CANS in place of another state-required form. Billing and payment procedures were aligned with the CANS to make completion of other redundant forms unnecessary. Team member Mark Waitlevertch of the Allegheny County public defender's office argued that he would not let his juvenile clients undergo a CANS due to the risk of self-incrimination; the group acknowledged that he was right and successfully advocated for state legislation to bar courtroom disclosure of assessment information.

Eventually the work group arrived at a final draft, though it did not remain "final" for long. As Orlando began holding informational and training sessions on the new CANS for casework staff in early 2009, new suggestions emerged—for instance, on ways to get more details about the client's educational needs. Rather than rushing ahead, Orlando slowed down the process to permit additional changes.

From July 2008 to June 2009, 150 county and provider staff were trained in administering the CANS, Lyons certified 16 as CANS trainers, and a temporary data system was constructed to store assessment information.

A challenging new service model: Wraparound

Wraparound's 10 Principles

Family voice and choice	Culturally competent
Team-based	Individualized
Natural supports	Strength-based
Collaborative	Unconditional
Community-based	Outcome-based

Integration of client registration, assessment, and planning were all significant steps—but what would come after that? How could the direct services provided through DHS be revamped in order to produce continued improvement of outcomes? The main answer to that question was High Fidelity Wraparound.

Although its philosophical foundations are not new, Wraparound began to take shape as a distinct service delivery model in the early 1990s. Its ten core principles (see sidebar) call for a team-based approach, intentionally guided by the family's view of its needs and priorities; recognizing and building on the family's strengths rather than focusing on weaknesses; and incorporating reliance on "natural supports" such as relatives, community resources, and places of worship that can remain involved with the family long after the professional treatment providers have gone.

Wraparound has gained stature as a treatment option through a growing body of research on its application, the establishment of a National Wraparound Initiative (which codified the ten principles in 2004), and the development of an instrument to measure the extent to which actual service delivery conforms to the principles. The term "High Fidelity Wraparound" serves to underscore movement leaders' contention that conscious, consistent fidelity to the principles is necessary in order to achieve the desired outcomes.

For Cherna, the selection of Wraparound as a delivery model had to do not just with the value of the principles, but also with who was disseminating them. Cherna had known John VanDenBerg professionally for 25 years and had brought him to Allegheny County as far back as 1996, for staff training on how to keep families intact.

Other local administrators also appreciated the choice; for example, Keith Solomon, who moved to the DHS Executive Office to support the initiative, had studied under VanDenBerg in the late 1990s and had applied Wraparound principles as a site supervisor in the first System of Care program. The executives at two of DHS's contracted behavioral health providers—Doug Spencer of the Allegheny Children's Initiative and Deb Freeman of the Human Services Administration Organization—had learned from VanDenBerg in the 1990s as well.

Even before receiving Casey Family Programs funding for technical assistance, DHS brought VanDenBerg to Pittsburgh in January 2008 to lay the groundwork for the planned initiative. His presentation on the value of team-based collaboration—including a representative illustration of a family of five whose complex needs caused them to receive services from 26 different staff with 12 separate treatment plans and 33 goals—resonated with DHS staff. Two of the seven work groups developed plans for important aspects of Wraparound implementation: the Workforce Development group focused on means of training staff to function as an integrated team consistent with Wraparound principles, while the Single Point of Accountability group examined what it would take to equip caseworkers as effective team leaders.

Meanwhile, DHS addressed the "where do we start" question by deciding to focus its Wraparound services initially on "high-end" youths with complex needs. These clients seemed most likely to benefit from service integration, since they were already involved with multiple child-serving systems, and represented the cases where Wraparound's intensive, comprehensive services had the greatest opportunity to improve outcomes without inflating costs.

Both providers and advocates describe Wraparound's unflinching insistence on "family voice and choice" as perhaps its most revolutionary characteristic. Granted, social work degree programs and caseworker orientations urge attentiveness to clients' needs and desires, but large caseloads, budget limitations, and the tendency to fall back on cookie-cutter planning when one is overworked erode the focus on being client-centered. Once one commits to fidelity to Wraparound principles, that mission drift is no longer permissible.

Walter Smith of Family Resources, a major child-serving nonprofit organization in Allegheny County, explained how business incentives usually work against family voice and choice: "If I want to balance my budget, I don't want to give families choices. The meetings will last longer and the families may ask for something we don't have available. It's a lot easier to give families a prepackaged program and call it choice. What's different here [in Wraparound] is that DHS is giving us resources so that we can give the family the ability to make real choices."

Spencer of Allegheny Children's Institute, which is serving one-third of the initial 100 families participating in Wraparound as of summer 2010, cited DHS's service integration efforts as another boost for family voice and choice. "Marc Cherna came to town with the vision of breaking down professional silos," Spencer explained. "Say the consumer comes for services through the mental health door; an assessment is performed, a prescription is made, and there is an assumption that Mental Health is in charge—whereas the family should be in charge and everyone else should be hired hands. I think DHS is giving families and their natural supports true ownership in designing the services that will guide them to self-sufficiency."

"High Fidelity Wraparound is a culture change," said Laurie Mulvey of the University of Pittsburgh Office of Child Development, who serves on the DHS advisory board known as the Children's Cabinet. "You will see the impact on children and families because they are listened to."

Pat Valentine, DHS's deputy director for the Office of Behavioral Health, finds the Wraparound "revolution" exciting too. "For some of the families in our system, it has been so long since anyone asked them what they want or what their dreams are. We are often too busy telling them their child needs to get his medication stabilized or stop acting out in school. Wraparound is based on the core conviction that the family possesses or can find the vast majority of the tools it needs to repair itself. This core conviction, and the willingness to back it up with resources, are changing the system."

Quality makes a difference

Quality control is a big deal in the Wraparound movement—so big that its proponents have adopted the title "High Fidelity Wraparound" (HFW) to emphasize that getting good results requires careful fidelity to the principles.

DHS Systems Integration Director Jeanine Rasky, who supervises the delivery of Wraparound, has found that staff members are ready to start implementing its principles after an initial six-day training program. Becoming thoroughly grounded in Wraparound, however, takes more time. "You have to demonstrate 120 skill sets, and the coaches review videotaped sessions to see if you have acquired the skill," Rasky explained.

While many participants have suggested that the extensive formal credentialing process could be streamlined, everyone speaks positively of the training program John VanDenBerg has constructed.

"The training gives you concrete strategies on how to put Wraparound's principles into practice," stated DHS's Keith Solomon, "but the credentialing involves actually applying those strategies to a real-life situation. They want to see you do it until you get it right; that's why the process can take such a long time. Although the credentialing process is extensive, it has to be there—otherwise it's too easy for staff to gravitate back to their past practices after the six days of training." Solomon added that it is important to have supervisors on site who understand the process and are trained to consistently reinforce the implementation of Wraparound principles.

Deb Freeman, executive director of one of Allegheny County's Wraparound provider agencies (Human Services Administration Organization, or HSAO), noted the tension between ensuring high fidelity and taking the program to scale. "If it takes 18 months to get to where you need to be and the average staff tenure is two and a half years, we'll always be retraining," she said. She agreed with Rasky that staff can understand, within six days of training, how Wraparound principles can be applied effectively. At the same time, she acknowledged the importance of having facilitators well enough trained that they can teach others effectively.

Allegheny County has also benefited from the state Department of Public Welfare's 2007 decision to launch a statewide Wraparound initiative. Allegheny was accepted as one of six "early implementer" counties, receiving additional technical assistance with Wraparound implementation. By fall 2009 DHS staff were attaining unusually high scores—in the 80 percent range—on a Wraparound fidelity instrument and were beginning to see the fruit of their labors.

Steven Freas, a joint planning team supervisor at HSAO, provided an example of how intentional application of Wraparound principles can make a difference: "We had a young lady who wanted to move out at age 18 and live with her cousin and aunt in Florida. While she was living in residential treatment the joint planning team built strong supports around her. The facilitator got the aunt and cousin on the phone for meetings; we got other natural supports involved, including relatives who visited her in residential treatment and planned for her discharge.

"Before Wraparound there would not have been so much thinking outside the box, but this process enabled the young lady and her family to make decisions with support. Her voice was heard, as were family members' voices as to what they would need to be okay with her move. Rather than just running off, this lady went to Florida with a specific action plan that has enabled her to be stable and successful."

Youth Support Partners: bold step, big reward

DHS has taken another bold step beyond rigorous implementation of Wraparound principles by employing a significant number—perhaps the largest contingent anywhere in the U.S.—of staff who have experienced the child welfare system personally.

"People who have been there always seem to be more effective in relating to the persons we are trying to serve," said DHS director Cherna. "[Former gang member and inmate] Richard Garland has credibility at the jail. People in recovery from mental illness are effective peer counselors. So why not take young people who have successfully gotten through the system and let them impart their strengths to others?"

But deploying these Youth Support Partners (YSPs) within the child welfare system brings unique challenges. YSPs bring great passion to their work but also need instruction in areas that social work professionals take for granted—from dress to communication skills to managing their 401(k) account. Moreover, placing young people (some under 20) with difficult backgrounds in confidential, often wrenching relationships with teenage or transition-age clients can reawaken the painful emotions of their own experiences. The biggest challenge is a balancing act: how to enable YSPs to perform like professionals while not undermining their ability to build bridges to the youths they serve.

DHS leadership intensely debated how best to hire, train, and support their YSPs. From the beginning, the training was extensive, encompassing Wraparound principles, team building, time management, professional behavior, setting emotional boundaries, and more. Dedicated to improving the system for other families, the YSPs welcomed this training and applied it well. But early experiences showed that they also needed ongoing support with both their emotional engagement and their still-complicated personal lives.

"Many of them don't have natural supports themselves," said Amanda Hirsh, who manages the YSP unit. "When a car got towed or a family member passed away, YSPs would turn to us for help." As DHS expanded its contingent of YSPs to 10 early in 2010, it settled on a management structure that includes Hirsh and two supervisors, one of whom (Aaron Thomas) was promoted after starting as a YSP. Although Thomas retains a partial caseload, the availability of three supervisors for 10 line staff ensures significant ongoing support. In addition, the YSPs meet monthly for group mentoring with an experienced child services director, Walter Smith of Family Resources.

Smith has noted that YSPs suffer acutely from a problem that affects many human service professionals: the tendency to identify with their clients' pain. "These youths see themselves in their clients, so it is hard for them to separate what they are feeling from what their clients feel," Smith said. "They have benefited greatly from learning how to depersonalize their work enough to be effective while still connecting with people."

As befits the distinctive job qualifications for a YSP, the selection process must also be somewhat nontraditional. Resumes were required—"they had a lot of personality to them," Hirsh recalled—but life experiences and a heartfelt concern for reaching youths in trouble were valued more highly than professional-looking, typo-free resumes. Candidates interviewed with community panels including youth, family, and partner agency representatives along with DHS staff; they also completed a questionnaire and a simulated job activity.

As DHS's Jeanine Rasky noted, YSPs are not only uniquely capable of connecting with their clients, but also excellent advisors to their coworkers: "We benefit from having former recipients of services on staff because they know the system and can tell us what does and doesn't work."

"The YSPs are tireless in their efforts to meet with youth," observed CYF caseworker Zachary Stewart. "And the families immediately recognize that having these young people talking to their children is something different. For me, getting a monthly home visit in can be like pulling teeth, but when the YSP comes they don't mysteriously fail to answer the door."

Sometimes the YSP becomes a role model without saying anything. Aaron Thomas's visit with a client at the county's juvenile detention center became a vivid illustration of how a troubled youth's life can get straightened out. As he and his client traveled through the building together, detention center staff greeted Thomas and asked how he was doing—for they recognized him from his own stay in the facility. YSPs, particularly in view of their own age, sometimes have trouble winning the respect of other team members. "I tell my YSPs they have to show that they deserve to be included as equals by showing up at meetings and doing what they say they will do," Thomas said. "I gained respect on my team because I was the one who could get the youth to communicate with me. When doctors from Western Psychiatric [Institute and Clinic] started calling me for advice, I knew I had made it."

"I wish every one of my clients had a YSP," Stewart declared. Indeed, the biggest problem with the YSP program appears to be that demand for their time far exceeds supply. As of late 2010, the 10 full-time YSPs had a total of 106 youths on their caseloads.

From rocky life to rock-solid support partner

Ashley Hartman has experienced a lot of heartache in her short life—from drugs, alcohol, foster care, truancy, teen pregnancy, rape, physical abuse, close friends in jail, and a sibling in the child welfare system. But at the ripe age of 19, Hartman has become a shining example of how a young woman with resilience can inspire other youths in trouble.

Hartman dropped out of school following the trauma of being raped by a friend's brother. A boyfriend provided an escape from her drug-influenced home life, but then she became pregnant with twins at age 14.

While many youths in such situations feel poorly served by the child welfare system, Hartman says the system did not fail her. On the contrary, Children, Youth, and Families (CYF) provided day care and transportation so that she could graduate with honors from Carrick High School. She was attending community college and working at a restaurant when she learned that the county was recruiting people like her to become YSPs. Hartman interviewed in November 2008, but then had to relocate after her twins' father became abusive. Thus, when funds to hire YSPs became available the following March, she was out of reach. Happily, DHS's Jacki Hoover frantically phoned counselors and relatives until she could track Hartman down and hire her.

Hartman is a passionate advocate for the value of peer counselors like herself. "I can remember my conversations with caseworkers when I was a teen parent," she said. "I would think to myself, 'How can they teach me how to hold a child when they don't even have kids? Or how can they say they know how I feel when they've never been raped?' Education is good, but overall, life experience is a more effective resource."

While Hartman considers her personal experience crucial to her work effectiveness, she has built on this experience through attentive engagement with the extensive training YSPs receive.

Because she has a deep emotional investment in her clients—"I had bags under my eyes at first from always trying to fix things for them," she recalled—the training on combining empathy with professionalism has been especially valuable. "Whenever something [in a client's story] brings flashbacks, it makes the bond closer," Hartman said. "I sometimes get teary-eyed but it does not take away from my professionalism—it shows youths that their story hurts us too but that they still have to learn how to succeed."
Hartman vividly remembers her first referral, a pregnant girl who was refusing prenatal care. Hartman offered to accompany the young woman to appointments, shared her own story, and helped her get back on track through delivering the baby and returning to school. For her and for many others, this YSP—still facing many adversities, but with a high school degree, a steady job, and a car—has become a credible role model.

"Clients can't believe how young I am and how far I've come," Hartman acknowledged. "I tell them that if I did it, they can do it too. Knowing that someone else has had similar experiences and still succeeded gives them motivation. It comes across differently when they hear it from someone who has been through it themselves, who is in their own culture, who has the same CDs in her car that they have on their iPod.

"YSPs should be tried everywhere," she concluded. "I know it is risky because we are so young, but a good hiring process can find the right people to take this job seriously."

A special organization for FSPs—and for families

Technically, DHS does not employ Family Support Partners. Instead the FSPs work for a special organization that nurtures their unique role as advocates for the families they serve. With encouragement and technical assistance from DHS staff, Allegheny Family Network began operating in 2007. At AFN all the staff—not just the 30 FSPs, but everyone from the executive director down—and 70 percent of the board have experience in raising a child with behavioral health needs. FSPs are currently working with a total of 105 youth.

Ruth Fox, AFN's executive director, emphasized that FSPs are the team members best positioned to understand families' perspectives and to help family members speak up. When Fox's daughter was receiving treatment for depression, she recalled, she and treatment team members "sat at a table with everyone telling me what to do. I knew some of their ideas would never work, but I did not feel empowered to say that because they were the professionals."

FSPs' separate chain of accountability enables families to see them differently from other team members even in uncomfortable situations like an unwanted out-of-home placement. "We can talk to families at their level and reach them, get them to open up and feel more comfortable," Fox said. "We can be up front about their situations and bridge the gap between the family and the clinical staff."

