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Innovations in the Field of Child Abuse and Neglect Prevention: A Review of the Literature

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September 2012

maltreatment prevention

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Introduction

Child maltreatment prevention policy and practice have been driven by a continuous stream of innovation generated by researchers, advocates, and practitioners working across disciplines to improve child safety and well-being. Settlement homes were established in the late 19th century, social work was professionalized in the early 20th century, child abuse injuries were identified and findings published by pediatric radiologist John Caffey and pediatrician Henry Kempe in the 1960s, and the federal government passed the Child Abuse Prevention and Treatment Act of 1972. Progress in the field has always been determined by the diligence of thought leaders in a multitude of professions and the collaboration of diverse and unlikely partners (Myers, 2011, p. 1166). Today, the nation faces an excruciating economic climate, and many parents find it hard to meet their children's most basic needs. Simultaneously, political pressure is mounting to cut social services and reduce government spending, and, as a result, there is a demand for child maltreatment prevention interventions to be founded on an evidence-based framework and for program efficacy trials that show positive outcomes for children, parents, families, and communities. Rigorous evaluations rely on experimental designs that are expensive to conduct. Regrettably, findings from such evaluations are often disappointing.

Despite these challenges, promising interventions continue to be developed and tested, particularly those that address early childhood development and provide services to new parents and newborns. Among these options, particular promise has been observed among various home visiting programs, which have demonstrated effectiveness in reducing maltreatment rates and harsh parenting, promoting positive child development, and strengthening parental capacity (Daro, 2011). Additionally, some center-based parent training efforts and universal school-based child sexual abuse prevention programs have shown positive results (Mikton & Butchart, 2009). These successes are tempered by the knowledge that the most vulnerable and marginalized families remain difficult to reach and engage. Important questions have yet to be answered about how isolated families can be targeted and enrolled in voluntary programs. These

families can be distrustful of outsiders or simply unable to participate for a great number of reasons—fear of child protective services, a lack of cultural understanding and humility demonstrated by professional and paraprofessional program staff, and/or barriers caused by a deficit of time, food, shelter, and basic health care. Although interventions that benefit individual participants are an important step, more strategic efforts are needed to create pathways to the most vulnerable while providing a more effective and comprehensive universal system of care for all.

Until now, experts have understood the prevention field within the context of Uri Bronfenbrenner's ecological model (Daro & Dodge, 2009). Under this model, many factors influence the behavior of the individual, and therefore, the prevention of maltreatment requires a complex set of supports within a larger system of services. This theory has led to the identification of both protective and risk factors that can either buffer families against stressful circumstances or increase their chances of suffering from various forms of abuse and neglect. Despite this understanding, the efforts of most researchers, policymakers, and practitioners have focused on the development, implementation, and measurement of specific interventions and their effects on individual outcomes. Programs founded on a clear theory of change with services targeting a limited number of causal factors are associated with higher rates of success, and—until now—researchers have had difficulty designing experiments that are able to link causality between programs and outcomes on multiple ecological levels (Daro, 2011). On the other hand, successful interventions cannot have a lasting impact if they are not part of a strategic plan that links programs within a system of services. Experts today recognize the need for broad community prevention initiatives (Daro & Dodge, 2009). Such efforts will require improved communications and understanding of communities—aspects of unique cultural characteristics and existing social capital and networks. This approach presents a great challenge to researchers attempting to design experiments and develop methodologies that will help us to better measure and understand the influence of context.

Moving forward, experts in the field of child abuse and neglect prevention face many external challenges, but they also draw on a vast body of existing knowledge and many bright spots of innovation. Technological advancements in social media and improved access to the internet present exciting new opportunities to engage parents, provide information while maintaining privacy, and increase contact. Additionally, much can be learned from successes and failures in other fields, and these events will continue to inform the work of maltreatment prevention just as they have throughout history.

The purpose of this paper is to take stock of where the field is today and to identify areas that offer rich opportunities for doing better. We examined work that had specifically focused on improving our understanding of child abuse and neglect as well as efforts that focused on deepening our understanding of basic human development, effective program planning, and promising systemic reforms. After briefly

presenting our methodological approach, the paper arrays our core findings in terms of eight promising trends or lines of learning. These trends include:

- Advances in neuroscience highlight the negative impacts of poor parenting and stress on a child's developing brain.
- Social context and culture can protect the developing child and strengthen parental capacity in important ways that can buffer against individual and contextual risk factors.
- Promising community prevention strategies create new opportunities and challenges in intervention design, implementation, and evaluation.
- An increasing number of federal policy initiatives are directing public investments towards evidence-based programs.
- New research findings continue to underscore the importance of addressing the needs of new parents and young children.
- Implementation science offers program managers effective research frameworks to monitor and strengthen the service delivery process and to improve the odds of replicating model programs with fidelity and quality.
- Maximizing population level change requires new understanding of how to construct and sustain effective state systems, local community collaboratives, and robust community-based organizations.
- New technologies offer important, cost-effective opportunities for advancing our reach into new populations and supporting direct service providers.

Although these are not the only areas which hold promise in improving our capacity to better target, design, and monitor child abuse prevention efforts, they collectively provide a solid platform for integrating research across disciplines and policy domains. The final section of the paper discusses some of these opportunities from the perspective of research, program planning and public policy.

Methods

In order to recognize and synthesize emerging innovations and trends across disciplines that might have an impact on the prevention of child abuse and neglect, we pinpointed three main objectives: (1) identify promising programs and program components that are gaining attention and notoriety, and determine if home visiting programs are still the most effective and prevalent programs utilized in prevention efforts; (2) uncover instances of successful collaboration across state agencies or improved methods of service delivery aimed at increasing efficiency and improving outcomes; and (3) discover frameworks and conceptual models in other disciplines that may be useful in efforts to improve child maltreatment prevention programs and policies.

To address these objectives, we first conducted a traditional literature review of an array of academic journals in order to pinpoint promising programs in the areas of child abuse and neglect prevention, public health, parenting and family support, and child development. We began by using the new search engine, Articles Plus, in beta phase on the University of Chicago website. This interdisciplinary search tool aggregates over 40,000 journals and periodicals. After this initial search, we expanded our efforts to include a variety of engines across fields—e.g., Academic Search Premier, APA PsycNET, Child Development and Adolescent Studies, EBSCO, Health Source, HeinOnline, JSTOR, LexisNexis Academic, Medline, NCBI, PubMed, Science Direct, Springer Link, and Westlaw. Our most consistent search terms included "child maltreatment prevention," "child abuse and neglect," "protective factors," "early childhood development," "family support," and "parent-child attachment." These searches produced numerous results. For example, a search of "child maltreatment" conducted on January 30, 2012 and limited to scholarly (peer-reviewed) journals published between 2009 and 2012 yielded 9,049 results. In addition to collecting information on new programs in the prevention field, we looked for recent progress and new research on ethnicity, race, and cultural difference, implementation and dissemination science, and the use of new technologies.

After building an initial and expansive base of literature (a bibliography with over 300 publications), we conducted interviews with 22 experts from a diverse array of fields, and asked them to identify key trends in their respective fields, including new and exciting programs and program components, emerging leaders, examples of successful collaboration, external forces affecting their work and their field, exciting advancements in technology, and the current topics of primary interest to them and their colleagues. (The names and affiliations of these experts are listed in Appendix A.)