FSPs' commitment to advocating for families sometimes puts them in a precarious relationship with other team members, as Toni Ballard, who supervises FSPs for AFN, explained. "The FSP's job is to help the family push for their choice until they feel empowered to do it themselves," Ballard said. "That is hard. They may feel the team will retaliate against them. But sometimes you have to go against the grain."

Ballard described a case where some team members wanted to limit the time the FSP spent with the family. "The family became enraged," Ballard recounted, "and said that if they didn't have access to the FSP they would fire everyone. The team members who wanted the FSP to pull back were used to being in charge of the team. But now the family is in charge of the team."

As FSPs need professional skills, empathy, and thick skin, the hiring process itself can be profoundly emotional. One interview became a healing experience for the interviewee, who had felt poorly served while raising a grandson with mental health issues. As she retold her experience, Ballard said, "all of a sudden she started crying. She commented that she did not think she was ready to support others because she was still dealing with issues herself. But she said [the interview] was the first time people had listened to what she had gone through."

AFN does public outreach as well, making presentations to clients of other human service agencies or meeting with consumers to explain High Fidelity Wraparound and the FSP's role. "We want people who can balance their anger at the system with their passion for making it right for others," said Laurie Mulvey, the University of Pittsburgh Office of Child Development staff member who also chairs the AFN board.

Mulvey sees value in Allegheny County's unusually complex organizational model: "In other counties one agency hires the YSP, FSP, coach, and supervisor and trains them all. Here you have multiple agencies with more chaos and confusion, but with more opportunity for family choice."

Ballard believes the introduction of Wraparound has made DHS caseworkers more openminded about listening to families rather than rushing to judgments. "It thrills me to see CYF working with FSPs to support families and give them a voice," Fox added. "Of course CYF has [child protection] mandates that are not negotiable, but the FSP can bring things to the table that would otherwise never be heard."

A new world for caseworkers

Wraparound brings with it a dramatic change in a caseworker's job. Accustomed to controlling key decisions about families' service plans, under Wraparound the caseworker becomes facilitator of a multisystem team that seeks to put the family in the driver's seat. It is thus essential to make caseworkers feel competent and comfortable amidst this culture change.

DHS's Jeanine Rasky, who was responsible for much of the staff and provider orientation regarding Wraparound, has found that the requirements of this approach, especially the team-based planning and extensive interfacing with natural and community supports, pose initial challenges for child welfare staff. "But once you explain the model, the need for smaller caseloads, the length of time that the team stays involved, and the use of YSPs and FSPs in a true partnership, there is an 'aha' moment," Rasky said. "The caseworkers realize that they don't have to do it all themselves but are part of a team who shares the workload, and they become very responsive."

Realizing that they are no longer expected to have all the answers—that their job is now to present an array of resources and help families identify the services they want—can relieve stress too. As Pat Valentine of DHS's Office of Behavioral Health put it: "To acknowledge that we are not the experts on everything can be threatening, but to recognize that we don't have to be the experts can be so freeing."

Jim Gavin, president of Community Care Behavioral Health, also emphasizes the importance of sensitivity to front-line workers' attitudes and concerns. "Changing the workforce culture is the primary vehicle for progressive change in human services," Gavin said, "so we should treat workers as stakeholders and include them in the dialogue so that they feel valued and take ownership of the project."

One key factor in changing the workforce culture is to change the expectations for which staff are held accountable. "Accountability has historically meant the relationship between payor and provider, when the true accountability should be to the consumer," Gavin stated. In contrast, under Wraparound DHS supervisors are looking more closely at whether service plans reflect the family's voice, a strength-based approach, or engagement of natural and community supports. "With Wraparound," said Keith Solomon of DHS's executive staff, "there is a shift in emphasis from making sure the youth has a plan to making sure the youth and family take ownership of their plan."

The two best ways to win staff's allegiance are to make their work easier and to demonstrate success. Thus far, Wraparound teams have done both for DHS caseworkers. Their cases are complex and intense, but they have smaller caseloads and more team support. And, although it is still too early to compile statistics, caseworkers and supervisors are anecdotally reporting better outcomes, thanks in large part to the support partners' successes in bridge building.

Caseworker Zachary Stewart presented a typical example in DHS's October 2009 meeting with Casey Family Programs. A 16-year-old girl named Courtney, whose anger, criminal behavior, and mental health issues had overwhelmed her mother and grandmother, refused to come out of her bedroom on a home visit. Stewart and two support partners talked with Courtney's grandmother, who eventually persuaded the girl to talk with YSP Ashley Hartman. Over the next weeks the two young women built a relationship, based on their shared experiences, that Stewart could never have achieved.

"Courtney had been in placement before and didn't want to talk to any therapist," Hartman reported. "She said nobody could understand her experience unless they'd lived it. Now she has agreed to go to therapy, is doing well in school, and sends me text messages all day."

About the experience of leading a Wraparound team, Stewart observed, "Having someone else to help set priorities has been good. When a teenager goes to court, the judge wonders who all these extra people are—but the support partners have been very outspoken and the judges have been receptive. I'd like to give every kid a YSP."

A Convinced Caseworker

Team-based, collaborative planning that respects the family's voice and choice sounds great in theory, but to make it happen on the front lines, you have to equip and inspire people like Zachary Stewart.

Stewart is a caseworker for DHS's Office of Children, Youth, and Families (CYF), so dedicated to his work that an early supervisor cautioned him not to spend too much time on his clients and burn out. He participated in the System of Care Initiative's early childhood program, receiving some training in Wraparound principles, though they were not as rigorously applied as in the present Improving Outcomes undertaking. When he was asked to become part of the High Fidelity Wraparound team, his first reaction was that it would mean more work with no more pay and no certainty of better results.

But that was before he got to experience the in-depth training and coaching that came with High Fidelity Wraparound—and before he saw Youth Support Partners (YSP) and Family Support Partners (FSP) in action. Intensive training and ongoing coaching helped to overcome the initial reluctance Stewart and others felt. "Instead of just having four days in a room and then being told to go out and do it, we have monthly reviews with people who helped to design Wraparound, showing us how to improve," he said. "I wish the certification process were faster, but the support is good."

Even though he feels he always respected clients' viewpoints, Stewart nevertheless believes Wraparound's emphasis on family voice and choice has affected his service focus. "As a regular caseworker," he explained, "I would come up with the family service plan goals, and meeting them was the fastest way for a client to get out of CYF. With Wraparound you are working with the family on their goals. When you put the focus on what families feel they need, a lot of other things fall into place."

Stewart has also come to appreciate both the teamwork and the independent perspectives that YSPs and FSPs provide. "We were with a family one night for two hours, working through an emergency issue," he said. "When I was starting to wear down I could ask the Family Support Partner what she has done with her own children [in similar situations], or I could ask the Youth Support Partner to talk about what the child might be thinking. It's not just that we have more people there; the support partners are free to say what they think."

DHS has started by applying Wraparound to high-risk teenagers; Stewart hopes it doesn't stop there. "When Marc [Cherna] asked me what more we can do to help," Stewart recalled, "I said let's give every child over age 10 a Youth Support Partner. Having a mentor for these kids can make such a difference."

A new world for residential providers too

John VanDenBerg once ran a residential treatment facility but resigned in disgust when he learned how many of the youths who showed promise in his program reverted to dysfunctional behavior upon returning home. "Intervention is of no value if it doesn't generalize to the home environment," he now asserts. "In a residential facility we modify the environment and modify the behavior, but then we send the youth home to a very different setting."

VanDenBerg advocates for shorter residential placements and tighter collaborations among residential providers, families, and communities.

His argument relies on premises that are hard to dispute:

- The longer a troubled youth stays in residential placement, the more the family develops without him or her, making eventual reunification more difficult.

- Residential treatment approaches not culturally relevant to the family will not be maintained when the youth returns home, making it unlikely that the youth will sustain any gains attained during the placement.

- If residential facility staff have no contact with parents, youths will probably not experience smooth transitions back into their home settings. Getting a residential staffer to even one post-discharge meeting with parents and a Wraparound team can help.

For residential providers to support the Improving Outcomes initiative's goals of shorter out-of-home placements and fewer repeat placements, a paradigm shift must take place. Rather than offering a temporary oasis removed from a troubled family life, residential providers must work with families toward successful reunification and remain involved through the post-placement transition period. But it is difficult for providers, many of them already under financial strain due to declining residential caseloads, to embrace these strategies as long as they are paid for each day of inpatient or group home care they deliver and not for welcoming parents or participating in transitions.

Thus DHS, after more than two years of preparation, began in late 2009 a move toward shifting the incentives for child welfare placement providers. With help from Fred Wulczyn of the University of Chicago's Chapin Hall policy center, DHS identified data that could be used, in the aggregate, as indicators of provider performance. Measures selected include the percentage of youths served who exit the child welfare system permanently (through family reunification, adoption or permanent legal custodianship) within two years; the percentage of clients reentering the system again within one year of their exit; and, as a measure of placement stability, the number of times a youth is moved between facilities for every 100 days in a provider's care. Recognizing that some agencies serve more difficult youths than others, DHS used a "hazard ratio" to adjust the results so as to take into account the attributes of each case.

DHS then calculated these data for child welfare providers, rated the providers in the top, middle, or bottom tier on each measurement, and shared these data with the organizations at individual meetings in January 2010. To encourage provider cooperation, DHS has taken a go-slow approach, indicating that, for now, the data will be used as a guide to improvement, not as a basis for revising or canceling existing referral contracts. Eventually, however, DHS hopes to reward residential providers financially for achieving success with their young clients, rather than on a per-day basis regardless of quality. It is also developing a similar performance-based system for in-home providers.

Wulczyn also tries to present the paradigm shift as nonthreateningly as possible. "Where you have multiple providers, it makes sense that there will be some differences," he explained. "That is not to say some are good and some bad, but simply that there will be variations between units that provide a service. It is important for the public sector to ascertain the extent to which that is true. Then that information can be shared with providers. We also recognize that there also are problems with how residential providers are reimbursed; under the current system, performance improvement is not rewarded financially. That is a difficult incentive structure, so removing financial barriers is an important component of reform."

Robust data, Wulczyn urged, are the key to improving services to children and families within an accountability framework; issues related to performance are harder to defend in a context of transparency. Simply releasing the ratings publicly can have a powerful effect. After the *New York Times* published performance assessments on New York City providers, consumers began asking to have their child not placed at a low-performing facility.

Erin Dalton, DHS's deputy director for the Office of Data Analysis, Research and Evaluation (DARE), said the first round of performance outcome review meetings with child welfare placement providers went very well, though "we haven't had hard conversations yet since the ones who wanted to come in were the better ones." Dalton found the providers not only receptive to change but willing to share best practices where appropriate; she had feared that the best facilities might be reluctant to help their "competition" improve. She and DHS hope subsequently to develop a similar performance-based system for in-home providers. This is not just about improving provider performance, it's about the critical link between provider performance and the overall performance of the child welfare system," Dalton said.

Currently, the most obvious measure (placement reductions) is being met. Child welfare placements have been reduced by 34 percent from January 1, 2007 to January 1, 2010 and days of care (a measure which includes cumulative days of placements) revealed an even deeper reduction in days of congregate care. Continuously reviewing key system measures is critical to the success of the Improving Outcomes initiative.

Evaluating what's really working

"At the end of every research report," Fred Wulczyn of Chapin Hall frequently reminds his listeners, "the researcher concludes that we need more data." That attitude is understandable in a research community whose main purpose is to expand knowledge. But in human services agencies, waiting until more questions are answered can delay action and prevent effective use of the data at hand.

"Often," Wulczyn said, "a group responding to data immediately starts asking about the other information they would like to have. Then two things can happen. Either they use the data they have to make the best decision possible, or they say 'we don't have all the data we need so we can go back to making decisions without data.' "

Wulczyn and DHS are doing all they can to avoid the latter result. The Improving Outcomes initiative includes a comprehensive data-gathering component, both to evaluate the project itself and to provide a firmer basis for future adjustment, expansion, or replication.

Chapin Hall is conducting an independent evaluation of DHS's Wraparound implementation, as well as of the two preceding pilot projects, the System of Care Initiative and Family Group Decision-Making, that had applied the "family voice and choice" and team-based planning principles in a similar manner.

The evaluation is designed to assess whether the following six desired outcomes have been achieved:

- Reduced number of children requiring out-of-home care
- Reduced average length of out-of-home stay
- Reduced number of placement moves, within or across systems
- Reduced frequency of reentry into care after release
- Reduced reliance on "high-level" placements (e.g., increased use of kinship care rather than residential facilities or group homes)
- Reduced cost—or, at least, achievement of the first five goals without increased cost

Evaluation design faces two big challenges: data collection and cause-effect analysis. To address the first problem, a longitudinal file with a unique, confidential identifier is created for each child, enabling researchers to view the full history of services provided to that youth and the resulting outcomes.

Linking cause and effect is more complicated, due to the various potentially confounding factors: youths are not randomly assigned to Wraparound, implementation effectiveness may vary across the county, and there is no way to create an otherwise identical non-Wraparound control group. Surmounting these difficulties calls for Chapin Hall's technical expertise in sifting through client demographics to construct a suitable comparison group while controlling for other variables.

To protect the integrity of its research, Chapin Hall staff are vigilant about maintaining their professional distance. "If you are engaged in continuous quality improvement, there really is no bad news," Wulczyn noted. "To the extent that we expose warts, we try to present the information in a way that encourages positive change. As long as administrators are interested in that, there is no problem."

DHS's Pat Valentine considers rigorous evaluation an essential component of Improving Outcomes. Most human service agencies, she commented, "don't properly prepare and fund evaluations to demonstrate the benefit (or lack of benefit) of what we do over a sufficient amount of time. Until we do, we will never really know what works and what doesn't."

Inua Ubuntu: communities lifting children up

Child welfare agencies battle the stigma of being "the people who take our children away." That challenge is most acute in the African-American community, which represents 12 percent of Allegheny County's population but 60 percent of its CYF caseload. And many of those cases evolve into tomorrow's juvenile justice or adult crime problems, causing disproportionate and immense suffering within African-American neighborhoods.

Marcia Sturdivant, Ph. D., DHS's deputy director of CYF, was determined to make her agency a positive player in the lives of troubled black children. Her vision has grown into Inua Ubuntu, an innovative effort to heal African-American families by mobilizing community resources.

Whenever a child is referred to CYF, the agency has 60 days to complete an assessment and decide whether that child should be accepted for services. While CYF must take protective action in abusive situations, many other referrals arise from concerns, such as truancy or parent-child conflict, that do not pose an immediate safety threat. Sturdivant believes that linking these children to robust community services rather than making them child welfare cases can improve outcomes and reduce the number of youths removed from their homes.

Based on this premise, Inua Ubuntu—the name is drawn from Swahili and Bantu words meaning "I am because we are," signifying that our communities lift us up—started with public meetings to discuss how to develop child services that would be community-based and intensive but not intrusive. "It is less intrusive," Sturdivant argued, "if you have a mentor meeting with you every day rather than government."

Sturdivant showed DHS's seriousness about the initiative by bringing money to the table. Three inner-city communities—the North Side, Hill District, and East Liberty—each identified a lead agency and collaborative partners, and DHS contracted with them to fund their activities.

Under the Inua Ubuntu intervention model (implementation of which began in March 2010), all new child welfare referrals involving African-American males are routed to a specially assigned Inua caseworker, who will take a cultural consultant from that community's lead agency on the home visit. The community-based agency will arrange needed services and mentoring while CYF monitors the case every 15 days until a resolution is reached.

If a child must be removed from home, there is a continuum of placement alternatives, beginning with kinship respite care (i.e., with relatives), followed by group home respite care lasting no more than 30 days. Also, day services at former Pittsburgh Steeler Mel Blount's youth home in Washington County are provided for children who need intensive intervention during the day but can return home each evening. Unaware of any similar community-based model for keeping kids out of the child welfare system, Sturdivant and DHS devised this one from scratch.