During our synthesis and analysis of the literature and conversations with thought leaders, we catalogued our findings according to the main levels of a social policy and planning framework:

- 1. Individual: research that advances our understanding of human function and brain development and the factors that shape behavior and attitudes of both children and parents
- 2. Social Context: investigation into more effective methods for influencing community, and increased understanding of unique differences, contexts, and social norms found within diverse neighborhoods and societal contexts
- 3. Interventions: impact and implementation studies on programs and new models that provide new insight through measured outcomes for participants, information about service delivery mechanisms, and new nonprofit management techniques
- 4. Systemic Reforms: research that addresses cross-agency collaboration and integration

In applying this framework to a broad body of research, some distinct and common trends arose. First, highly influential advancements have been made in neuroscience and genetics that improve our understanding of early childhood development and the impacts of trauma in a multitude of forms. Second, current socioeconomic trends are having very real effects on parents as they face more dire challenges, have less free time, and experience more stress-inducing complications. Third, researchers, policymakers, and practitioners are focusing on infrastructure and systems building by moving beyond model replication and shifting their attention to implementation in order to build systems that support successful program development. These efforts are aided by a number of new techniques, including the integration of technological advancements that enhance performance and the engagement of community through outreach and the development of respectful partnerships. Finally, the growing use of administrative data and integrated data management systems allow for researchers to gain a more complete picture of a person's experience across public service systems, to more efficiently monitor implementation and intervention fidelity, and to use advanced analytical methods and sophisticated statistical techniques in tracking program and policy impacts over time.

The balance of this paper discusses these developments within the context of eight major trends, each of which holds specific promise for advancing child abuse prevention efforts. While not an exhaustive review of all new research and innovation in the field, the paper provides those engaged in promoting child abuse prevention programming and policy reform a roadmap for exploring potential innovations.

Trend #1: Advances in neuroscience highlight the negative impacts of poor parenting and stress on a child's developing brain.

In 2000, the seminal volume *Neurons to Neighborhoods: The Science of Early Childhood Development* was published. The book was the culmination of the efforts of a 17-person committee to collect cutting edge scientific research, survey current programming in early education, and make recommendations for policy and practice moving forward. Funded by a cross-section of public and private entities, the committee spent two and a half years examining the profound advancements in social, behavioral, and neurobiological sciences of the time, as well as the distinct changes in the realities for families in the U.S. (Shonkoff & Phillips, 2000). Despite the strong economy during the 1990s, poor families were experiencing increasing economic hardship and parents across income levels were working longer hours, resulting in more childcare hours for young children. Additionally, cultural diversity continued to grow, and racial disparities across health and developmental outcomes remained prevalent. At the time, promising advancements in child development research were not informing the policies and interventions developed to serve the public, and the committee was charged with creating an agenda for bringing science, policy, and programming together. They identified a set of interdisciplinary core concepts to child development and used these concepts to shape recommendations for future policy and practice (Shonkoff & Phillips, 2000).

The core concepts of the research and the committee's deliberations show that biology, experience, and culture all contribute to human development. Additionally, learning self-regulation is an essential piece of early childhood development, and the ability to self-regulate is essential to every domain of behavior throughout a person's life. Children actively participate in their development, and relationships with their caregivers (most often parents) are essential to the process. That being said, the individual nature of each child's path makes it difficult to differentiate disorders and impairments from simple variation, and there are many significant transitions that occur differently for each child. While early childhood is a crucial developmental time, a person remains both vulnerable and resilient into adulthood. Finally, scientists established that interventions in early childhood can create protective factors and stave off risk factors and result in better outcomes for participants.

From these results, the committee concluded that the time from birth to 5 years old is a critical span for brain and language development, as well as for emotional, social, and regulatory advancements (Shonkoff & Phillips, 2000). Children entering kindergarten show vast discrepancies in academic ability, and strong associations exist between economic and social indicators and level of school readiness. The committee urged that these differences be addressed in our policies and programming for pre-kindergarten education. Finally, children are sensitive to trauma and can fall victim to grief and depression, and the committee believed that mental health concerns early in life were not addressed adequately in most interventions of the time (Shonkoff & Phillips, 2000).

Today, pediatrician and coeditor of *Neurons to Neighborhoods* Jack Shonkoff, among others, is studying the effects of stress on early brain development and the lasting impacts stress can have on mental health through adulthood. The brain undergoes accelerated development from the prenatal period through the first few years of life. During this time, neural connections in the brain are being formed, and "serve and return" activities—when an adult responds to an infant's coos and other verbalizations in a controlled manner—are instrumental to the healthy development of motor skills, language, memory, emotion, and behavioral control. Attentive care giving from adults is absolutely essential during formative years when the brain is most sensitive to external forces (Center on the Developing Child, 2012).

Shonkoff and his colleagues at the Center on the Developing Child at Harvard University have identified three types of stress that can trigger the stress response system: positive, tolerable, and toxic (Center on the Developing Child, 2012). Positive stress occurs when a child is faced with normal, everyday stressors that are buffered by an adult caregiver. In this case, the stress response system is triggered and hormone levels go up but then return to baseline as the child learns coping mechanisms. Tolerable stress is caused by a tragic event like the loss of a loved one or a serious injury, but in such instances the child is nurtured and protected by a caring adult. Finally, stress can become toxic when it is prolonged (e.g., living in

extreme poverty, experiences of abuse and/or chronic neglect, substance abuse by a parent, exposure to domestic or community violence) and when an adult is not present to mitigate the hardships. In such cases, the stress response system remains on high alert with heightened hormone levels (Center on the Developing Child, 2012). Long-term effects can include developmental delays—particularly delays affecting the essential development of executive function—a higher likelihood of mental health and substance abuse issues, and health problems like heart disease and diabetes (Committee on Psychosocial Aspects of Child and Family Health et al., 2011).

Technological and methodological advances have played a large part in the rapid progress in the field of cognitive neuroscience. New MRI and fMRI capabilities have led to an annual increase in papers published in the field of pediatric neuroimaging every year since 1996. Human and animal studies have led to a better understanding of both functional and structural changes in the developing brain (Blakemore, 2011). The Oregon Social Learning Center, a nonprofit, multidisciplinary research center associated with the University of Oregon, has produced important work on child development and healthy family functioning. Phil Fisher, senior scientist at OSLC and professor of clinical psychology at the University of Oregon, is involved in basic research connecting the effects of early stress on neurobiological systems, particularly the effects of stress on the development of executive function. Through the use of fMRI and other technologies, he has connected early life stress to cognitive impairments in adolescence. In a number of studies, Fisher and his colleagues have tested the hypothalamic-pituitary-adrenocortical (HPA) axis of children in a variety of settings and their resulting cortisol levels. The HPA axis is a neuroendocrine system that helps the body maintain balance when faced with stressful situations. Findings have shown atypical cortisol levels associated with abuse or neglect (Oosterman, De Schipper, Fisher, Dozier, & Schuengel, 2011), a caregiver experiencing high stress (Fisher & Stoolmiller, 2008), exposure to prenatal substance abuse (Fisher, Kim, Bruce, & Pears, 2011; Fisher et al., 2011a), and time in the foster care system (Fisher, Van Ryzin, & Gunnar, 2011; Fisher, Stoolmiller, Mannering, Takahashi, & Chamberlain, 2011; Pears, Heywood, Kim, & Fisher, 2011). These findings lead researchers and policymakers to raise questions about the types of interventions that will most effectively ensure healthy brain development, and about whether it is possible for interventions to change neural processes in brains that have already undergone damage due to trauma. Bryck and Fisher suggest that the most recent findings on neural plasticity provide evidence that it may be possible to design interventions to reverse negative effects on brain development caused by environmental trauma in childhood, particularly in regard to executive function development (2011).

Many interventions designed to benefit preschool age children have been proven effective in improving the development of executive function (Center on the Developing Child at Harvard University, 2011).

One such intervention, Tools of the Mind, is a curriculum intended to develop self-regulation in 3- and 4-year olds by teaching reading and math skills using a technique that is mediated through social interactions between peers and teachers with a focus on play. A randomized control trial tested the efficacy of this intervention against a control group of children enrolled in a standard literacy curriculum. Outcomes were measured by social behavior, language, and growth of literacy. The treatment group showed fewer problem behaviors than the control group, indicating that the Tools of the Mind curriculum provided benefits to the process of executive function development (Barnett et al., 2008). As a result of this intervention, children in the treatment group had lower scores on a problem behavior scale, indicating improved executive function and better, overall, classroom quality. More modest findings suggest that the Tools of the Mind curriculum also resulted in better language development in children, although these levels of improvement did not reach statistical significance in multilevel models or after multiple comparison adjustments were made (Barnett et al., 2008).

Dr. Fisher also has been involved in the development of multiple evidence-based prevention interventions aimed at improving outcomes for foster youth, including the Multidimensional Treatment Foster Care Program (MTFC). MTFC has three versions, serving adolescents (12–17), middle childhood (7–11), and preschool age (3–6). The intervention is a cost-effective, community-based program focused on the goal of decreasing problem behavior and improving social and behavioral skills. Program employees are engaged with children in one-on-one therapy, provide trainings to foster parents and biological parents, and check in with other adults in the youth's life (e.g., teachers and parole officers). MTFC-P, the preschool intervention, has been proven to effectively promote secure attachment in children and contribute to the achievement of successful permanent placements. Rigorous randomized control trials have been conducted (Fisher, Kim, & Pears, 2009; Leve, Fisher, & Chamberlain, 2009), and MTFC is recognized as a strong evidence-based program by University of Colorado's Blueprints for Violence Prevention and the Coalition for Evidence-Based Policy.

Mary Dozier, professor of psychology at the University of Delaware, studies the emotional, behavioral, and cognitive development of foster children, with a particular focus on attachment. Over the last 10 years, she has developed a program called Attachment and Biobehavioral Catch-up Intervention (ABC), intended to help children learn to self-regulate. The program targets new foster parents and has three main goals: (1) help caregivers learn to reinterpret the behaviors of their child that can be alienating and dissociative, (2) help caregivers overcome their own issues that prevent them from providing nurturing care, and (3) create an environment in which children can develop regulatory capabilities. Over 10 weeks, parents are instructed on how to care for and respond to their child.

In a random control trial experiment designed to evaluate ABC, preliminary results found ABC program promising—children in the treatment group demonstrated significantly less avoidance of nurturing caregiving from their foster parents (Dozier et al., 2009). Complementarily, in another evaluation of ABC that measured cortisol levels (hormones produced under stressful situations) in infants and toddlers, children with parents in the treatment group showed lower initial levels of cortisol than children not receiving the intervention (Dozier, Peloso, Lewis, Laurenceau, & Levine, 2008). Dozier believes these results are encouraging because the program demonstrates that, in a relatively short amount of time, parents can be instructed successfully in how to become more effective nurturers. As a result, children can more easily form healthy attachments to their parents, leading to better developmental outcomes overall. A second randomized control trial confirmed that the children of parents at high risk for maltreatment in the ABC intervention showed lower rates of disorganized attachment and higher rates of secure attachment than those in the control group (Bernard et al., 2012). In a workshop held in January 2012, Dozier discussed how recent advancements in neurobiological science have helped us to understand the development, function, and plasticity of the brain, and this knowledge can serve us in creating more effective interventions that may be able to reverse the effects of early adverse experience (IOM & NRC, 2012).

In 2011, a collection of medical bodies—including the Committee on Psychosocial Aspects of Child and Family Health; the Committee on Early Childhood, Adoption, and Dependent Care; and the Section on Developmental and Behavioral Pediatrics—published several articles in the academic journal, *Pediatrics*, and disseminated a press release calling attention to toxic stress in the lives of children. In these publications, they link the effects of toxic stress to the failure to develop coping skills and adaptive capabilities and "unhealthy lifestyles" (e.g., substance abuse, poor diet, lack of exercise) that can lead to fragmented social networks and financial hardship in adulthood. Additionally, they reiterate the importance of adult caregivers as a buffer to children to keep stress levels within a healthy range (Committee on Psychosocial Aspects of Child and Family Health et al., 2011). Shonkoff et al. outline an ecobiodevelopmental (EBD) framework that describes the "inextricable interaction between biology (as defined by genetic predispositions) and ecology (as defined by the social and physical environment)" (2011, p. 234). In other words, both nature and nurture are critical components to human development, and they exist in a symbiotic relationship to one another. Each of these articles identifies the field of human development as multidisciplinary and emphasizes the importance of collaborative efforts and information exchange between the fields of neuroscience, molecular biology, genomics, developmental psychology, epidemiology, sociology, and economics.

Trend #2: Social context and culture can protect the developing child and strengthen parental capacity in important ways that can buffer against individual and contextual risk factors.

As the body of research surrounding brain development burgeons, extensive efforts are being made to understand other factors affecting the development of the child that can lead to poor outcomes, such as behavioral problems, trouble in school, and mental health issues. Scientists are building on the vast body of work surrounding the long-term and cumulative effects of adversity on child development by attempting to parse out various interpersonal and contextual risk factors that might negatively impact development. Such risk factors include poverty, community violence, parents who have experienced physical abuse or chronic neglect in their own childhood, child maltreatment, contact with the foster care system, parental mental illness, maternal substance abuse, intimate partner violence in the home, and other trauma-inducing experiences (Jones Harden, Monahan, & Yoches, 2011). Recent studies have confirmed that exposure to poverty has greater effects on infants and young children than on adolescents (Halle et al., 2009; Knitzer & Perry, 2009), and the negative ramifications of this exposure continue into adulthood for education, employment, behavior, and health outcomes (Duncan, Ziol-Guest, & Kalil, 2010).