"The only way to make change," Sturdivant stated, "is to recognize where we fall short and try something different. It might not work, but you have to try it. I can't look at these kids and say I didn't try to do anything to help."

Keeping stakeholders in the loop

With so much change taking place in Allegheny County's child-serving systems, keeping stakeholders meaningfully informed and engaged becomes essential. DHS ensures this regular information exchange through quarterly meetings of its "Children's Cabinet."

The Cabinet had existed from 2000 to 2005 as a group of key decision makers on human services issues. When Cherna revived it in 2007 he had a different goal in mind: to convene a more diverse, inclusive group for quarterly meetings at which they would hear about recent developments at DHS and have the opportunity to offer input. Local funders, partner agencies, counseling professionals, and a significant number of consumers attend. Cherna personally leads the meetings and facilitates discussion. The Cabinet "is a good way to connect with other people and learn what the county is doing," said Mary Carrasco, who directs the Department of International and Community Health at Pittsburgh Mercy Health System.

"I see ideas come up that trigger responses in other people that might not have occurred if we weren't discussing the ideas as a group." DHS also receives valuable guidance from the Cabinet; for example, Dr. Carrasco recently pointed out how a plan for DHS client data sharing would have to be adjusted to comply with HIPAA privacy requirements.

To ensure the inclusion of clients and family members, DHS's Jacki Hoover visits prospective consumer participants to explain the Cabinet and its value. Barbara Witherspoon, a retired nurse raising two grandchildren with special needs, has attended regularly and become an important liaison between DHS and consumers in her home community of Wilkinsburg.

"I started out wanting to make sure we were receiving the right services, but not knowing how to advocate," Witherspoon recalled. "Now I understand what programs like High Fidelity Wraparound are about and I can explain them to other families." DHS also helped Witherspoon construct a one-day program for adults raising grandchildren, which attracted 50 grandparents.

"We have done a lot of brainstorming and all our suggestions are taken into consideration," stated Leah Walker, adoptive parent of two former foster children. Walker said she values the chance to help youths in the system "come out into the world with a lot less baggage."

Can we afford it?

No program, regardless of quality, can survive unless someone pays for it. Several aspects of the Improving Outcomes model, such as family-driven planning, the use of support partners, and the intensive coaching provided to caseworkers, can add to service costs. Is the model financially sustainable? Can it be taken to scale affordably?

If so, Jim Gavin, president of Community Care Behavioral Health, the managed care organization for Medicaid-funded mental health services in Allegheny County, will likely be a big part of the solution. Community Care has been widely praised for its out-of-the-box thinking in finding ways to apply Medicaid funds more effectively.

"There is new energy in the game," Gavin said of the innovative components of Improving Outcomes, "and we have to find a way to support that. But typically it's complicated to adapt the economics to support the energy."

Gavin has a history of creatively using Community Care's purse strings to drive organizational change. He has required contractors to increase the percentage of total funds that go to case managers; encouraged pay raises for caseworkers in order to stabilize the workforce; made providers commit to participation in training collaboratives; and included parent satisfaction as a criterion in assessing clinical teams' performance.

Pat Valentine stressed the importance of Gavin and Community Care's efforts to rewrite descriptions for "supplemental services" so as to permit funding of programs such as Wraparound. "Community Care understands," she said, "that they can't just look at the Medicaid-reimbursable part of services—that they need to work with us to develop a more holistic plan for families with multiple needs. So they devote enormous amounts of time to non-Medicaid planning processes that they wouldn't have to do and aren't getting paid for."

Valentine understands the sustainability challenge quite well. She has seen the System of Care Initiative undergo significant changes when federal funding ended, because Pennsylvania could not secure a state waiver to reimburse nonmedical System of Care services, such as family support and service coordination, with Medicaid funds.

Valentine thinks the federal Substance Abuse and Mental Health Services Administration (SAMHSA, which gave Allegheny County three grants for System of Care) and Center for Medicare and Medicaid Services (CMS) must not talk to each other, "because SAMHSA funds these wonderfully creative things for five years and then CMS will not allow Medicaid funds to be used to reimburse them." The funding dilemma drives Valentine back to stressing the need for excellent program evaluation, so as to demonstrate that these additional expenditures are paying for themselves through better client outcomes.

DHS Caseworker Zachary Stewart feels confident that Improving Outcomes can demonstrate its fiscal as well as its programmatic value. "Initially it might cost more," he acknowledged, "but I believe more of our clients are going to get straightened out, stay out of jail, not have police called to their house, and not be a drain on public resources. If our goal is to get people off the public dole, this is a better way to do it."

It's about leadership

Evaluation of the major elements of Improving Outcomes are not yet available, but a summary of what has been achieved so far is quite impressive:

- DHS and provider staff have been effectively trained in Wraparound principles, with high fidelity scores and a widely acknowledged improvement in enabling family voice and choice. Descriptive statistics on High Fidelity Wraparound are available in the DHS Improving Outcomes quarterly reports.
- Three provider agencies have begun working with about 100 high-end youths and their families selected to be the first recipients of High Fidelity Wraparound services.
- Ten Youth Support Partners and 30 Family Support Partners—believed to be the largest contingent of support partners in the country—have been trained and mobilized.
- Common registration, common assessment, and integrated data management processes are in place to get all team members on the same page and ensure that children and families have "no wrong door"—that is, that they get the same services regardless of how they enter the system.
- A major community-based initiative to address the disproportionately high prevalence of African Americans in the child welfare system has established a strong base of acceptance in target neighborhoods.
- DHS has taken effective first steps toward revamping the undesirable incentives surrounding compensation of residential treatment facilities.

Participants both inside and outside DHS are optimistic that, when project data become available beginning in 2011, they will show further improvement in Allegheny County's service to children in need, justifying the significant investments made by Casey Family Programs and local foundations and positioning DHS as a model for national replication.

But they also warn that it won't be enough for other jurisdictions simply to replicate strategic plans and training curricula. Consistently, they insist that the quality, dedication, and risk-taking innovativeness of DHS leadership comprise an indispensable part of the agency's success.

"The model of services we have put in place has helped, but it's leadership and courage that have made the difference," declared Walter Smith, executive director of Family Resources. "We would not be here if Marc Cherna hadn't been able to withstand the political battles that followed when he changed how the system was funded and reduced the number of children in residential placement. DHS deputies and provider agency directors have been on board too, saying that even if their business is going to lose money, we should make this change because it is the right thing to do. I tell other communities that you could take all these models and throw them into an environment without the leadership and cooperation we have, and they won't work."

Allegheny Family Network's Toni Ballard said that, in Cherna, Sturdivant, and Valentine, the county "has people at the forefront of child welfare saying we have to look at how families can empower and strengthen one another. People are recognizing that, if our leaders are on board, we have to come on board."

Deb Freeman attributes DHS's successes to the presence of leaders who are willing to undertake "the tension of trying to create something—to sit through hard discussions, hear everyone's perspective, and try to reach common ground. It's hard work, but these people are willing to do it time and time again. That is what allows for creative kinds of programming."

At a January 2010 meeting with DHS and Casey Family Programs, John VanDenBerg summed up the significance of what is happening in Allegheny County. "How many large American cities," he asked rhetorically, "have a truly integrated system where family don't end up with duplicated plans and everyone is working under the same principles? None."

Now one agency is well on the way. But the story won't be over, and DHS staff and partners won't be satisfied, until the impressive systemic changes they have brought about lead to unmistakable transformations in the lives of the children and families they serve.

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Session VI

Raising Consciousness, Reframing Issues, Generating Public Will

Approaches to Preventing Child Abuse

The Health Visitors Concept

C. Henry Kempe, MD

A better title for this lecture would be "A Vindication of the Rights of Children," after the classic essay, "A Vindication of the Rights of Woman," written in 1792 by Mary Wollstonecraft, which set forth the plight of women in those days.

Children in the Western world (though not yet in the southern hemisphere) have made striking progress in the past 200 years. Seen against a background of virtually being nonpersons, they are slowly emerging as citizens with rights of their own. In 1763, the poor-law governors (that is, the welfare department) of the parishes of St Andrew's and St George's in London were entrusted with 59 infants: of these, all but two had died two years later. But not only the poor died. Between 1767 and 1769 in London, in the absence of epidemic disease, there were 16,000 baptisms and 8,000 infant burials reported—half the children died. Because of this appalling mortality in the first years of life, George Armstrong opened his clinic for poor children in 1769, focusing on the period from birth to age 4. He quickly achieved success in lowering the mortality of his patients, though it was at great personal and financial sacrifice. He was what in this day would be called a "bleeding heart," but he did not just show constant pity for the needy young; he also possessed three other qualities: he was a hard worker, he was an activist, and he was a visionary. He worked very hard, making his rounds on his paying patients in Hampstead in the morning and then, generally, walking five miles to his clinic downtown. He saw over 4,000 patients each year, spending about 2½ hours in his clinic each day. He was greatly concerned with the importance of ensuring easy access to care. He was an activist in instituting the first infant clinic anywhere. Early on, when he sought support from patrons, each paid one guinea per child per year to sponsor a child and then two guineas for the second child per sponsored year. In time, the overworked clinic helpers tried to limit his patients to those with sponsorships in hand, excluding those without—in other words, those patients who didn't have their clinic card. Let me quote Armstrong: "This hindered their coming more than can well be imagined. The circumstance, by the by, may afford a useful hint: to be very cautious of any obstacle that is thrown in the way, if we mean to render charity generously useful." He was primarily concerned with "a good start," the time from birth to age 4 years. And he was a visionary: preventive medicine was his long suit—good hygiene, feeding, health care of the youngest.

A hundred years later, in 1874, Mary Ellen, a child living with stepparents in New York, was cruelly treated, and it required the Society for the Prevention of Cruelty to Animals (there was no Society for Prevention of Cruelty to Children) to intervene on her behalf as a member of the animal kingdom. She was removed to safer quarters. Soon came child labor laws and universal, free education. In the last 50 years increasing attention is being paid to the health of young children and we are now, in 1975, addressing the civil rights of children.

Prenatal, Perinatal, and Postnatal Observations

Throughout the Western world it has become almost routine for children to have periodic health assessments. As part of this assessment, we

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do a standard history and physical examination, the technique of which is pretty well accepted all over the world. I propose that these be supplemented by standardized observations in the prenatal, perinatal, and postnatal care of families. Table 1 lists ten warning areas in prenatal care indicative of need for extra services.

You will note that none of these observations, nor those made during and after delivery, has anything to do with social class, education, or financial status. They deal with attitudes and feelings.

If prenatal observations are not possible, then much of this information can be obtained, along with delivery room observations, on the first postpartum day.

During delivery, mother, doctor, and nurses are very busy. But they are busy with the perineal end of the mother, and birth is often a struggle between the obstetrician and the uterus from which he skillfully extracts the child. The mother's head is three miles upstream.

I and my colleagues encourage fathers to be present in the delivery room, and more than 90% come. We ask our nurses to look at the mother (and the father, if he is present) and answer just three questions: How does she look? What does she say? What does she do? The parents' reactions to their newly born child are carefully observed. Are the parents passive, showing no active interest in the baby, not holding it? Are they disappointed in its sex? Are their reactions hostile or their comments inappropriate? Is there eye contact?

Observation of reactions after the baby goes home is also important. Significant warning signals are listed in Table 2. Positive factors, which may partially offset these, are listed in Table 3.

My colleagues and I have tried to determine whether our child abuse and "failure to thrive" patients came from the group we thought to be in need of extra services. We studied 300 consecutive births and concluded that 20% of them seemed to be in need of extra services. We divided these families into two groups by random numbers: The control risk group received the best care that is routinely provided, including a single visit by a visiting nurse, regular well-baby appointments and, also, a telephone call to the physician caring for the family, in which we voiced our concern about the parent's attitude toward the baby. The second risk group received active intervention through the extra services shown in Table 4. Detailed results of this study will be reported separately, but we found no instance of child abuse by the 240 mothers about whom we had no concern, and that the modest intervention given to half of our risk families significantly reduced the incidence of many problems including abuse and "failure to thrive."

Similar efforts are in progress in California, New York, Colorado, North Carolina, the District of Columbia, and elsewhere, using mostly visiting nurses, although a number of these programs have begun to utilize lay health visitors. The intervention we propose can be carried out simply. It is available to each of us in our current pediatric settings. However, since a large percentage of children who need help are not brought to us for "checkups" and do not have meaningful contact with any type of health personnel on a regular and ongoing

Table 1.—Observations of Parents-to-be in Physician's Office or Prenatal Clinic

1. Are the parents overconcerned with the baby's sex?
2. Are they overconcerned with the baby's performance? Do they worry that he will not meet the standard?
3. Is there an attempt to deny that there is a pregnancy (mother not willing to gain weight, no plans whatsoever, refusal to talk about the situation)?
4. Is this child going to be one child too many? Could he be the "last straw"?
5. Is there great depression over this pregnancy?
6. Is the mother alone and frightened, especially by the physical changes caused by the pregnancy? Do careful explanations fail to dissipate these fears?
7. Is support lacking from husband and/or family?
8. Where is the family living? Do they have a listed telephone number? Are there relatives and friends nearby?
9. Did the mother and/or father formerly want an abortion but not go through with it or waited until it was too late?
10. Have the parents considered relinquishment of their child? Why did they change their minds?

Table 2.—Observations to be Made at Postpartum Checkups and Pediatric Checkups

1. Does the mother have fun with the baby?
2. Does the mother establish eye contact (direct in face position) with the baby?
3. How does the mother talk to her baby? Is everything she expresses a demand?
4. Are most of her verbalizations about the child negative?
5. Does she remain disappointed over the child's sex?
6. What is the child's name? Where did it come from? When did they name the child?
7. Are the mother's expectations for the child's development far beyond the child's capabilities?
8. Is the mother very bothered by the baby's crying? How does she feel about the crying?
9. Does the mother see the baby as too demanding during feedings? Is she repulsed by the messiness? Does she ignore the baby's demands to be fed?
10. What is the mother's reaction to the task of changing diapers?
11. When the baby cries, does she or can she comfort him?
12. What was/is the husband's and/or family's reaction to the baby?
13. What kind of support is the mother receiving?
14. Are there sibling rivalry problems?
15. Is the husband jealous of the baby's drain on the mother's time and affection?
16. When the mother brings the child to the physician's office, does she get involved and take control over the baby's needs and what's going to happen (during the examination and while in the waiting room) or does she relinquish control to the physician or nurse (undressing the child, holding him, allowing him to express his fears, etc)?
17. Can attention be focused on the child in the mother's presence? Can the mother see something positive for her in that?
18. Does the mother make nonexistent complaints about the baby? Does she describe to you a child that you don't see there at all? Does she call with strange stories that the child has, for example, stopped breathing, turned color, or is doing something "on purpose" to aggravate the parent?
19. Does the mother make emergency calls for very small things, not major things?

Table 3.—Positive Family Circumstances

1. The parents see likeable attributes in the baby and perceive him as an individual.
2. The baby is healthy and not too disruptive to the parents' life-style.
3. Either parent can rescue the child or relieve one another in a crisis.
4. The parents' marriage is stable.
5. The parents have a good friend or relative to turn to, a sound "need-meeting" system.
6. The parents exhibit coping abilities, ie, the capacity to plan, and understand the need for adjustments because of the new baby.
7. The mother is intelligent and her health is good.
8. The parents had helpful role models when they grew up.
9. The parents can have fun together and with their personal interests and hobbies.
10. The parents practice birth control; the baby was planned or wanted.
11. The father has a steady job. The family has its own home, and living conditions are stable.
12. The father is supportive of the mother and involved in the care of the baby.