Because a child's relationship with his/her primary caregiver is closely linked to developmental and functional outcomes, a number of relationship-based clinical interventions have been developed for children who experience trauma in early childhood (Ghosh Ippen, Harris, Van Horn, & Lieberman, 2011). Kolko, Iselin, and Gully report positive outcomes measures for both children and parents enrolled in Alternatives for Families: A Cognitive Behavioral Training Therapy (AF-CBT) at a community-based child protection center (2011), and Lam, Fals-Stewart, and Kelley conducted a pilot study measuring positive outcomes in a Parent Skills program with Behavioral Couples Therapy (2009). Another current method of treatment that has been tested extensively in recent research is Parent-Child Interaction Therapy (PCIT). PCIT is an evidence-based model that engages both the parent and the child. The parent participates in didactic sessions to learn parenting skills, but is also aided while s/he is with the child by wearing an earpiece so that s/he may receive coaching from a therapist behind a one-way mirror. A number of recent studies have reported improved outcomes for both children and parents in PCIT programs implemented in clinical and field settings that target different subpopulations. The resulting papers discuss findings from a program for depressed mothers in a hospital-based outpatient clinic (Timmer et al., 2011), a program working with depressed preschoolers (Lenze, Pautsch, & Luby, 2011), the implementation of PCIT at a number of urban community mental health clinics (Budd, Hella, Bae, Meyerson, & Watkin, 2011), a randomized control trial of high-risk female caregivers in Australia (Thomas & Zimmer-Gembeck, 2011), and a program adapted for low-income African American families (Fernandez, Butler, & Eyberg, 2011). Several studies also suggest that PCIT coupled with a self-motivational orientation can increase retention and reduce child welfare recidivism rates (Chaffin, Funderburk, Bard, Valle, & Gurwitch, 2011; Chaffin et al., 2009). PCIT has recently been adapted for a program called Honoring Children—Making Relatives, where it fits within a framework supporting Native American traditional beliefs. This program is part of a series of evidence-based treatment models that have been transformed by the Indian Country Child Trauma Center to serve Native American populations (BigFoot & Funderburk, 2012). The National Child Traumatic Stress Network has also generated research and compiled resources on trauma-focused treatments for children and families, and they specifically address the unique attributes of early childhood trauma.[1]

Cultural context is an essential part of creating interventions that can reduce child maltreatment and enhance healthy child development in the United States. Overall, there is a dearth of current research

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[1] The National Traumatic Stress Network (NCTSN) was established by Congress in 2000. The Network is comprised of academic and community service centers, and utilizes research and practice experience related to child development, traumatic experience, and cultural difference. NCTSN is sponsored by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration and the U.S. Department of Health and Human Services. The Network is committed to increasing the evidence-base on trauma-informed services, providing educational materials, and disseminating new knowledge. Their website provides resources on Early Childhood Trauma: http://www.nctsnet.org/trauma-types/early-childhood-trauma.

relating to cultural difference and race in the field of child abuse and neglect prevention. However, some recent studies addressing cultural relevance and evidence-based programming have been published.

Wells, Merritt, and Briggs explore existing racism and bias in the child welfare system and propose steps for producing more culturally intelligent research and interventions (2009). They argue that when evidence-based interventions are culturally competent they are proven effective by evaluations of specific populations (i.e., in order for a model to be considered an evidence-based program, it must be rigorously evaluated in a setting where participants are of the minority population it hopes to serve) and the community members served must "own and accept" the intervention as an important aspect of their lives (Wells, Merritt, & Briggs, 2009, p. 1166). To develop and successfully implement more culturally intelligent interventions in child welfare, Wells et al. recommend involvement of the community from the beginning, continual program modifications along the way, and integration of existing literature on bias and social behavior to develop evaluation methods for identifying inequality perpetuated by staff or the processes and procedures of the intervention.

Castro, Barrera, and Holleran Steiker looked more closely at the specifics of the adaptation process and found many instances where adaptations were justified (2010). In a literature review, the authors outline the different approaches to and frameworks for structural analyses of culture, and they discuss the modern challenges of creating cultural adaptations for evidence-based interventions. They define the "fidelity-adaptation dilemma" as the debate between the opinion that to achieve positive results interventions should not be adapted and the belief that interventions must be adaptable to address diversity in consumer bases. The authors frame the paper around four important questions surrounding the fidelity-adaptation debate: (1) Is it justifiable to adapt existing evidence-based interventions for cultural difference? (2) When cultural adaptations are being undertaken what procedures should be followed by those developing the adaptation? (3) Is there existing evidence to prove that adaptations can be successful? 4) How can "within-group cultural variation" be addressed in adaptations? (Castro, Barrera, & Holleran Steiker, 2010, p. 215).

With the support of current research, Castro et al. (2010) conclude that the evidence supports the effectiveness of cultural adaptation for program models, and they make recommendations for program adaptation when the intervention is meant to serve a population with wide cultural variance. Moving forward, they call for research that tests the original intervention against its adaptation so that direct comparisons can be made. Additionally, they believe that when building adaptations, larger environmental and contextual factors should be considered, like the religion, gender, and social class of intended target populations, as well as larger socioeconomic conditions (Castro et al., 2010, p. 233). They encourage intervention developers to clearly define core components of interventions and the mechanisms

through which these concepts are disseminated so that when adaptations are made, these core concepts can remain paramount to the adapted intervention. Finally, they discuss the importance of creating flexibility within adaptations so that different dosages can be applied to address variation within the target population (Castro et al., 2010).

Self-Brown et al. (2011) examine the cultural adaptations to programming that occurred during the implementation of a home visiting program, SafeCare, in six states. Providers were interviewed about the process, and they did not recommend structured adaptations for each ethnic group; instead, they discussed how certain components of the model needed to be carefully considered and adapted for each community where the program was introduced. They highlight a need for further research in the area of cultural context as it relates to program implementation.

Cultural influence is one of many characteristics considered in larger assessments of neighborhood context. Today, scholars are developing research agendas to measure the complexities of neighborhood conditions at the systems level and their effects on maltreatment rates. Jill Korbin, of the Schubert Center for Child Studies and the Childhood Studies Program in the College of Arts and Sciences at Case Western Reserve University, believes that neighborhoods have a multidimensional influence on families and these influences can be measured through mixed-methods research utilizing sophisticated statistical techniques (IOM & NRC, 2012). During a recent presentation sponsored by the Institute of Medicine, Korbin reported on three theoretical approaches that have been used to identify and measure the relationship between child maltreatment and neighborhood context: (1) an examination of the association between *structural characteristics* of a neighborhood, e.g., demographics and child maltreatment behaviors and reports; (2) study of the effect of *neighborhood processes* on maltreatment; and (3) an investigation of the *differences in dynamics* amongst neighborhoods (IOM & NRC, 2012). Moving forward, Korbin believes we can use these strategies for developing a better understanding of neighborhood influence. These strategies could enlighten our understanding about behavioral influence of neighborhood conditions; clarify definitions, recognition, and reporting of factors involved; and finally, identify the family and child characteristics that influence residential selection (IOM & NRC, 2012).

Every community has variations in demographics, socioeconomics, cultural contexts, existing resources, and social networks. Such differences not only define a community's relative risk but also its relative strengths, particularly in the area of social capital (Hashima, 2009). In fact, predetermining certain personal characteristics of a parent or caregiver that might make him/her a "high risk" for child maltreatment can be interpreted as problematic and offending. In many communities challenged by poverty and violence, residents exhibit creativity and commitment to childrearing that result in positive effects that ripple outward. Garbarino and Sherman conducted a study on two different communities with

similar demographics but different rates of maltreatment in order to pinpoint such differences. They found that the community with less maltreatment was more integrated, had more positive reports about neighbors, and better interactions between people overall (Garbarino & Sherman, 1980). While unique and productive forms of social capital may exist, they may not be recognized by outsiders entering a community to implement new programs or provide services. For new interventions to be successful, it is imperative that they work with the existing strengths and networks in the community, and are compatible with social norms and commonly held beliefs. The leadership of the intervention must be trusted within the community, so that the community is engaged and given the opportunity to provide feedback and input. Finally, program staff can be more successful when they are either local residents or have been educated about the people and place they will be serving in a sensitive and respectful way.

For decades, some practitioners, policymakers, and researchers have been calling for a move away from the notion of "cultural competence" to one of "cultural humility." In medical education and training programs in the health care field, administrators have the challenge of creating a curriculum that teaches medical students, nurses, and other staff to respectfully deliver effective services to an increasingly diverse U.S. population. Traditionally, cultural competence has been taught as a discrete set of quantifiable information that can be learned and then tested by a standardized exam. However, Tervalon and Murray-Garcia believe that "cultural competence in a clinical practice is best defined not by a discrete endpoint, but as a committed and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves" (1998, p. 118). Cultural humility training has been implemented in residency programs and has shown to be a viable and promising approach to diversity education (Juarez et al., 2006).

Other disciplines are also adapting the concept of cultural humility in the training process. Ross evaluates a cultural humility curriculum component in a community development and planning graduate program. The classes integrate community-based participatory research methods and a framework for ongoing self-reflection (Ross, 2010). The child welfare, prevention, and child abuse and neglect fields are serving diverse populations with regard to race, ethnicity, culture, class, gender, and sexuality. These differences have major implications for how interventions should be chosen, models adapted and implemented, data collected, and evaluations conducted and reported.

Trend #3: Promising community prevention strategies create new opportunities and challenges in intervention design, implementation, and evaluation.

As many researchers and practitioners grapple with the complexity of developing and implementing effective interventions, others have chosen to approach the issue of child abuse and neglect prevention from the community perspective. Child abuse is consistently a result of a confluence of many negative factors, and community prevention efforts make an attempt to address these risk factors using the principles of ecological theory (IOM & NRC, 2012). Such initiatives have the unique ability to draw on the cultural and social norms of the community to strengthen the impacts of programming that addresses the multifaceted needs of parents and children. Although these community strategies hold great promise for preventing child maltreatment, Daro and Dodge have cautioned that multifaceted and comprehensive interventions are costly. Generating and maintaining the necessary stakeholder buy-in also is a challenge (2009).

Among the most widely replicated community reform efforts targeting positive child development is the Strengthening Families Initiative developed by the Center for the Study of Social Policy with funding from the Doris Duke Charitable Foundation. Initiated in 2001, Strengthening Families is based on a simple framework of five core protective factors that have shown the greatest impact on reducing child maltreatment rates: parental resilience, social connections, knowledge of parenting and child

development, concrete support in times of need, and social and emotional competence of children. The protective factors framework provides a simple, easy to understand, universal approach to benefit families through the access point of early intervention. A number of tools and guidelines for practitioners, families, and other partners have been developed. Seven states initially received funds to implement a pilot Strengthening Families initiative through interagency collaboration in their child welfare systems, schools, correctional institutions, and their mental health and health care services. Currently, 32 states are working with the protective factors framework.[2] As a result of the protective factors movement, researchers have developed and tested a survey instrument to measure the individual differences in multiple protective factors in families. A recent study indicates that the tool provides a valid and reliable method for community-based prevention programs to evaluate families and more fully understand the population they are working to serve (Counts, Buffington, Chang-Rios, Rasmussen, & Preacher, 2010).

Another instance of a community-based prevention intervention that utilizes protective factors developed out of a partnership between the Yup'ik people, an American Indian group in southwestern Alaska, and the Center for Alaska Native Health Research (CANHR). The community resides in a remote location only accessible by small plane, boat, or snowmobile, and is 90 percent Yup'ik. The already impoverished area has experienced considerable economic hardship in the past decade as a result of increasing gas prices and decreasing salmon populations. In 2004, Alaska's suicide rate was the highest in the country, and the Yukon-Kuskokwin Delta region, the home of the Yup'ik, had the highest rate within Alaska (Allen, Mohatt, Fok, & Henry, 2009, p. 277). With these challenges as a backdrop, the CANHR and a local community planning group worked with the Yup'ik residents to develop an intervention that would acknowledge the community's deep commitment to their cultural heritage. Rather than focusing on risk factors, the developers created a "Qungasvik," or toolbox, of protective factors with which to promote youth sobriety and recognize and celebrate the many gifts associated with being Yup'ik. They also developed modules, or activities, at the individual, family, and community level that integrated evidence-based practice with the experience and lifestyle of the local people (Center for Alaska Native Health Research, 2008). Allen et al. (2009) conducted a quasi-experimental design of the intervention and developed measures for determining effects of the program. Informants completed community assessment surveys at four different times to determine organizational readiness for prevention programming. Additionally, caregivers assessed behaviors that were associated with protective factors from suicide and alcohol abuse. Findings were positive and significant for both measures (Allen, Mohatt, Fok, & Henry, 2009).

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[2] A new proposal is under development that will apply the protective factors framework more broadly across a number of federally-funded child welfare and family support efforts.

Other efforts to alter community practice principles and shift parental standards have focused on the development and implementation of a series of specific interventions. One of the most widely researched efforts embracing this approach is the Positive Parenting Program (Triple P). Triple P is a multi-level system of parenting interventions that addresses the needs of families on many different levels and administers interventions at many different dosages. The system works to improve social, emotional, and developmental outcomes for children by working with parents to build their knowledge base and skill level while increasing their confidence (Mazzucchelli & Sanders, 2010). There are five levels of interventions that serve parents with children ages 0 through 16. The complete package of services is introduced through "universal Triple P," a massive media campaign that takes advantage of local television, internet, radio, newspaper, and school systems to distribute their message to parents. From there, levels of service become increasingly specialized with the intention of eventually targeting the most vulnerable and isolated members of the community in need of intensive behavioral family interventions (Daro & Dodge, 2009). Sanders et al. presented a large scale population trial of the Triple P intervention called Every Family (2008). It was the first evaluation of a positive parenting strategy to produce significant longitudinal and population-based effects. Triple P and other community-level interventions are doing promising work for families in a range of settings, and with a growing base of evidence, they will become an increasingly viable and attractive option for policymakers moving forward.

Within the U.S., the Harlem Children's Zone (HCZ) is a community-based initiative that has been highly influential in the fields of early childhood, primary, and secondary education. Launched by the president of a local afterschool programs center, Jeffrey Canada, HCZ was created in order to focus on a small segment of children within a certain physical jurisdiction in Harlem by creating a "conveyor belt" of services that would take them from "cradle to college" (Dobbie & Fryer, 2011). Canada felt that traditional piecemeal programming provided by community centers were not enough to address the needs of children and families in neighborhoods challenged by poverty, violence, and other risk factors. While HCZ has had a high profile in the press and within the greater field of education, no rigorous evaluation had been completed either proving or refuting causal evidence until 2011. Dobbie and Fryer exploit the lottery system for admittance to the charter schools in HCZ to compare outcomes for youth who grew up in HCZ and attended school there, youth who attended school there but grew up outside the Zone, and youth who neither lived there nor went to school there (2011). The study's findings conclude that children attending the exceptional charter schools within the Zone were able to close the black/white achievement gap in math and, in some cases, in reading as well. Additionally, it did not matter if children lived inside the Zone or outside the Zone, suggesting that the other community services like early childhood education programming, tutoring, and athletic and art classes did not increase the chances of success in school.

While this study leaves many questions unanswered about the effectiveness of HCZ-provided social services, it does have very interesting implications regarding evaluative outcome measures and individual impacts on children. Under the charismatic leadership of Jeffrey Canada, the program has been celebrated and promoted using strong anecdotal evidence that illustrates vast improvements—due to the program's conveyor belt approach—in the lives of those children growing up in the Zone. Dobbie and Fryer suggest that educational improvements measured in HCZ charter school students may well be attributed solely to the experience of attending high-quality schools. Today, findings of rigorous evaluations are powerful, as evidence-based programming is held up as the gold standard in government policies and funding opportunities. As a result, the relationship between academia and community becomes increasingly important for developing, implementing, and testing new programs and initiatives.