Table 4.—Special Well-Child Care for High-Risk Families

1. Promote maternal attachment to the newborn.
2. Phone the mother during the first two days at home.
3. Provide more frequent office visits.
4. Give more attention to the mother.
5. Emphasize nutrition.
6. Counsel discipline only for accident prevention.
7. Emphasize accident prevention.
8. Use compliments rather than criticism.
9. Accept phone calls at home.
10. Arrange for regular home visits by a public health nurse or a lay health visitor.

basis, it is clear that something else is needed.

The Health Visitors System

I propose that we in the United States develop a system of lay health visitors, although nurses can be used when available, and that these health visitors work with traditional health professionals in assuring that the basic health needs of every child are met, especially during the first four years of life.

This program for utilization of health visitors should be a national one, but any state, or any one of our 3,362 counties, could start right now. Any county could—but no county yet has. In most places the health visitor will not be a nurse. Instead, the ideal candidate will be a successful mother who is able and interested in sharing her experience and goodwill with less experienced young families. She could well be chosen by her neighbors as one of their trusted own. The health visitor will form a bridge between these families and the health care system.

It is true that virtually all European child health visitors are trained nurses and that they do very much good, but it must also be said, in all candor, that their orientation is largely toward mother-crafting skills. They tend to shy away from matters of feelings, and they are relatively passive in dealing with the families who don't want their services. Recently, one experienced European health visitor told me, "If they won't let me in, I don't do a thing. It's their kid, after all, and I have no right to interfere." She said that this was the general feeling of the nurses in her local district. This attitude is also often found in Scandinavian countries where I visited: all have good health visitor systems; nobody wants to violate the rights of parents.

So the system itself is not enough. One has to have meaningful access. Lay health visitors can be trained in a period of a few days, because they will be learning just a few facts to be grafted on the important foundation that they already have, namely, their success as mothers and their intimate knowledge of the community that they serve.

Our first concern has to do with the parent-child relationship. We know that difficulties are often encountered when there is a prolonged separation such as in prematurity or early illness in infancy, when there are obstetrical complications such as cesarean section or maternal illness—all these interfere with bonding in some families. I was taught that some mothers couldn't love their newborn babies because they suffered from postpartum depression. I now know that as many postpartum depressions are caused by the mother's finding that she doesn't love her baby. The health visitors will also be involved in helping to fulfill the health needs of siblings, fathers, grandparents, and others.

Ideally, the health visitor should get to know the family during the pregnancy period. She should have knowledge of what happened at delivery and during the first few postpartum days so that she may be more able to assist effectively when she makes postnatal visits. The physician may want to notify the health visitor very early in the pregnancy so that she can be of support to the mother-to-be. She can provide advice on how to prepare for the child's arrival, types of supplies that will be needed, and she may even provide some supplies. Many of our mothers have greatly benefited by gifts of disposable diapers and infant formula so they could have one hour of rest each day. To be more specific, we should subsidize young mothers. We are the only Western nation that does not do so.

If the health visitor's first contact with mother and father is in the hospital, she can gain critical information at that time. On the first or second day after the arrival of the family at home, she will visit, leave her telephone number, and encourage calls. This will be the essential lifeline between the family and herself. It is nonthreatening and therefore useful.

If the need is there, visits will be frequent. Doctors will have an invaluable resource in the health visitor when they are troubled about the progress of a young infant, and they will be able to gain great insight into the possibility of a postpartum depression, serious marital problems, financial crises, or existing attachment difficulties. Such problems are more likely to come to the attention of the trusted lay health visitor as she visits in the home than in the brief, well-child visit in a busy office or clinic.

I propose that health visitors be utilized regularly, not only in the first months of life, but at least twice

yearly in the second year of life and until the child reaches school age. At that time many of the health visitor's duties will be taken over by the teacher, the school nurse, or the school nurse practitioner.

On the basis of our experience to date, my co-workers and I think that one health visitor can care for 50 to 60 children, provided she works about four or five hours a day. Since there are millions of mature women whose children are in school and who are otherwise not gainfully employed, we already have a large number of excellent candidates for a very worthwhile career in which they would make a maximum contribution by helping others. These women have developed important skills of mothering, and I would rather that they share these skills than take jobs in a bakery. On the basis of the current birth rate of 3.2 million per year, we would gradually plan to phase in, over five years, 60,000 health visitors—a goal that could be easily attained.

What would such a program cost? It would cost less than 1% of our defense budget or less than 6% of the requested increase in military spending for next year. But, since most of us don't like to hear what we spend on defense, let me say instead that it would cost one third of the money already set aside for stand-by authority for the bureaucracy needed for gas rationing, if that unhappy event should come to pass.

Role of the Health Visitor

What will the health visitor do and where will she function? She will go out to the home where she will weigh the child and graph its progress on a weight chart, but most importantly she will look at the child, at the mother, at the setting in which the family lives, and determine how things are going, what problems exist, and how the family is coping with these problems. It has been found that health visitors are fully capable of determining which children are at risk, whether they are thriving adequately or not doing well, whether the child is unloved or deprived, whether the mother's inexperience or the father's lack of support are interfering with the care of the child. Is the child seeing a health professional on schedule? Have recommendations been carried out? Does the family understand what services are available and can they be induced to obtain them?

The health visitor will help to educate the family on the need for basic immunization, good nutrition for the whole family, and periodic examinations by the physician. The health visitor can also see the child when it is brought to her office, which may be in a local grammar school, a fire station, a health department office, a neighborhood shopping center, a high-rise apartment house, or a housing development—anyplace.

Of great importance is the fact that the health visitor can, between visits, be available by telephone for parents who are in need of advice and assistance. If the family moves, she can be the one who assists in a transfer to a health facility in another city as well as arranging for a health visitor from the new neighborhood.

Children's Rights to Protection and Health Care

It should be emphasized that the use of health visitors should be a universal phenomenon. This is not a kind of detection service to identify child abuse. It is not a service for the poor or the minorities but rather an expected, tax-supported right of every family, along with fire protection, police protection, and clean water—societal services that we all deserve to have and from which no one can be easily excluded.

The concept of the health visitor as a compulsory, universal service for the child is similar to the concept of compulsory, universal schooling. In preparation for this talk, I've been reading about how public education came about, a hundred years ago. All the hue and cry that we hear about this concept of free, universal, adequate health care for children were precisely the ones raised against the concept of free, universal public education a hundred years ago. But that debate is over; today, free, effective basic education is a right. This came about because society decided that each young person must be able to take his place in the labor force as an independent, self-supporting citizen and, in order to do so, he had to read and write.

By the same token we must now insist that each child is entitled to effective comprehensive health care, and that when parents are not motivated to seek it, society, on behalf of the child, must compel it. It seems incomprehensible that we have compulsory education, with truancy laws to enforce attendance and, I might add, imprisonment of parents who deny their child an education, and yet we do not establish similar safeguards for the child's very survival between birth and age 6.

A free society does not want to interfere with the rights of parents to be let alone and to raise their children in any way that they desire. But, far too often, children are considered the property or chattel of their parents, many of whom think that they are entitled to dispose of them at will. Unfortunately, such a system ignores the rights of children and results in tragic failures that will adversely affect the children's lives or even result in their deaths.

When an airplane takes off, the pilot is required to go through a unvaried series of safety checks. He has no choice—they must be carried out. Often there are double checks of those things that are considered especially important. If the successful operation of an airplane requires such routine supervision, it is all the more important that the takeoff and subsequent passage of a young family be similarly supervised to assure a safe arrival.

Under our traditional system of pediatric care, which depends on parent motivation, we often find that we are spending a good deal of our time and effort in giving excellent service to many families who don't really need much of it. We do so because they come to us for such care, they are delighted to keep their appointments, they are a joy for us to have in our offices, and they make our days pleasant and fulfilling ones. Such motivated families provide a sunny interval in our work and are a great boon to our mental health: in fact we

couldn't practice without it, and they do deserve excellent care. But it is the very isolated families—those who are unmotivated, who break appointments, who are unappreciative and unresponsive—to whom we must reach out protectively. When we see such a family, instead of saying: "Well, we tried . . ." and giving up, we must say, "This behavior is so unusual and worrisome that we must intervene actively." We must do this first by persuasion and education and trying to be as helpful as we can, but if that fails, we must initiate active intervention through child protection services. We cannot sit helplessly by and mistakenly believe that there is nothing we can do. In a very well-organized infant care service, such as is provided by Sweden, where over 95% of all newborns are followed up in child health centers for periodic care in the first year, only 2.5% of the battered babies were reported from these centers. The assumption is that either routine well-baby care, as we know it, misses a lot or the 5% who elect not to be in the system account for most of the problems.

Curiously, professionals are far behind the citizenry in their desire to provide effective protection to the threatened child. Will the health visitor be seen as someone who can be truly useful and accepted like a member of the old, lamented, extended family, particularly to those who are frightened and alone, or will they be looked on as another bureaucratic layer of busybodies who come between those who need help and those who can provide it? I believe that, to a large extent, this will depend on whether the program is started for all people, rich or poor, black or white, brown or red, or whether it is limited, once again, to the disadvantaged or the minorities. To my mind, only a universal program will develop quality and be successful. I think private practitioners will welcome the health visitor as a universal outreach program of their practice that will become operative when patients miss appointments and when follow-up visits in the home seem desirable and more social information is needed. Let me stress that this is not a program to bring every child to a clinic. It is a program to facilitate and make sure there is *access to comprehensive health care for each child.*

Everybody agrees that every child should be under the care of somebody in the health field, particularly in the first years of life, and I think the health visitor plan is the only way to bring this about.

If it should turn out that local or state health departments are not very interested or are unwilling to undertake the health visitor program, there may be other approaches for its implementation. The state of Michigan, for example, has placed the charge on the Department of Education to assure that everyone is "educable." In theory this gives the Department the right to provide screening procedures and comprehensive health care to make every child school-ready. But if neither the Department of Health nor the Department of Education in a given state can be brought to be involved in this program we might then fall back on a system that already exists in many places.

We can utilize our hospitals as a base to establish a system of aftercare. Admittedly, it is aftercare that lasts five years. Once we decide that a skilled delivery is only the beginning and that we then must provide follow-up, then, I think, it's very easy to see that the hospital could extend its postnatal care into the health visitor concept. Some do so now for premature infants and for certain chronic diseases.

It is economically quite feasible to insist that the young child have access to health care in the broad sense. France actually pays families to seek regular and compulsory child care; such a subsidy is thought to be a very good investment in the ultimate health of its citizens. Similarly, a program to prepare all children for regular school in Amsterdam and in other Dutch cities provides excellent, comprehensive day care for a great number of children who are mentally disturbed or emotionally deprived. In many countries, government leaders believe that it is better to invest money in the first five years of a child's life than to have to develop special programs and institutions for the provision of special education for those whose problems were not recognized early in life. Although the United States spends a lot of money to detect preventable disease, to a considerable degree these funds are misdirected. For example, it is hard to believe that there is currently in Congress a bill that proposes that all our newborns be screened for adenine deaminase deficiency disease, which occurs in approximately one in 200,000 births. This would, of course, be an important screening test for the 15 children in whom this condition is detected each year, but even among those 15 children, it would only matter for those who are also lucky enough to have an identical tissue-type twin as a transplant donor—an unlikely event.

The Cost of Child Abuse

We need to bring some order to our priorities. It would seem to be more important that we give sufficient emphasis to the assessment of the child who might be neglected or abused, since suspected child abuse and neglect is now being reported approximately 300,000 times each year in our country. About 60,000 children end up with significant injuries; some 2,000 of them die and 6,000 have permanent brain damage. The cost of institutional care for a severely brain damaged child in our country is $700,000 for a lifetime. Many other children are scarred by sexual abuse, incest, and rape. Those who do recover are likely to have significant emotional difficulties and most manifest this in the form of serious learning problems in school. Although in most fatal cases of child abuse the family's problems have been recognized before the child's death, many others have never been active participants in any segment of the health care system.

The late effects of child abuse may manifest themselves in ways that are not generally recognized. My associates, Brandt Steele, MD, and Joan Hopkins, RN, studied delinquent children on the first occasion they were seen in a detention center in a mixed urban-rural county near Denver. The population of youngsters was approximately 85% Caucasian, 14% Chicano,

and 1% black. Of 100 well-documented cases, which involved interviews with not only the delinquent young but also their parents, all the hospitals, physicians, and schools, it was found that 84 of those youngsters had been abused before the age of 6 years. Ninety-two had been bruised, sustained lacerations or fractures, or were involved in incest in the preceding year or so prior to being identified by the authorities. Only one of this group of 100 delinquents came from a family on welfare, and only three had an alcoholic parent. These were not children from broken homes or the ghettos, but the type all of us are likely to see.

Our country literally wastes hundreds of thousands of our precious children. Even though we confess that they are our future and therefore our most valuable national asset, we don't act as if they were.

Recently, considerable emphasis has been placed on the provision of "early periodic screening, diagnosis, and treatment" (EPSDT), but for only those Medicaid clients who are motivated to present their children for screening. It is another helpful attempt to provide health care for many children. One would expect that this would include extensive attention to the emotional growth and development of the child. But that is not to be. Most of our screening tests ignore the significant problems of parent-child interaction. To a considerable degree the emphasis is on those conditions and diseases that had had the greatest attention from various pressure groups or lend themselves to a quick checklist. It has been argued that it is far easier to have a checklist and a screening test when you are dealing with easily quantitated observations and that in the field of maternal attachment and the child's emotional health such observations cannot be readily made. Nonsense! Pediatricians have for years made such observations competently, and to exclude them from instruments sanctioned as national policy in the health care field of children does not make sense.

Specific diseases, even those that are quite uncommon, should be prevented whenever possible, but this should not be done at the expense of giving adequate attention to the whole child, his family, their total health status, including those emotional as well as physical factors that might affect the child's welfare. There is something I know about every battered child I've seen—he does not have phenylketonuria. There is more to a child's life than teeth, hearing, and vision.

In many ways it would be better to start this program at the grass roots level; perhaps our state governors should take the lead. The people in the community, laymen as well as health professionals, will have to work together in developing an understanding that health is a personal asset that every child deserves and should have even if it would require limited intrusion into family privacy by society. Just as any fireman will enter a burning house and try to put out the fire even though he doesn't receive a specific request to do so by the owners, so those of us who are qualified to assess and correct the problems that produce child abuse and "failure to thrive" should have the authority to intervene effectively for the good of the suffering child. Let us face the fact that there are large numbers of American children living with troubled families whose emotional house is on fire. Something must be done before their lives are forever distorted and destroyed.

When marriages fail, we have an institution called divorce, but between parent and child, divorce is not yet socially sanctioned. I suggest that voluntary relinquishment should be put forth as a desirable social act—to be encouraged for many of these families. When that fails, legal termination of parental rights should be attempted. However, such termination is a difficult thing to achieve in our country because the laws are so vague. In my state of Colorado, for example, parents must be proved to be untreatable, and remain so, before the state will uphold terminations by our juvenile court judges, a process that could take five to ten years. But each child is on a schedule of his own emotional development. He doesn't give us the luxury of waiting five years. He needs loving parents right now, and the same parents, not a series of ten foster homes. For 20 years, courts have lectured me on the rights of parents, but only two judges in my state have spoken effectively on the rights of children. Courts only interpret laws passed by legislators and the actions of legislators reflect us and our communities—they reflect the voters. Regrettably, children don't vote. Unless we change the conscience of our adult voting communities, child abuse will continue to be managed by partial, Band-Aid solutions. I think all of us have the duty to educate and to be a conscience for our communities. It is significant that not one of our nation's presidents nor any one of our many governors in our 200-year history is remembered as a champion of children.

Where the state is supreme, this particular problem is easily managed: in a dictatorship each child belongs to the state and you may not damage state property. The really first-rate attention paid to the health of all children in less free societies makes you wonder whether one of our cherished democratic freedoms is the right to maim our own children. When I brought this question to the attention of one of our judges, he said, "That may be the price we have to pay." Who pays the price? Nobody has asked the child.

"A man's home is his castle," but all too often the child is a prisoner in its dungeon. It is a dungeon of constant anger, dislike, aggression, or even hatred. We must guarantee that the child will be saved when there is danger to his health and life resulting from failure in parenting. In order to do this we must see the child, and the child must have access to us.

Current national health insurance proposals are largely directed toward sickness care and financial management of the high cost of hospitalization. None specifically provide for universal and outreach health care for our young children as a right. For every federal dollar spent on our older citizens, just 5 cents goes to the preschool-age child. Obviously, people of all ages need good health care, but the investment in our children's health care has been tightfisted, frag-

mented, devoid of planning, and therefore in many instances has never accomplished what it set out to do. In the coming battles for health insurance we must be absolutely certain to advance the cause of comprehensive child care; otherwise, most of the money will go to the hospitals. The state of California, to its credit, has mandated a health evaluation for all its 5- and 6-year-old children in order to receive a school health certificate before the child can enter first grade. But, obviously, this new change is far too late for many children.

In the past we have accepted inadequate and limited programs–EPSDT, Mother and Child, and Children and Youth, as well as many other categorical efforts–hoping that, like pieces of a jigsaw puzzle, there would evolve a complete picture when the last piece fell into place. We have settled for small steps in the belief that something is better than nothing and that a comprehensive system would eventually result. Instead we have a nonsystem, fragmented, oriented not toward comprehensive health care, but at the very best, gradually moving from episodic sickness care to screening only for organic disease. But that has never been the philosophy of pediatrics as we know it. It has especially not been the philosophy of this distinguished organization. Let us, therefore, now ask for what really makes sense by placing our priority on "the good start," as George Armstrong suggested, on the infant from conception to school age with the understanding that "the good start" has to involve attention to the rights of the child for tender care and love. No child can thrive without it.

Conclusion

1. In a free society the newborn child does not belong to the state nor to his parents, but to himself in care of his parents. When parenting is defective or blatantly harmful, prompt, effective intervention by society is essential on behalf of the suffering child and also his suffering parents.

2. Universal, egalitarian, and compulsory health supervision, in the broadest sense of the term, is the right of every child. Access to regular health supervision should not be left to the motivation of the parents but must be guaranteed by society.

3. Predicting and preventing of much child abuse is practical, if standard observations are made early.

4. As a bridge between the young family and health services, the utilization of visiting nurses or, more often in most places, indigenous health visitors who are successful, supportive, mature mothers acceptable to their communities, is to my mind, the most inexpensive, least threatening, and most efficient approach for giving the child the greatest possible chance to reach his potential.

It is truly grand that we can pay tribute here to a modest and innovative man, 200 years after his time. George Armstrong serves as a model for us. May we, like him, strive to be "bleeding hearts," hard workers, activists, and visionaries. We are, after all, the principal health advocates of all our children. Let us now resolve to fight for their total civil rights. Let us not, I beg of you, settle for anything less.

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CHILD PROTECTION IN ENGLAND – EARLY INTERVENTION

Mary Welstead

CHILD PROTECTION IN ENGLAND - EARLY INTERVENTION

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CHILD PROTECTION IN ENGLAND
EARLY INTERVENTION

I. INTRODUCTION

In its first two years in office, the Coalition Government has shown itself to be concerned about, and seriously committed to improving the life of, children. It is not insignificant that several members of the Cabinet have young children and are personally aware of the importance of early intervention in children's lives. As a consequence, the Government decided to commission four major reports relating to child protection;[1] the importance of early intervention has been a key feature of all of them. Although the Government responded positively to all four reports, it gave high priority to the Munro Review and has agreed to adopt in full all of the recommendations proposed in that Review.[2]

Thus, the message being proclaimed in England as evidenced by these reports is very clear; early intervention does matter to children, their families, and society as a whole to ensure social stability.

II. THE STARTING POINT FOR CHANGE-THE DEATHS OF TWO CHILDREN

i. Victoria Climbié

In 2000, Victoria Climbié, an eight-year-old girl from the Ivory Coast was brutally killed in London, after several years of severe physical and emotional abuse, by her great aunt

[1] The four reviews are: The Munro Review which is in three parts:
https://www.education.gov.uk/publications/standard/publicationDetail/Page1/DFE-00548-2010;
https://www.education.gov.uk/publications/eOrderingDownload/Munro_Interim-report.pdf;
http://www.education.gov.uk/munroreview/downloads/8875_DfE_Munro_Report_TAGGED.pdf;
Early Intervention: The Next Steps, Graham Allen MP (2011)
http://www.dwp.gov.uk/docs/early-intervention-next-steps.pdf;
The Foundation Years: preventing poor children becoming poor adults, Frank Field MP (2010)
http://webarchive.nationalarchives.gov.uk/20110120090128/http://povertyreview.independent.gov.uk/media/20254/poverty-report.pdf;
The Early Years: Foundations for life, health and learning, Dame Clare Tickell (2010)
http://media.education.gov.uk/MediaFiles/B/1/5/{B15EFF0D-A4DF-4294-93A1-1E1B88C13F68}Tickell%20review.pdf

[2] A child-centred system - The Government's response to the Munro Review of child protection (2011),
https://www.education.gov.uk/publications/standard/publicationDetail/Page1/DFE-00064-2011

and the latter's boyfriend. The couple had tied her up for days at a time, burnt her with cigarettes and beaten her with bicycle chains, hammers and wire.

Following Victoria's death, a public enquiry, headed by Lord Laming,[3] was held. He discovered that before she died, the police, the social services department of four local authorities, the health service, the National Society for the Prevention of Cruelty to Children (NSPCC), and several local churches, were all aware of signs of Victoria's abuse but all of them had failed to act. Lord Laming's Report is a tragic story of failure on the part of the system and all those responsible for her protection.[4] His Report was, however, criticised for focusing too much on the specific case of Victoria Climbié and not on the issue of child protection in general.

As a consequence of the Laming Report, major changes in child protection policies were introduced: the Every Child Matters Initiative;[5] the Children Act 2004; the Children Act 2006; Contact Point, a Government database designed to hold information on all children in England, and the appointment of a Children's Commissioner.

ii. Baby P

Seven years after the death of Victoria Climbié, a seventeen-month-old boy, known as Baby P, died at the hands of his mother and her partner. He was found to have a number of very severe injuries. Baby P had been on the Local Authority at-risk register and had received 60 visits from social workers, police and health professionals over a period of eight months immediately prior to his death (**see Appendix I**). He had lived in the same local authority area as Victoria Climbié.

Once again, his death was followed by an enquiry headed by Lord Laming. He reported that

'Professional practice and judgment, as said by many who contributed evidence to this report, are being compromised by an over-complicated, lengthy and tick-box assessment and recording system. The direct interaction and engagement with children and their families, which is at the core of social work, is said to be at risk as the needs of a work management tool overtake those of evidence-based assessment, sound analysis and professional judgment about risk of harm.'[6]

The head of the Local Authority's children's services responsible for Baby P was dismissed and, subsequently, brought successful legal proceedings for procedurally unfair dismissal. After the court hearing she made the following public statement:

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[3] Lord Laming was the chief inspector of social services and a former social worker

[4] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008654

[5] http://www.education.gov.uk/consultations/downloadableDocs/EveryChildMatters.pdf

[6] http://www.crsp.ac.uk/downloads/publications/safeguarding/lord_laming_review.pdf

'This is much more complex than saying "You are responsible. Let's sack you and the whole psyche of the nation can be at peace". You cannot stop the death of children. Across the country there are 39,000 children on child protection registers today. As a director of children's services I cannot control what the police do, I cannot control what health does. I cannot control the fact that when a social worker rings to get an appointment at a hospital she cannot get it for four months, I cannot control the fact when a social worker is referring a child for abuse that she rings up and finds that a case has not been allocated to a police officer for four months… I am not in the blame game. I don't do blame.'[7]

Public outrage, fuelled by the popular press, demanded retribution and further Government action to ensure that there would be no repeat of such a violent death as that experienced by Baby P. The Government preferred to take a more measured approach to the reform of child protection rather than react instantly to a comparatively rare, albeit horrific, event. [8]

iii. The Government's Response to the Deaths

The Right Honourable Michael Gove MP [9] (Secretary of State for Education, whose Department has responsibility for children) reached the conclusion that much of the previous legislation, procedures and processes, put into place to protect children had failed. They had had the unfortunate effect of creating an over bureaucratised system which was more concerned with compliance on rules than with the consideration of children's needs. Major changes were urgently required and not just to protect children like Victoria Climbié and Baby P but to improve the lives of all children. However, the changes needed to be well thought out - hence the four reports.

III. THE ORGANISATION OF CHILD PROTECTION IN ENGLAND

Child protection in England is the responsibility of the Government Department for Children, Schools and Families (DCSF). It issues both statutory and non-statutory guidance to local authorities, which have responsibility (*inter alia)* for providing and coordinating services for children in the local community (**see Appendix II**).

This guidance is currently in a state of flux as significant changes are being made in response to the four reports and particularly to the Munro Review of Child Protection.

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[7] The Independent (UK), May 28 2011

[8] On average, every week in England and Wales at least one child is killed at the hands of another person. Children under one are the age group most at-risk of being killed at the hands of another person, www.nspcc.org.uk/news-and-views/media-centre/key-information-for-journalists/facts-and-figures/Facts-and-figures_wda73664.html

[9] Michael Gove is a Minister in the Right Honourable David Cameron's Coalition Government and is personally as well as professionally interested in the needs of children. He was very happily adopted at the age of 4 months and now has 2 young children of his own. He is committed to make life better for all children

IV. THE FOUR REPORTS

A. The Munro Review of Child Protection (2011)

The Munro Review is, arguably, the most important of all the four reviews on child protection. It is in three parts,[10] and makes comprehensive recommendations for the reform of child protection in England. The recommendations are based on meetings with professionals from all sectors of the child protection system and with 250 children and young people and parents, who had experienced the system. Professor Munro[11] and her team were significantly influenced by the latter's experiences. The main thrust of the Review is that children will be better protected by more interaction with professionals, and less form filling and box ticking, to assess what will help them.

In this brief review of early intervention in England, I am limiting myself to a very small part of the Munro Review which is of relevance to this topic. However, before doing so, it is necessary to look briefly at the two major principles which underpin Munro's view of child protection.

i. A Child Centred System

The Munro Review places children at the centre of any reform of child protection.[12] Professor Munro maintains most forcefully that children should not be treated as objects and moved around from placement to placement and from professional to professional with no real understanding of what is happening. This principle would seem to be self-evident, yet all too often children have been made to take a second place to bureaucracy, convenience, and simplistic solutions. The implication is that all children will be safe if only the rules are followed; of course, this is not the case.

a.) professional continuity

The message from children who were interviewed by Munro and her team was clear; in any intervention by professionals in their lives, they want continuity in their relationship with that professional. One young child had been rescued from abuse but had had to deal with 40 different people in her first 6 months in care.

b.) listen to the children

Children told the Munro team that they want to be able to talk openly about personal and painful problems, away from parents or carers, with a professional whom they have come to trust. They want professionals to explain to them what is happening and not, as one child complained, 10 minutes before an important meeting to decide her future.

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[10] See fn 1

[11] Professor Eileen Munro is Professor of Social Policy at the London School of Economics. Professor Munro qualified, and practised as a social worker for several years, before going on to gain a wide range of research experience in child protection and mental health.

[12] https://www.education.gov.uk/publications/eOrderingDownload/Munro_Interim-report.pdf

Munro recommended that in any intervention into children's lives, wherever possible and depending on their age and understanding, children's views should be taken into account. Children who have been badly treated often feel powerless and vulnerable; intervention without allowing them to voice their needs can exacerbate those feelings. Older children can speak for themselves; younger children need empathetic professionals who are able to interpret their needs for them.

c.) learn how to listen

Many professionals, Munro found, felt ill-equipped to talk with children. They lacked the necessary skills of listening, conveying genuine interest, empathetic concern, understanding, emotional warmth, respect for the child, and the capacity to reflect the child's emotions back to him or her and help them manage them,[13] not an easy task for a social worker with a work overload. Professionals should be trained to acquire these skills.

ii. A Systems Approach

Professor Munro, a keen supporter of systems theory,[14] proposed that it should be used to understand the failure of past attempts to reform child protection and to improve child protection in the future. This approach has been used in the aviation, oil and nuclear industries where the risk of human error can have disastrous consequences. Systems theory applied to those industries has shown that human error can be significantly reduced if one looks at the effect organisational factors have on an individual's performance in the workplace. [15]

a.) holism

Systems theory views problems in a holistic way. Unlike atomistic approaches, which split problems into parts and look at each one in isolation (**see Appendix III**), a systems approach asks the question *'are we doing the right thing?'* not *'are we doing the thing right?* (**see Appendix IV**)

Holism acknowledges that risk and uncertainty will always be part of child protection; it can never be completely avoided. It requires professionals to think in a radically different, and adaptive, manner. According to Munro, they must take an evaluative approach to assess all the factors which influence what they do and which affect the outcome for children. The question must be constantly asked 'what is the right thing for children?' There will be circumstances where rules should govern conduct and ones where it will be

[13] See e.g Jones DBH, Communications with Vulnerable Children. A Guide for Practitioners (London, Gaskell (2003))

[14] The Munro Review of Child Protection Part One: A Systems Analysis; Munro E, Hubbard A, A Systems Approach to Evaluating Organisational Change in Children's Social Care, (2011) British Journal of Social Work 41, 726-743; Munro E, Learning to Reduce Risk in Child protection (2010) British Journal of Social Work 40, 1135-1151

[15] In the case of the aviation industry, accidents have been reduced from 80 per million commercial departures in 1959 to 1.1 in 2000.

appropriate to break rules in order to protect a child. Those responsible for managing child protection work must decide what aspects of child protection work should be governed by rules and what aspects are better served by the autonomous judgements of those on the ground as they respond to the problems facing them. Professionals will gain feedback from their practices which will suggest that modifications, sometimes counter-intuitive ones, should be made to them in the future. These modifications will not remain fixed in time but will continue to be evaluated via ongoing feedback.

b.) Multi-Disciplinary teams

Central to the systems approach is the creation of multi-disciplinary teams of, *inter alia*, social workers, clinical therapists, health workers, and administrators. Munro recommends that there should be considerable team autonomy, and shared responsibility, in dealing with individual cases. Team members must have the ability to critically reflect on appropriate ways forward. Interaction with children will be an essential part of their work.

c.) Training for change

Munro recognises that change will not be easy for the professionals involved in child protection and that training will be essential. However, because the systems approach involves all participants in decision making, it may help them to feel motivated to do things in a different way.

iii. Early Help – The Improvement of Life Chances and the Prevention of Abuse

Munro stresses the case for early help, both in the sense of offering help early on in a child's life before any problems are apparent, and in providing help at an early stage of a problem.[16] Early help should not be aimed just at preventing abuse or neglect but at improving the life chances of children generally.