The Division of Violence Prevention (DVP) at the Centers for Disease Control (CDC) has spent the last 12 years investing in the notion that building partnerships between community and researchers is necessary to addressing community-level problems. In 2000, the CDC created the National Academic Centers of Excellence (ACE) for Youth Violence Prevention. Between 2000 and 2005, 10 ACEs were funded with the goal of creating opportunities for interdisciplinary research to address the problem of youth violence, solidifying partnerships between communities and researchers, installing an infrastructure that would support effective youth violence programs, and empowering communities to act against youth violence. Over the second phase of funding (2005–2010), ACEs partnered with specific communities to work towards achieving the original goals set while focusing on the unique strengths, challenges, and needs of that community (Vivolo, Matjasko, & Massetti, 2011). In 2010, the CDC released an announcement encouraging ACEs to apply for funding to work with a community to both implement and evaluate a multi-faceted, evidence-based initiative to reduce youth violence. The interventions will serve both high-risk and universal populations, and the evaluations will measure outcomes on the individual, relationship, and community level (Vivolo et al., 2011). Additionally, an ACE Program Logic Model was created to help define necessary inputs, activities of the ACEs, intended results of the interventions or "outputs", and short- and long-term outcome goals.

The ACEs strategy is built on two main assertions: that a community-wide, multi-faceted approach is needed to reduce youth violence and strong partnerships between researchers and community are necessary to successfully implement effective evidence-based programming (Vivolo et al., 2011). In a study of specific cases from the Nashville Urban Partnership Academic Center for Excellence, Nation et al. complicate the idea of "university-community partnerships" (Nation, Bess, Voight, Perkins, & Juarez, 2011). In one example from their study, evaluative research follows a community-initiated project, and therefore, the community holds the power and has the final say in decisions about the research. In this

instance, the community itself can become divided over certain issues, and these disagreements have to be tempered through compromise. In other examples, community-engaged research is instigated by academic leadership, and while the community is invited to the table at all parts of the process, researchers have control over the decision-making process (Nation et al., 2011). These differences suggest that community-based interventions and evaluations are diverse in their structure, development, and implementation, and researchers should carefully consider all possible permutations as they work with neighborhoods on prevention-related projects.

Social norms are another important aspect of community-level prevention initiatives. Individuals are strongly influenced by peers, social mores, and a common sense of values and ethics held by one's community. Normative feedback interventions are used to help researchers understand what people *think* their neighbors think, and potentially, how those perceptions can be changed. For example, a city wanted to improve a community's curbside recycling program, so a survey was conducted to determine perceived beliefs about recycling. Residents were asked questions about their own recycling vigilance and about how vigilant they perceived their neighbors to be. The data showed that people supported recycling but assumed that their views were not shared by their neighbors. In truth, most residents expressed similar levels of support for the program. When the results of the survey were shared with all those in the community, curbside recycling rates improved (Schultz, 1999).

Sometimes, behavior can be changed by correcting a misperception about normative beliefs (Schultz, 1999). In a study on smoking cessation, research showed that smoking habits are highly influenced by peer networks, and entire social circles of people tend to quit smoking together (Christakis & Fowler, 2008). Would it be possible to think about child abuse and neglect prevention in this same frame? Normative feedback is successful not because it is telling people what to do, but because it is making people aware of what others believe. Could normative feedback be used to free channels of perception about child maltreatment? When people feel supported—and not judged—by those around them, interventions can have better results.

Trend #4: An increasing number of federal policy initiatives are directing public investments towards evidence-based programs.

In the current economic and political climate, the drive to fund evidence-based, tested programming has strengthened. During President Obama's tenure in the White House, his administration has worked with the Office of Management and Budget (OMB) to roll out a series of "evidence-based initiatives" with the main goals of expanding effective government social programs, eliminating ineffective programs, advancing the use of evidence-based programming, and creating the opportunity for high-quality research to be undertaken to evaluate any new programs implemented as a result of his policies (Haskins& Baron, 2011, p. 6). At least two major federal initiatives have been launched to extend the availability of evidence-based programs serving young children. On March 23, 2010, President Obama signed the Affordable Care Act into law, and through an amendment of Title V of the Social Security Act, the Maternal, Infant, and Early Childhood Home Visiting program (MIECHV) was authorized. Over 5 years, this program will allocate $1.5 billion worth of grants to states to implement evidence-based home visiting programs. The program is administered through the Health Resources and Services Administration (HRSA) in partnership with the Administration for Children and Families (ACF). An initial grant was provided to all states that completed a detailed application in the spring of 2010. This application included a comprehensive needs assessment to identify the communities most at-risk for poor maternal and child health. States were required to take stock of each community's greatest deficiencies, assets, and resources and to create a plan to address the unique needs of that community.

All state grantees are required to invest at least 75 percent of their funding in evidence-based program models approved by HRSA. In 2009, Home Visiting Evidence of Effectiveness (HomVEE) initiative, supported by ACF, was charged with the task of assessing the research available on 22 home visiting programs. . Of the original 22, nine programs were initially named effective by high-quality impact evaluations, and subsequently approved by HRSA for state implementation.[3] State grantees also are required to set quantifiable benchmarks for 3 and 5 years after implementation in order to show improvements in six core domains—maternal and child health, childhood injury prevention, school readiness and achievement, crime or domestic violence, economic self-sufficiency, and efforts to coordinate with existing community resources. HRSA distributed an additional $91 million to states for FY2010 and $124 million for FY2011 to implement their state plans. In September of 2011, and another $100 million was awarded in the form of Competitive Expansion and Competitive Development funds. In the nine states awarded expansion grants, high-quality home visiting programs are part of an emerging comprehensive early childhood system, and the funds will aid in continued efforts toward this goal. Thirteen development states received funding to build on existing small-scale home visiting programs (U.S. Department of Health and Human Services, 2011). The U.S. Department of Health and Human Services intends for the nine expansion states to serve as models for the continued development of a nationwide system of care for early childhood.

In addition to the Maternal, Infant, and Early Childhood Home Visiting program, the U.S. Department of Health and Human Services rolled out a $500 million competitive grant competition in collaboration with the U.S. Department of Education called Race for the Top–Early Learning Challenge (RTT-ELC). The goal of the funding is to aid states in their efforts to: (1) increase the number of low-income and disadvantaged infants, toddlers, and preschoolers who are enrolled in a high-quality education program; (2) create an integrated system of programs and services; (3) require that assessments conform to the early childhood education standards of the National Research Council. In October of 2011, 35 states, Puerto Rico, and Washington, DC applied for grants of $50 to $100 million. The amount awarded was determined by the relative population of low-income children served by the state. The states recommended for funding were California, Delaware, Maryland, Massachusetts, Minnesota, North Carolina, Ohio, Rhode Island, and Washington.[4]

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[3] The nine evidence-based programs chosen as "national models" and green-lighted for implementation as part of the MIECH-V program are: (1) Child FIRST, (2) Early Head Start-Home Visiting, (3) Early Intervention Program for Adolescent Mothers (EIP), (4) Family Check-Up, (5) Healthy Families America (HFA), (6) Healthy Steps, (7) Home Instruction for Parents of Preschool Youngsters (HIPPY), (8) Nurse Family Partnership (NFP), and (9) Parents as Teachers (PAT). For more information on the home visiting models assessed for effectiveness, visit the U.S. Department of Health and Human Services Home Visiting Evidence of Effectiveness website: http://homvee.acf.hhs.gov/Default.aspx.
[4] Department of Education website: http://www2.ed.gov/programs/racetothetop-earlylearningchallenge/awards.html

A growing evidence base surrounding teen pregnancy prevention programming led the Obama administration to commission a literature review on existing research to inform a decision about launching a federal initiative in this area. In the review conducted by Mathematica Policy Research, a nonpartisan research firm, program models associated with high-quality research were identified. However, only two of these programs showed sustained reductions in teen pregnancy in random control trials (Haskins & Baron, 2011).[5] In 2010, under the Obama administration's Teen Pregnancy Prevention Initiative (TPPI), the Office of Adolescent Health (OAH) awarded $75 million to programs that had high-quality research supporting their effectiveness. Seventy-five programs were chosen from 32 states.[6] Another $15 million was awarded to support promising strategies to second-tier "demonstration programs."[7] The OAH also partnered with the Centers for Disease Control (CDC) to support community-wide models in eight locations.[8]

Federal money is also funding, through the Department of Health and Human Services (HHS), a fatherhood initiative founded on the principle of evidence-based planning.[9] In 2005, the Deficit Reduction Act provided $150 million to fund "healthy marriage promotion and responsible fatherhood." In 2010, the Claims Resolution Act reauthorized funds to support responsible fatherhood through multiple approaches. The Administration for Children and Families (ACF) provides a resource called the National Responsible Fatherhood Clearinghouse (NRFC), a media campaign to disseminate information about responsible fatherhood and healthy marriage that includes a website aggregating resources available to individuals and families.[10] The Claims Resolution Act also provides $75 million each year to fund activities like counseling, mentoring, and marriage and relationship education. The ACF Office of Planning, Research, and Evaluation (OPRE) created the Strengthening Families Evidence Review, a database of research on fatherhood programming.[11]

President Obama's evidence-based initiatives to support healthy families and positive parenting are creating a blueprint for how to address large social problems in an effective and efficient way. In this approach, the administration identifies the target social problem, chooses model programs that are proven to work through rigorous and high-quality research, funds the large-scale implementation of model programming, and requires continued evaluation of ongoing interventions. While these methods are

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[5] More information about evidence-based programs identified by the review can be found at the Office of Adolescent Health website: http://www.hhs.gov/ash/oah/oah-initiatives/tpp/programs.html.
[6] More information about individual projects is available from the Office of Adolescent Health: http://www.hhs.gov/ash/oah/oah-initiatives/tpp/grantees/tpp-tier1.pdf
[7] Demonstration programs funded by OAH: http://www.hhs.gov/ash/oah/oah-initiatives/tpp/grantees/tpp-tier2.pdf
[8] Information on community-based teen pregnancy prevention efforts can be found at the CDC website: http://www.cdc.gov/TeenPregnancy/State-Community-Orgs.htm.
[9] Information about the initiative is available from the HHS Promoting Responsible Fatherhood website: http://fatherhood.hhs.gov/2010Initiative/index.shtml.
[10] ACF maintains the NRFC website to provide up-to-date information to families: http://fatherhood.gov/home.
[11] ACF OPRE resources on fatherhood programming research: http://www.acf.hhs.gov/programs/opre/strengthen/proven_promising/index.html.

logical and responsible and would, in time, lead to a reduction in programming cuts due to the elimination of ineffectual programs and the streamlining of operational ones, the current economic crisis has led to a political climate of fiscal austerity (Haskins & Baron, 2011). Such attitudes present a danger to all of the current evidence-based initiatives, and may lead to an overall downsizing of social spending in the United States over the next several years, despite an increase in the quality and depth of research available to guide policy investment.

Trend #5: New research findings continue to underscore the importance of addressing the needs of new parents and young children.

The importance of early childhood in shaping subsequent development and emotional well-being has been proven. However, during the time from birth until about 5 years of age there is no common access point or system which has ongoing contact with these children, a reality which complicates the process of structuring an efficient system of outreach and support to this population. From a policy standpoint, once children enter school, it is much easier to universally determine children's needs, monitor their progress and their challenges, and engage with families. Before kindergarten, it is much harder to establish systematic connections with the children and families that would benefit the most from programs designed to optimize developmental outcomes, teach good parenting techniques, and develop protective factors. The recent research on early childhood development outlined in this paper has focused on universal elements of positive change. However, parenting needs vary widely based on factors like culture and income level, and thus successful techniques for engaging parents in different communities and across different populations vary. These differences are difficult to measure, and generally, parents improvise with what is available to them. Few existing interventions that have been evaluated show promising measurable outcomes, and academics, policymakers, and practitioners have competing views about whether to target the highest need, most at-risk families, or to focus on developing universal assessments of all families, with more specific services provided based upon a family's level of need. Despite the challenges of early intervention, programs that utilize home visiting services continue to demonstrate, through rigorous evaluations, a capacity to achieve measurable and meaningful

improvements in a number of core outcomes with a notable proportion of their target populations. Some of the most notable evaluations of home visiting programs published in the last several years involve several evidence-based models and are highlighted here.

Nurse Family Partnership (NFP) is one of the most widely implemented home-visiting models. It currently has sites in 26 states, and serves over 20,000 families every year (Howard & Brooks-Gunn, 2009). In the NFP model, registered nurses initiate home visits with low-income, first-time mothers during pregnancy and continue to visit families until the child is 2 years of age. The services span three main stages of early childhood: prenatal, infanthood, and toddlerhood. Nurses provide services that impart knowledge about a healthy pregnancy, preparation for birth, nursing, parenting skills, and family planning efforts moving forward. Since 1977, randomized control trials have been conducted on programs in three different states. In 2010, longitudinal follow-up results were published on NFP's first clinical trial in Elmira, NY, reporting on outcomes for 19-year-olds whose mothers had participated in NFP. Findings showed that girls in the treatment group were less likely to have been arrested and convicted than girls in the control group. Additionally, girls in the treatment group had fewer children and less Medicaid use (Eckenrode et al., 2010).

Also in 2010, several articles were published reporting the findings from a 12-year follow-up of NFP's second randomized clinical trial conducted in Memphis, Tennessee. The first article measured differences in substance abuse, behavioral problems, and academic performance among children enrolled in the trial as infants. The 12-year-old children of participating mothers self-reported lower rates of alcohol, cigarettes, and marijuana use, fewer clinical or borderline mental health disorders, and higher test results on a number of academic measures than control group youth (Kitzman et al., 2010). In a second article, the authors examined the effects of NFP on the primarily African American sample by measuring the mother's cohabitation and relationship status with the biological father, the duration and stability of her relationships, incidence of intimate partner violence, drug use, reliance on welfare, arrests, foster care placements, and additional births. Results indicated that 12 years later, mothers enrolled in NFP for the birth and infancy of their first child were less likely to be impaired by drug use, had longer partner relationships, and had lower participation rates in the food stamp program, Medicaid, and other welfare programs. The government saved over $1,000 on each mother in NFP (2006 dollars), an aggregate savings of $12,300. The total cost for the program was $11,511, so, in theory, the savings outweighed the investment in the intervention (Olds et al., 2010).