It is well established that children should receive help before they have any, or only minor, adverse experiences. Young babies, in particular, need caring adults who respond with consistency and warmth if they are to thrive and develop emotional bonds. Munro cites Allen who has explained that,

'This secure attachment with those close to them leads to the development of empathy, trust and wellbeing. In contrast, an impoverished, neglectful or abusive environment often results in a child who doesn't develop empathy, learn how to regulate their emotions or develop social skills, and this can lead to an increased risk of mental health problems, relationship difficulties, anti-social behaviour and aggression … some forms of insecure attachment are associated with significantly elevated levels of perpetrating domestic violence, higher levels of alcohol and substance misuse …' [17]

[16] http://www.education.gov.uk/munroreview/downloads/8875_DfE_Munro_Report_TAGGED.pdf (Chapter 5)

[17] http://media.education.gov.uk/assets/files/%20pdf/g/graham%20allens%20review%20of%20early%20intervention.pdf (p.12); see also, *inter alia*, Macmillan, H. et al. (2009), 'Interventions to prevent child maltreatment and associated impairment', The Lancet, Vol

Munro also cites a recent paper, published by the Royal Society, which highlights that there are changes in the brain taking place throughout life, but the number decreases with age. The worst and deepest brain damage occurs before birth and in the first 18 months of life when the emotional circuits are forming. [18]

In addition Munro puts the argument that early help is cost-effective when compared with expenditure if serious problems develop later. [19]

iv. Current Policies

Munro acknowledges that the Government has already recognised the importance of early help in improving outcomes for children by building on programmes instituted by the previous Government as well as putting new ones in place. These include:

- ***The National Service Framework for Children, Young People and Maternity Services*** which provides guidelines to promote the health and well-being of children, and mothers and to ensure the provision of high quality services to meet their needs;[20]
- ***The Family Nurse Partnership*** which has been in place since April 2007. It helps young first time mothers through a programme of intensive home visiting from early pregnancy until the child is two.
- ***The Every Child Matters: Change for Children Programme*** which is premised on early intervention;
- ***The Early Intervention Grant (EIG)*** of £2,222 million (2011–12) and £2,307 million (2012–13) is being allocated to local authorities in England to fund programmes and activities for children and families as well as specialist services where intensive support is needed;

373, pp250–266; National Research Council (2000), From Neurons to Neighbourhoods: The Science of Early Childhood Development, Washington D.C., http://www.nap.edu/openbook.php?isbn=0309069882

[18]The Royal Society, (2011), Brain Waves Module 2: Neuroscience implications for education and lifelong learning, http://royalsociety.org/policy/projects/brain-waves/education-lifelong-learning/

[19]Field F, The Foundation Years: preventing poor children from becoming poor adults (2010), http://webarchive.nationalarchives.gov.uk/20110120090128/http://povertyreview.independent.gov.uk/media/20254/poverty-report.pdf

[20] Department of Health and Department for Education and Skills (2004), National Service Framework for Children, Young People and Maternity Services, London, Department of Health, http://www.dh.gov.uk/en/%20Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4089101

- ***The Social Mobility Strategy, Opening Doors, Breaking Barriers*** aims for everyone to have a fair opportunity to fulfil his or her potential, regardless of the circumstances of their birth; [21]
- ***The Child Poverty Strategy*** aims to tackle the causes of disadvantage by breaking the vicious cycle of deprivation and a new Social Mobility and Child Poverty Commission has been established; [22]
- ***The Sure Start Children's Centre programme*** (**see Appendix V**) and the Health Visitor Programme. (The Government has committed to increase the number of health visitors by 50 per cent by 2015). Munro found that these centres have been regarded as a success story.[23] They are currently open to all families and not just ones labelled problematic, therefore, there is no stigma attached to visiting one. The centres aim to know their communities well and provide specific services for parents and children in a multiplicity of ways. They also act as hubs for multi-agency teams. Recent recommendations have been made to change the emphasis of the centres and limit help to more vulnerable families; [24]
- ***The Families with Multiple Problems Programme*** was developed to coordinate help for those families whose problems require a range of different forms of support. Evidence has shown that without coordination, these children and families can be targeted by up to 20 different professionals which is disruptive to the family and not cost effective. Coordinated family interventions can lead to a 30–50 per cent reduction in problems associated with family functioning, crime, health and education, within 12 months; [25]
- ***Charitable organisations*** have been encouraged to provide support for parents of young children. Home Start UK and Community Service Volunteers (CSV), are both involved in early intervention programmes. They use volunteers to help families where more formal intervention is unnecessary.[26] Volunteers are formally supervised by professionals on a regular basis.

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[21] HM Government (2011), Opening Doors, Breaking Barriers: A Strategy for Social Mobility, http://www.dpm.cabinetoffice.gov.uk/sites/default/files_dpm/resources/opening-doors-breaking-barriers.pdf

[22] HM Government (2011), A New Approach to Child Poverty: Tackling the Causes of Disadvantage and Transforming Families' Lives, https://www.education.gov.uk/publications/eOrderingDownload/CM-8061.pdf

[23] Department for Children, Schools and Families (2008), The Sure Start Journey: A Summary of Evidence Sharing responsibility for the provision of early help, https://www.education.gov.uk/publications/standard/Surestart/Page1/DCSF-00220-2008

[24] http://www.publications.parliament.uk/pa/cm201011/cmselect/cmeduc/768/76804.htm

[25] Department for Education (2010), Monitoring and evaluation of Family Intervention Projects to March 2010, www.education.gov.uk/rsgateway/DB/STR/d000956/index.shtml

[26] Tunstill, J. (2007), Volunteers in Child Protection: A study and evaluation of CSV's pilot projects in Sunderland and Bromley – Executive Summary, Community Service Volunteers, www.csv.org.uk/sites/default/files/ViCP%20Research%20-%20Executive%20Summary.pdf

v. Identifying Those in Need of Early Intervention

a.) problems of identification

Munro is very aware that making decisions about the future of children who are, or may be, suffering harm is often complex. Abuse and neglect rarely present in an unequivocal way, and no one wishes to accuse parents of damaging their children and put them through a stressful assessment unnecessarily. A systems approach may help professionals to make these difficult decisions.

Munro gives the example of a social worker who found that one of three children was never present when a home visit took place; the child was said to be visiting the grandmother. A judicious judgement to intervene, revealed that the child was locked in a bedroom and starving.

b.) Consequences of errors

If a wrong identification is made, the consequences can be dire.[27] Munro found that in 2009-2010, out of 603,700 referrals to children's social care services, only 39,100 were subjected to a child protection plan. Referrals tend to increase when there has been a major child death story in the media. An increase in unwarranted referrals can reduce the ability of children's social care to provide effective protection to those children who are suffering, or likely to suffer, harm or offer help to those who do not need a protection plan but, rather, some other form of help.

c.) parental cooperation or coercion

Munro recommended that *w*here a problem has been identified, strenuous efforts should be made to gain a parent's cooperation wherever possible and appropriate. Parents who voluntarily engage with support services tend to make more progress. Serious concerns, of course, may make it necessary to take a more coercive approach. When to do so is the dilemma professionals face.

d.) important agencies for the identification of children in need

- ***schools***

Schools are particularly well placed to identify children in need of help. Evidence to the Munro Review from Head Teachers was that they often have difficulty in accessing help for children about whom they have concerns. High local thresholds for intervention may mean that social care services are unable to provide the sort of help needed in comparatively low risk situations. A lack of feedback from some children's social care services means that teachers and Head Teachers do not learn how to select cases for referral more accurately, or learn how to access alternative services if, indeed, such services exist. Munro stresses the importance of alternative services to support the needs of vulnerable children, who are not in need of protection but who clearly need help, and recommends that these services be increased.

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[27] A child abuse scandal occurred in Cleveland, England in 1987, where 121 cases of suspected child sexual abuse were over-enthusiastically diagnosed by Dr Marietta Higgs and Dr Geoffrey Wyatt who were hospital paediatricians. Court hearings found that the majority of the cases were incorrectly diagnosed, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1834212/

- ***the police***

The police have a crucial role to play in the identification and support of children at risk. Patrol officers and Safer Neighbourhood policing staff, [28] are regularly involved in incidents of domestic abuse, substance misuse and mental health issues. This places them in a strong position to identify children living in those households who may be in need of early help or protection.

- ***health services***

Doctors, health visitors and nurses are also well placed to identify problems through ante-natal and post-natal programmes, and attendance of parents and children for health checks and immunisations which are available for all families.

e.) multi-agency teams

Developing multi-agency teams for responding to referrals and deciding which type of help, if any, is needed is essential. Around the country a number of areas are already developing these teams. However, Munro warns that even when such teams exist and their members are experts, they cannot guarantee that the right judgements will be made. Some cases of abuse and neglect are well concealed and there is a limit to how thoroughly family life can be scrutinised.

vi. Cooperation and Resource Sharing

Cooperation, and a sharing of resources, between all the agencies involved with children is necessary. A lack of cooperation leads to confusion, inefficiency, ineffectiveness and parents do not receive the information they need.

vii. Data Sharing

Child protection requires sharing of data. Nationally prescribed recording of information and software specifications make it difficult for local authorities to respond in an innovative way to particular problems in their own area. Any sharing of data should make it clear whether a child, where maturity permits, or their parents have consented to sharing personal and sensitive information with other services.

viii. Family drug and alcohol court

Parental substance misuse is one of the factors in up to two-thirds of all families going through care proceedings. Munro describes the workings of a pilot Family Drug and Alcohol Court which was set up in London in 2008 to confront this problem (**see Appendix VI**). It is the first such court in England and is funded by the Government and by three local authorities. The court is based on US models and aims to help parents obtain treatment so that families can stay together. Munro cites an evaluation study which found that parents who attend the court get immediate access to treatment and benefit from assistance in dealing with their other problems such as parenting abilities, housing and domestic violence. These

[28] http://www.met.police.uk/saferneighbourhoods/

parents were also found to control their substance abuse and to take advantage of other services offered by the court. There was a higher rate of family reunification for these parents than for parents outside the pilot study. It was felt that the court could also play a valuable role for families living together at the end of their treatment by the provision of a short-term aftercare service. [29] A Pre-birth assessment and intervention service, provided by a specialist team, is now being trialled by the three pilot local authorities who fund the court.

ix. Budgetary Cuts

The Munro Review expressed concern at the evidence of budgetary cuts to early support and prevention services because of the current financial situation. Since preventative services do more to reduce abuse and neglect than reactive services, the Review regards financial support of coordinating services, through community budgets, as essential.

B. Early Intervention: The Next Steps – An Independent Report to Her Majesty's Government, Graham Allen MP (2011)

In January 2011, Graham Allen MP presented a cross-party report to the Government on Early Intervention (Allen capitalises the expression deliberately to denote its specialised meaning in his report as help for young children, and help to enable older children to become good parents). [30] Allen had grown up in, and become MP for, one of the most deprived constituencies in England, and was affected by witnessing the waste of so many children's lives which could have been prevented by investment in early intervention.

i. Benefits of Early Intervention

The Report is lengthy, some 155 pages, and much of it is based on other researchers' evidence relating to the social and economic benefits of early intervention. Allen stresses that Early Intervention

'… has impacts way beyond the individual and family concerned: every taxpayer pays the cost of low educational achievement, poor work aspirations, drink and drug misuse, teenage pregnancy, criminality and unfulfilled lifetimes on benefits. But it is not just about money – important as this is, especially now – it is about social disruption, fractured lives, broken families and sheer human waste'. [31]

He views Early Intervention as low in cost, high in results, and with long-term beneficial effects on children. The social and emotional foundation it provides helps to keep them happy, healthy, and achieving throughout their lives. It breaks the cycle of broken families and social disruption by equipping children to raise their own families. It also reduces public spending in the long-term. Yet, he found that the provision of Early

[29] www.nuffieldfoundation.org/evaluation-pilot-family-drug-and-alcohol-court

[30] Allen's second report (July 2011), Early Intervention:Smart Investment, Massive Savings, discusses the financial implications of Early Intervention, http://grahamallenmp.files.wordpress.com/2011/01/406540_earlyintervention_acc.pdf

[31] Ibid at ix

Intervention programmes to be patchy and, too often, overwhelmed by institutional and financial obstacles. There tended to be a bias in favour of late intervention when social problems were already well entrenched, even though these policies are known to be expensive and of limited success.

ii. *The Recommendations*

- Adoption of the concept of the foundation years of 0-5 (including pregnancy), and give it the same status as primary or secondary education;
- View education as a continuous cycle which prepares children to be the parents of the next generation;
- Improve the capabilities of those working with 0-5 year olds;
- Set up a National Parenting Campaign and provide parents with the information and support they need to help their children;
- Ensure that children are genuinely ready for school;
- Increase general awareness of the importance of Early Intervention and develop an Early Intervention culture;
- Place Early Intervention at the centre of all child related issues;
- Improve the effectiveness of staff such as teachers, social workers, nurses and doctors, and of existing policies and infrastructure;
- Provide data and measurement tools necessary to help identify those in need and to track progress;
- Create the right financial freedoms for local areas to pool budgets and work across agencies to tackle shared problems and share data relating to Early Intervention; [32]
- Evaluate the cost effectiveness of Early Intervention programmes; [33]
- Local decision making about content of Early Learning Programmes;
- An Early Intervention Foundation, independent of the Government, to be set up and funded by private investment to encourage the spread of Early Intervention programmes and assess them. The Foundation would also be responsible for private fundraising for investment in Early Intervention.

iii. Pilot Study: Croydon Total Place

Allen describes the pilot study in which Croydon Council and NHS Croydon undertook a review into a child's journey from conception to age 7, both from their perspective as service providers and from that of the client families. The understanding gained from the review made them change their vision for the future and invest in Early Intervention.

a.) the pilot study's proposals:

- Geographically based Family Engagement Partnership Teams;
- An Early Years Academy to train staff;
- The Croydon Family Space Web Service which provides information for families.

b.) the task of the Family Engagement Partnership Teams

- Identify and respond to the wider needs and vulnerabilities of mothers, and direct them to social networks for support;

[32] Ibid at xvii
[33] Ibid Appendix B

- Look out for early warning signs such as missed medical and other family welfare appointments and follow them through;
- Take particular care of the most vulnerable parents, such as teenagers, via the Family Nurse Partnership.
- Spot early, and respond quickly to, needs in areas such as attachment problems, motor skills, emotional and behavioural issues, speech and language, maternal mental ill health, and domestic conflict and refer clients to appropriate services which will be made available;
- Identification and response to take place well before children were believed to be at risk;
- Address any gaps in childhood development before a child starts school.[34]

iv. Reaction to the Allen Report

The chief executives of 26 local authorities have agreed in principle, and subject to Government approval, to sign up to putting Early Intervention at the centre of their strategies and to start to implement some of the recommendations from the Allen Report.

C. The Foundation Years: preventing poor children from becoming poor adults: The Report of the Independent Review on Poverty and Life Chances, Rt Hon Frank Field MP (2010)

In December 2010, Frank Field [35] presented an independent review on poverty and life chances to the Prime Minister.

i. A New Approach

Field maintains that the issue of child poverty needs to be addressed in a fundamentally different way from past efforts. Simply providing extra income for poor people is insufficient to make any real changes to a child's life chances as an adult. He found overwhelming evidence that

' … children's life chances are heavily predicated on their development in the first five years of life. It is family background, parental education, good parenting and the opportunities for learning and development in those crucial years that together matter more to children than money, in determining whether their potential is realised in adult life. The things that matter most are a healthy pregnancy; good maternal mental health;

[34] NHS Croydon and Croydon Council (2010) Child: Family: Place: Radical Efficiency to Improve Outcomes for Young Children, http://www.croydon.gov.uk/contents/departments/democracy/pdf/617342/child-family-place.pdf

[35] Frank Field MP has spent most of his adult life involved in the prevention of poverty, first at the Child Poverty Action Group and later as an MP

secure bonding with the child; love and responsiveness of parents along with clear boundaries, as well as opportunities for a child's cognitive, language and social and emotional development. Good services matter too: health services, Children's Centres and high quality childcare…the most effective and cost-effective way to help and support young families is in the earliest years of a child's life.'[36]

Field found that although a range of services exist which support parents and children in their early years, they are fragmented, not well understood and not easily accessed by those who might benefit most. There was also a lack of clear evidence as to which services provided the best returns.

ii. A Set of Life Chance Indicators

The Reports overarching recommendations are that a set of Life Chance Indicators should be developed to measure how successful the country is at making life's outcomes for children more equal, and that parents must be enabled to achieve the aspirations they have for their children. To drive this policy, Field proposes:

- That a programme, The Foundation Years, be established which would cover the period from 0-5. The programme would become the first stage of a tripartite system of education (**see Appendix VII**);
- An increase in the public understanding of the importance of early development is essential;
- The Government should gradually move funding towards early childhood and weight it in favour of the most disadvantaged children;
- All disadvantaged children should have access to affordable, full-time, graduate-led childcare from the age of two which would help parents returning to work as well as aid child development;
- Sure Start Children's Centres should re-focus on their original purpose and provide targeted help for disadvantaged families and the financing of them should depend on this;
- Local Authorities should open up Children's Centres or services within them and ensure that there is not waste by a replication of existing services. These centres should become the hub of the local community and include parenting classes for all new parents. Midwives and health visitors would work closely with the Centres. Some services for non-disadvantaged children should be provided to avoid stigmatising those who are disadvantaged but it is the latter who should be targeted via pooled data which track them;
- Services provided should be ones which have been evaluated for their effectiveness;
- Non-working parents should spend one session a week with their children in the nursery which the children attend.
- Parenting skills should be included in the school curriculum;
- Local Authorities should join together to establish Life Chances Commissions to drive policy;

[36] http://webarchive.nationalarchives.gov.uk/20110120090128/http://povertyreview.independent.gov.uk/media/20254/poverty-report.pdf at p.5

- The Government should develop and publish annually a measure of 'service quality' to provide evidence of whether children, particularly in low income families, have access to high quality services. [37]

D. The Early Years: Foundations for life, health and learning, An Independent Report on the Early Years Foundation Stage, Dame Clare Tickell (2010)

i. A Statutory Framework for the Early Years Foundation Stage (EYFS) (2008)

EYFS was introduced in 2008 to ensure that every child could have the best possible start in life and support to fulfil their potential. It was based on the belief that a child's experience in the early years has a major impact on his or her future life chances. It set the standard for:

- The learning, development and care young children should experience when being cared for outside of their family home, to ensure that every child makes progress, that no child gets left behind, and to end the distinction between care and learning;
- An inspection and regulation regime;
- Equality of opportunity and anti-discriminatory practice;
- A partnership between parents and professionals, and between all the out of home settings that the child attends;
- The provision of information for parents via a website;
- The establishment of a secure foundation for future learning through learning and development that is planned around the individual needs and interests of the child, and informed by the use of ongoing observational assessment;
- The provision of an e-Profile for each child throughout his or her first year at school to support the making of final judgements for EYFS profile.

ii. Improving EYFS

Although EYFS has proven to improve the outcomes for children, 44% of children are still not considered to have reached a good level of development by the end of their 5th year. Criticisms have also been made that EYFS is too bureaucratic and prescriptive.

In 2010, the Tickell Report considered the criticisms that had been made of EYFS. It makes recommendations which would help to improve problematic areas. Some of these have been put in place to commence in 2012. The reports main recommendations include:

- Redrafting the framework to make it easier to understand;
- The provision of a high quality and interactive online version of the framework;

[37] Ibid pp 5-9

- The provision of information for parents about EYFS which also emphasises their role as partners in children's learning;
- The prime areas of learning should be personal, social and emotional development, communication and language and physical development; these skills should be applied to literacy, mathematics, expressive arts and design and understanding the world;
- All those involved in providing early care for children should provide, on request from parents (or their substitutes), at some point between the child's| 2nd and 3rd year, a short written summary of their child's development; the summary could be put into the child's early health record (the Red Book) ;
- Paperwork should be kept to a minimum;
- Different approaches to assessment should be made for children with special needs;
- Assessment of children should be based primarily on observation of children in their daily activities;
- An investigation should take place into how children's English language skills can be improved;
- How to keep children safe should be made more explicit;
- Staff children ratios in the first year of school should be improved;
- The long-term aim that early childhood education should become a graduate profession should be retained.

V. EARLY INTERVENTION AND ADOPTION

Where children have to be removed from their family on a permanent basis, it is important that early action is taken to provide them with a new permanent home preferably by way of adoption.

i. Action Plan for Adoption

In March 2012, the Government published its Action Plan for Adoption which is the first stage of a larger programme of reforms for children in care. The Plan centres on speeding up the process of adoption, overhauling the system for prospective adopters, and improving the performance of local authorities who are responsible for adoption. [38]

[38] Michael Gove, the Minister responsible for the new proposals on an adoption has talked movingly and positively about his own experiences as an adoptive child and his determination to improve the prospects for children in need of a home,

'And it's because I know what an amazing thing it is to be an adoptive parent, and how much being brought up in the right home meant for my life, that I want more children to have the opportunities I enjoyed. But one of the tragedies of our times is that while the number of children who need love, stability and security is higher than ever, finding them an adoptive family has become more difficult than ever.
That's not because there is any shortage of men and women who want to give disadvantaged children a secure family life. It's because we have inherited a system that embodies so many wrong values and desperately needs reform.
Children in dysfunctional homes at risk of abuse are kept in danger for too long because politically correct rules mean we won't challenge unfit parents.

ii. The Plan's Proposals

The Plan's Proposals include:

- Legislation to reduce the number of adoptions delayed to achieve a perfect or near ethnic match between adoptive parents and the adoptive child;
- Swifter use of the National Adoption Register to find the right adopters for a child wherever they might live;
- Encourage all local authorities to attempt to place children with their potential adopters in anticipation of the court's placement order;
- Radically speed up the adopter assessment process so that two months are spent in training and information gathering - a pre-qualification phase -followed by four months of full assessment;
- Introduce a "fast-track" process for those who have adopted before or who are foster carers wanting to adopt a child in their care;
- Develop the concept of a 'National Gateway to Adoption' as a reliable source of advice and information for those thinking about adoption;
- Measure improvements in tackling delay across the system, through a new performance scorecard. [39]

This last proposal has been criticised as an over-bureaucratic approach which fails to take into account the complexity of placing older children who may have problems.[40]

VI. CONCLUSION

In October 2011, the Government broadly welcomed the recommendations of the Allen Report, the Field Report and the Tickell Report; it had already accepted in entirety all the

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When children at risk are rescued, they are left in temporary care for months on end. Judges who have enjoyed all the advantages of a privileged upbringing then take forever to decide the fate of the most disadvantaged children in the country.
And adults who long to invest love and care in children who have been starved of affection all their lives are denied the chance to become adoptive parents for trivial reasons. So generous-hearted adults who smoke, are overweight or have a certain skin colour aren't allowed to give children a second chance in their own families — while feckless and capricious individuals who may be bringing up children in homes scarred by violence, abuse and neglect are allowed to keep children imprisoned in squalor and condemned to misery.'
*(*http://www.dailymail.co.uk/news/article-2057850/Michael-Gove-describes-adoption-transformed-life.html#ixzz1nhl2hGC1)

[39] http://www.education.gov.uk/inthenews/inthenews/a00205135/action-plan-sets-out-radical-overhaul-of-adoption-system. Further proposals will be published later in the year

[40] The Times UK, March 23 2012

proposals of the Munro Review.[41] However, change is not only in the hands of the Government; it is dependent on all those who work in child protection. Change is never straightforward and is so often resisted in favour of the status quo. As Machiavelli has pointed out,

> *'And let it be noted that there is no more delicate matter to take in hand, nor more dangerous to conduct, nor more doubtful in its success, than to set up as a leader in the introduction of changes. For he who innovates will have for his enemies all those who are well off under the existing order of things, and only the lukewarm supporters in those who might be better off under the new. This lukewarm temper arises partly from the fear of adversaries who have the laws on their side and partly from the incredulity of mankind, who will never admit the merit of anything new, until they have seen it proved by the event.*[42]

The recommendations of four major reports in two years are perhaps too many to take on board for those involved in the organisation of child protection at a local level. Too much information and suggestions for innovation can lead to a feeling of overload and a sense of despair over whether such major changes are possible. There is a danger that these feelings will lead to minimal action or even non-action.

In a time of economic austerity, demands for change may also be delayed by claims that evaluation of the effectiveness of pilot projects, and a cost benefit analysis of them, must be undertaken first.

In spite of these concerns, there are already signs of a positive move towards early intervention by those working at the forefront of child protection.

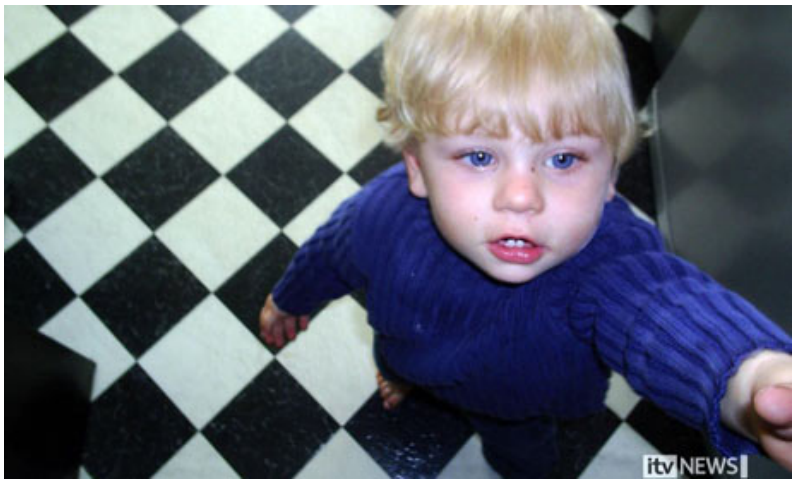
CAP Fellow and CAP Graduate Program Coordinator
Visiting Professor University of Buckingham, England

[41] http://www.education.gov.uk/childrenandyoungpeople/earlylearningandchildcare/early/a00192398/supporting-families-in-the-foundation-years; see also Appendix Supporting Children in the Foundation Years

[42] The Prince Ch V1 v4 (The Harvard Classics 1909–14)

APPENDIX I
DEATH OF BABY P **(see page 2)**

Baby P's abuse, contact with child protection and death, the trials of his mother and stepfather and the doctors and social workers involved in the case



2006

1 March: Baby P, Peter, is born.

17 July: His father leaves the family home in Haringey.

November/December: Unknown to professionals involved in the case, the mother's new boyfriend moves in to the home.

11 December: His mother and maternal grandmother are arrested after a GP spots Peter has a head injury and other bruises.

22 December: Peter is placed on the Haringey child protection register for physical abuse and neglect.

2007

26 January: Peter is returned to his mother, though she is still on police bail.

9 April: His mother takes him to North Middlesex hospital. Staff identify bruises and scratches on his face, head and body.

1 June: Social worker Maria Ward informs the police of bruising on Peter's face during an unannounced visit. Staff at North Middlesex hospital find 12 areas of bruising. Social services arrange for a family friend to supervise the baby's care.

29 June: Jason Owen moves into the home with a 15-year-old runaway girl.

25 July: At a legal planning meeting it is decided that the case did not meet the threshold for care proceedings.

30 July: Ward makes her last visit to see Peter. He has chocolate smears over his face and hands, and anti-bacterial cream on his scalp.

1 August: Peter is taken to St Anne's hospital. Dr Sabah al-Zayyat notes bruises to his body and face but does not perform a full examination because he is "miserable and cranky".

2 August: Police tell the mother she will not be prosecuted in relation to Peter's injuries.

3 August: Following a 999 call, Peter is taken to hospital but pronounced dead on arrival.

2008

August: Dr al-Zayyat is banned from working unsupervised by the General Medical Council for 18 months.

11 November: Owen and the 32-year-old boyfriend of Peter's mother are found guilty of causing Peter's death. The mother had pleaded guilty to the same charge.

1 December: A independent review declares Haringey's child protection services to be exceptionally "inadequate". Council leader George Meehan and cabinet member for children and young people Liz Santry resign. The children's secretary, Ed Balls, orders the removal of the director of children's services, Sharon Shoesmith, from her post. She is sacked later that month.

2009

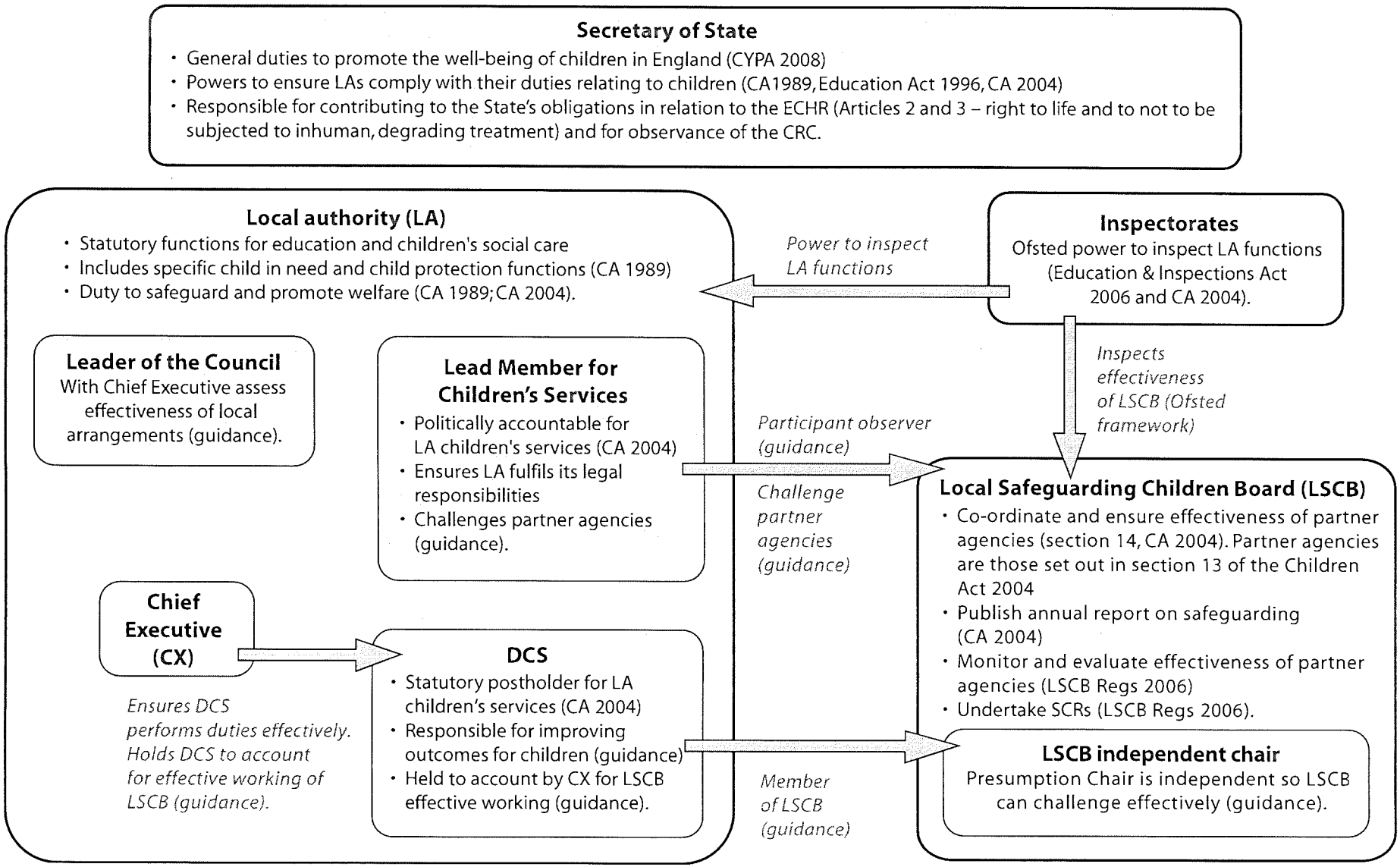
19 February: Dr Jerome Ikwueke, a GP who saw Peter 14 times before his death, is suspended by the GMC.

29 April: Haringey council dismisses a social worker and three managers for failings in Peter's case.

1 May: The boyfriend of Peter's mother is convicted of raping a two-year-old girl in north London.

22 May: The second serious case review into Peter's death concludes that child protection staff should have been able to stop the abuse "at the first serious incident". The boyfriend of Peter's mother is jailed for life. His mother is jailed indefinitely. Owen, the lodger, is given an indeterminate sentence for public protection.

ORGANISATION OF CHILD PROTECTION IN ENGLAND



APPENDIX III
THE MUNRO REVIEW – A HOLISTIC APPROACH **(See page 5)**

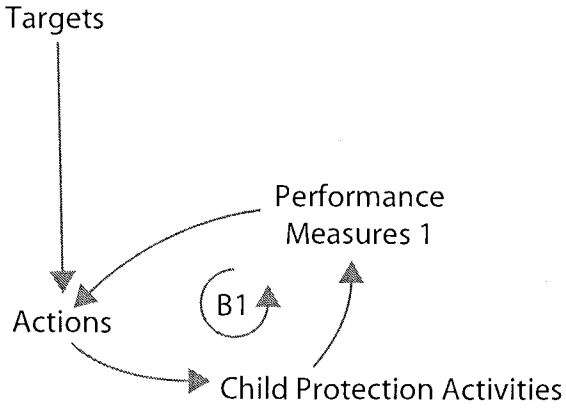
	Atomistic Approach To Child Protection	Holistic Approach To Child Protection
Nature	• Narrow: tending to concentrate on individual parts or elements	• Broad: elements seen as standing in relation to each other
Perspective	• Isolated 'problems'	• Whole system
Cause and Effect	• Looking only at immediate and/or proximal effects • Short chains of causality	• Separated in space and time • Long chains of causality, ripple effects, unintended consequences, feedback effects
Style of Recommendations	• Regulation and compliance • Technocratic	• Strengthening professionalism • Socio-technical
Results (observed and sought)	• Narrow range of responses to children's and young people's needs • Defensive management of risk • Command and control management; frameworks and procedures; squeezing out professional discretion • Compliance culture • Focus on standardised processes, frameworks and procedures	• Requisite variety in responses to meeting children's and young people's needs • Acceptance of irreducible risk • Supportive and enabling management • Learning culture • Focus on children, their needs, appropriate pathways beneficial outcomes

APPENDIX IV

THE MUNRO REVIEW – DOING THE RIGHT THING v. DOING THE THING RIGHT

(See page 5)

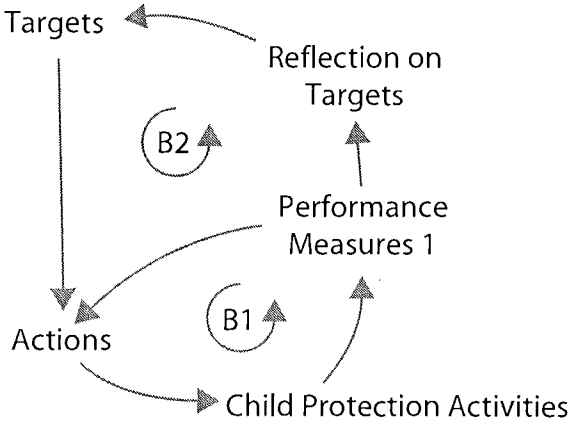
Single loop: Child Protection System – Are we doing what is specified?



1.18 This can be contrasted with the broader, more reflective learning approach that is a characteristic of holistic thinking. This is double loop learning, in which the question that is being asked is: *have we specified the right thing to do?*

1.19 With double loop learning a second loop uses the value of the performance measure to reflect on whether the correct target for the child protection system has been set. This new balancing loop – B2 – allows the target itself to be changed, or updated as the system 'learns' more about what a sensible target might be.

Double loop: Reflective Child Protection System – have we specified the right thing to do?



1.20 The review will question whether we have done too little double loop learning, i.e. standing back and reflecting on whether we have got the balance right in the demands made on social workers and other professionals and the resources provided to help them.

APPENDIX V
THE MUNRO REVIEW - THE SURE START CHILDREN'S CENTRE PROGRAMME
(See page 8)

Sure Start Children's Centres

Children's centres provide a variety of advice and support for parents and carers. Their services are available to you from pregnancy right through to when your child goes into reception class at primary school.

How children's centres can help you

There are more than 3,600 children's centres in England. They bring all the different support agencies together to offer a range of services to meet you and your child's needs, all in one place.
They're somewhere your child can make friends and learn as they play. You can get professional advice on health and family matters, learn about training and job opportunities or just socialise with other people.

Services children's centres must offer

Children's centres are developed in line with the needs of the local community so no one children's centre is the same. However, there is a core set of services they must provide:

- child and family health services, ranging from health visitors to breastfeeding support
- most centres offer high quality childcare and early learning - those that don't can help advise on local childcare options
- advice on parenting, local childcare options and access to specialist services for families like speech therapy, healthy eating advice or help with managing money
- help for you to find work or training opportunities, using links to local Jobcentre Plus offices and training providers

Other services you might be offered

The services available to you will depend on your local area. At many children's centres you can:

- see a dentist, dietician or physiotherapist
- visit the 'stop smoking' clinic
- get faster access to expert advice, support and short-term breaks if your child has learning difficulties or disabilities
- talk to Citizens Advice
- take parenting classes
- improve your English if it is not your first language - with someone from your own culture

APPENDIX VI
THE MUNRO REVIEW – THE FAMILY, DRUG AND ALCOHOL COURT **(See page 10)**

Case Study

Findings from the Brunel University independent evaluation of the Family Drug and Alcohol Court

The Family Drug and Alcohol Court (FDAC) is a new approach to care proceedings, in cases where parental substance misuse is a key element in the local authority decision to bring proceedings. It is being piloted at the Inner London Family Proceedings Court. It began in January 2008 and runs until March 2012. It is funded by the Department of Education, the Ministry of Justice, the Home Office, the Department of Health and the three pilot authorities (Camden, Islington, and Westminster). It is the first court in England and Wales to take a problem-solving approach to care proceedings.

FDAC has a specialist multi-disciplinary team attached to the court which includes adult substance misuse workers, child and family social workers, and adult and child psychiatrists. Team members use a variety of methods, including motivational interviewing, to engage parents. Reflective practice is used to promote objectivity. The team works closely with the network around the family and coordinates the different parts of the plan. Regular planning meetings with parents, social workers and other professionals help promote a clear division of responsibilities and avoid duplication. At court, the same judge deals with the case throughout and regular court reviews of parents' progress are held without the presence of legal representatives.

The independent evaluation conducted at Brunel University by Professor Judith Harwin, Mary Ryan, Jo Tunnard, Dr Subhash Pokhrel, Bachar Alrouh, Dr Carla Matias and Dr Sharon Momemian-Schneider, funded by the Nuffield Foundation and the Home Office, indicates that this problem-solving court approach is more successful than ordinary court and service delivery in engaging parents with lengthy substance misuse histories. The majority of families had been known to children's services for many years and had multiple psychosocial problems.

The study tracked all cases entering FDAC in the first 18 months of the pilot and compared them with cases involving substance misuse entering ordinary care proceedings at the same time. Of these, 41 FDAC and 19 comparison families reached final order by the end of the fieldwork period.

The evaluation found that:

- More FDAC parents had stopped misusing drugs or alcohol at the end of the care proceedings than those in the comparison group (48 per cent v 39 per cent mothers and 36 per cent v 0 per cent fathers):

- As a result, family reunification at the end of proceeding was 18 per cent higher in FDAC than comparison cases: 39 per cent of FDAC mothers were reunited with their children by the final court order, compared with 21 per cent in the comparison group. A follow-up study will examine the longer-term outcomes in cases where children went home;
- FDAC parents accessed substance misuse services more quickly, received a broader range of services, and were more successful at staying in treatment throughout the proceedings. More FDAC parents received help from housing, benefits and domestic violence services;
- There was more constructive use of court time and few contested hearings. When parents could not control their substance misuse, children were placed more quickly in an alternative permanent family (on average seven weeks quicker);
- There were cost savings to local authorizes, and potential savings identified for the court and the legal services commission. The average cost of the FDAC team per family is £8,740 over the life of the case. This is off-set by the savings to local authorities from more children staying within their family. FDAC also reduced costs through:
  - shorter care placements (£4,00 per child less);
  - shorter court hearings and fewer hearings with legal representatives present (saving local authorities £682 per family):
  - fewer contested cases: and
  - savings in the work of the specialist team that is equivalent to the work carried out by experts in ordinary care cases (£1,200 per case less).
- All but two of the 36 parents interviewed would recommend FDAC to other parents. They particularly liked the emotional and practical support from the FDAC team and seeing the same judge every time. All the professionals considered FDAC to be a better approach than ordinary care proceedings and were clear that it should be rolled out. So did the parent mentors.

A small-scale study can make only tentative suggestions about what lies behind its results. But the single biggest difference between FDAC and comparison cases was the receiving of FDAC by parents in the pilot authorities. Otherwise, the families were very similar. The FDAC specialist multi-disciplinary team is now trialling a pre-birth assessment and intervention service in the three pilot local authorities. This aims to improve outcomes through earlier intervention at a pre-court stage.

Given research evidence on the fragility of reunification when parents have misused substances, the evaluation has recommended that a short-term aftercare service from FDAC should be developed, to help parents sustain their recovery and continue providing safe care.

Parental substance misuse is a significant factor in up to two thirds of all care proceedings and, according to a London survey, was the most frequent parental factor in long-term children and family social work, affecting 34 per cent of all cases.

APPENDIX VII
THE FIELD REPORT – THE FOUNDATION YEARS SERVICE **(See page 14)**

To start we might think about what the Foundation Years would ideally look like from the point of view of a family – let us call them Ella and John – going through the challenge of raising a young child on a low income. Ella is not in work and John is in a low paid job, this is their first child, and they do not have a large family support network nearby (Ella's parents live a couple of hours away, and John has fallen out with his parents).

On finding out she's pregnant Ella goes to her GP surgery where she's referred to the midwife. She sees the midwife eight or nine times through her pregnancy, with John also invited along to the visits where Ella is comfortable. The midwife tells Ella about the early years Fairness Premium, which allows families on a low income to access a package of additional services, including early education and childcare which gives Ella and John time away from caring, free books, etc. The midwife also explains that they would like to share some selected information with the Children's Centre so that services can run more smoothly, which Ella agrees to (she thought this happened anyway).

The midwife books Ella and John onto a local "Preparation for Parenthood' ante-natal group, which includes the opportunity to meet other parents and learn about the importance of early attachment and caring for a new baby. The group is held at the local Children's Centre where they can meet their health visitor – and the parents are shown around the Centre and the facilities. The staff talk to the parents about its range of services, make sure they feel welcome, and let them know what services they are entitled to and what is paid for:

Some ante-natal classes are held in other premises, but someone from the Children's Centre comes along to introduce themselves. Ella and John are also introduced to their health visitor at this session. (For people who miss the ante-natal class there are other opportunities to meet up with the health visitor and key Children's Centre staff.)

The prospective parents are talked through the main routes of support:

- The Children's Centre, which provides a hub which most services can either be accessed from, or signposted to. Many appointments are either at the Children's Centre or the local GPs Surgery.

- A health visitor, with the midwife, who provide expert guidance on caring for a new baby and helping them make the transition to parenthood along with a team of professional workers and volunteers. The team is focused on people who have problems attending the Children's Centre, or families who may need extra support. The team has good links with the local GP's surgeries and the Children's Centre. Each family gets the chance to build up a relationship with the health visitor and their team.

- Voluntary support which supplements the formal support and provides either less formal help, or, with supervision, support for parents statutory services cannot get to. This will take different forms in different local areas, but Children's Centres and health visitors help to build up capacity in the sector.

The most important people for Ella and John are their friends and family. The ante-natal group builds friendships so they meet outside the formal group and support each other. The same group is also invited to follow up meetings, including on breastfeeding. A volunteer from a local parents' group comes along to encourage the future parents to meet regularly. There is also a volunteer community parent scheme, which provides low level support to new parents (supplementing health visitors).

Ella gives birth in a local hospital.

A health visitor comes to see Ella, John and Aiden soon after the birth at their home. The health visitor books the visit for a time when John can make it. She talks Ella through some tips for continuing to breastfeed. Ella has found it difficult but wants to keep trying as she knows how important it is for her baby. The health visitor puts her in touch with a local peer support group, and visits regularly over the next couple of weeks to support the family. The health visitor encourages Ella and John to go back to their 'Preparation for Parenthood' group which is continuing until all the babies are six weeks old. They think they may then join the positive parenting course run by the Children's Centre. (All parents are asked whether they want to go on one of these, but the health visitor makes more effort with young parents, or parents in more challenging circumstances.)

Ella and John register the birth at the local Children's Centre. After the registration, a family benefits advisor, based in the centre, checks whether they need any help with child benefit or other forms, and checks they know about the service facilities and parenting courses.

They discuss again the importance of early attachment and talking to young children. Ella and John are struggling with the additional work of bringing up Aiden. The Health visitor notes this and makes sure they are visited every month to check they are OK: that feeding is going OK, and to keep encouraging them to play with Aiden. The health visitor becomes less frequent when they notice that Ella and John are coping better and regularly going to the Children's Centre (so Centre based services can provide more of the support).

The Children's Centre staff talk to Ella and John around Aiden's first birthday (and around subsequent birthdays) about what the second year may be like, and what new challenges they are likely to face. The health visiting team review all children before their first birthday and are on hand if needed in between.

The family move house when Aiden is one and a half, moving out of the catchment area of the local Children's Centre. The Local Authority collects Housing Benefit records, and Children's Centre attendance records are part of its data system. It uses these to identify that the family has moved. Someone from the health visiting team goes to see them and invites them to their nearest Children's Centre and helps make sure support is as seamless as possible.

The Children's Centre regularly consults the parents on what it offers, while giving them a simple overview on the evidence behind different elements of what it does.

From age two Aiden gets a free early education place for 15 hours a week. (There is some free early education for children younger than two who key workers think will benefit from it.) Ella is encouraged to use some of that time to start working towards a qualification. The staff at the nursery support Aiden's learning through play. They invite Ella and John to spend a couple of hours in the nursery every couple of months to see what the nursery staff are doing and discuss what the parents can do to help their children. Ella has always struggled with reading and so has not read to Aiden: the nursery staff discuss this with her, encourage her to sign up to an adult skills course and show her how she can tell stories to Aiden using picture books.

There is a café in the Centre which is run as a local social enterprise. Ella volunteers at this for two mornings a week while Aiden is in childcare. She gets to know more people from volunteering and feels more comfortable about applying for work as Aiden gets older. Some other parents volunteer with the stay and play services at the crèche (although these services remain professionally led). A small number of parents gain qualifications through the work they do volunteering.

At two and a half Aiden has a development check with a health visitor. This looks at his health, cognitive and social and emotional development. It is used to provide pointers where development is not as strong as it should be. The information is also aggregated up and used to understand how children in the area as a whole are progressing, feeding into the overall assessment of the Children's Centre (and the part of their payment that is related to results).

At the development check the health visitor notes that Aiden's speech is not developing as fast as would normally be expected. The health visitor uses part of the Fairness Premium for Aiden to access one session a week with a speech therapist, and – with Ella and John's agreement – speaks with staff at Aiden's nursery about how they can help support Aiden's language development.

As Ella gets more confident she volunteers as a community parent providing support and information to other new parents in the community.

As Aiden approaches school age, the family gets invited to look round the local primary school and are talked through the changes. The Children's Centre knows that the school will be conducting Aiden's development check when he starts school and that the results will help determine the Children's Centre's budget. The Children's Centre and school have good relations and pass on information so that the school knows how Aiden has been doing up to that point.