In 2011, Rubin et al, reported findings on reductions of subsequent pregnancies for mothers in the state of Pennsylvania. They used data from 23 NFP replication sites (17 urban, 6 rural), and matched NFP clients to controls using propensity score matching strategies. Results indicated that after a year-long

implementation period, pregnancy planning efforts began to show reductions in the occurrence of second pregnancies. The reductions were strongest among young mothers living in rural parts of the state (Rubin et al., 2011).

The Healthy Families America model was influenced by the combination of universal assessment and targeted intensive services for those in greatest need, utilized in Hawaii's Healthy Start, a home visiting program on the island of Oahu that began in 1975. Healthy Families America began in the continental U.S. in 1993, supported by Prevent Child Abuse America and the Ronald McDonald Foundation (Howard & Brooks-Gunn, 2009). In this model, professionals and paraprofessionals provide intensive home visits to families identified through a systematic screening process as being at risk for child maltreatment and other negative child outcomes. Services begin during pregnancy or at birth and continue until the child is between 3 and 5 years old. Program staff serves as a support to help with parenting skills, to promote healthy child development, and to aid in the achievement of self-sufficiency for mothers. A direct goal of the program is to prevent child abuse and neglect (Howard & Brooks-Gunn, 2009). Over the last several years, new studies have been published based on evaluations in HFA:

- *Hawaii Healthy Start.* At Hawaii Healthy Start, a randomized control trial was conducted to determine whether the program in Oahu was associated with changes in intimate partner violence (victimization and perpetration) and, if so, which types (physical, verbal, sexual). The timeline for data collection in the study included 3 years of programming and 3 additional years of follow-up. Results were measured by maternal self-reporting. During the program, rates of both perpetrated and victimized intimate partner violence fell significantly for the treatment group compared with the control group, particularly for physical abuse. However, in the long term the between-group difference was not significant (Bair-Merritt et al., 2010).

- *Healthy Families New York (HFNY).* HFNY was first established in 1995, and now operates at 39 sites across New York State. In 2000, a longitudinal three-site randomized control trial was established to determine the effectiveness of the state home visiting program administered by the state. A 2008 publication reported that the randomized control trial found that mothers assigned to HFNY were one-quarter less likely to have committed serious acts of child abuse than mothers in the control group by the time their children celebrated their 2nd birthday, and that mothers in the treatment group were also less likely to engage in acts of minor aggression and harsh parenting by the time their children were 2 (DuMont et al., 2008). By the seventh year of the intervention, DuMont and colleagues reported that mothers in HFNY were less likely to seriously physically abuse and more likely to use nonviolent forms of discipline than mothers in the control group. Additionally, children from the HFNY group were more likely to participate in a gifted program at school, less likely to be

enrolled in special education services, and less likely to cut class. HFNY students performed below average less often than students in the control group, and were less likely to repeat a grade. A cost-benefit analysis found that overall, 15 percent of government spending was recovered through a reduction in welfare services utilized by mothers (DuMont et al., 2010). The findings of a 2009 report highlighted the importance of the prenatal aspects of the program, including social support, health education, and access to services. The risk of delivering low birth weight babies was significantly reduced by participation in HFNY (Lee et al., 2009). Rodriguez et al. looked at maternal parenting competencies and harsh parenting and found that mothers in the treatment group showed increased measures of positive parenting in maternal responsiveness and cognitive engagement. Parents in the treatment group were less likely to use harsh parenting techniques (Rodriguez, Dumont, Mitchell-Herzfeld, Walden, & Greene, 2010).

- *Healthy Families Arizona (HFA).*LeCroy and Krysik conducted a randomized control trial at one site of HFA with a sample size of 195 families (2011). The site chosen was first established in 1991, and all home visitor staff were trained using the approved curriculum of Healthy Families America and had either a BA or the equivalent in years of experience. LeCroy and Krysik measured significantly greater outcomes in the experimental group in comparison with the control group across five domains: violent parenting behavior, parenting attitudes and practices, parenting support, mental health and coping, and maternal outcomes. The authors suggest that while there has been large movement towards the use of evidence-based practices in home visitation programming, much more research is needed: "There are still too few rigorous trials of program models and measurement issues remain serious threats to understanding the capacity of programs to produce important outcomes" (LeCroy & Krysik, 2011, p. 5).

Family Check-up (FCU) is an intervention that provides three visits to a family from a psychologist or other professional with a comparable advanced degree. At the end of the third visit, the visitor refers the family and child to appropriate intervention: parent training, aids for the child, or other referrals within the community. This model is intended to work with families that are at high risk of maltreatment when faced with life challenges. In 2008, a number of studies published findings from a randomized control trial of 731 mothers with 2-year-olds that were enrolled in WIC programs in Pittsburgh, PA, Eugene, OR, or Charlottesville, VA. Each family had a history of child behavior problems, challenges like maternal depression or substance abuse, and low socioeconomic status. The intervention began with a videotaped home visit, during which mothers answered a questionnaire, children were engaged and observed, and parent-child interaction was witnessed. The study reported on mothers and child behaviors from visits when the children were 2, 3, and 4 years old. One paper used latent growth models to determine that children at all three measurement points exhibited reduced behavior problems when compared with the

control group. Mothers were observed to have improved positive behavior support for their children (Dishion et al., 2008). A latent transition analysis approach produced complementary findings (Connell et al., 2008). In 2009, an evaluation showed improvements in maternal depression in the treatment group, leading to reduced behavior problems in children (Shaw, Connell, Dishion, Wilson, & Gardner, 2009). Finally, a study examined school readiness measures, and found that "collateral benefits" were seen in inhibitory control and language outcomes (Lunkenheimer et al., 2008). More recently, several studies have been published on FCU programs implemented in schools to engage families around management and relationship issues and to reduce risk behaviors in middle school and high school age children (Stormshak & Dishion, 2009). Lower rates of family conflict, antisocial behavior, alcohol consumption, and association with deviant schoolmates were measured in the treatment group (Van Ryzin, Stormshak, & Dishion, 2011).

Child and Family Interagency, Resource, Support, and Training (ChildFIRST) is a home visiting program with two main components. The first is a system of care that coordinates service provision for the family based on the ecological model. The needs of the child are met by a continuum of coordinated services, including mental health, health care, early care, education, protective care, and social supports. The system of care is intended to take into account the unique needs and cultural context of every family. The second component is a psychotherapeutic, parent-child interaction therapy nested within this system of care. The goal of the therapy is to improve parent-child relationships while creating an environment for healthy emotional and cognitive development. The model is intended to work with multi-risk families with young children, where child conduct and emotional problems may already be an issue.

In 2011, results from a randomized control trial conducted in Bridgeport, Connecticut were published. The study intended to determine the effectiveness of ChildFIRST in a real-world setting, as families were recruited from a local primary care center or the Supplementary Nutrition Program for Women, Infants, and Children (WIC). One hundred fifty seven mothers with children age 6 months to 36 months participated. Results showed significant effects for ChildFIRST mothers and children on a number of indicators. Children had better language skills and fewer behavioral problems compared to the services as usual group. Mothers also benefited, showing fewer negative psychological symptoms after a year and less parenting stress after 6 months. Three years after baseline measures were taken, there was less involvement from child protective services in ChildFIRST families. Finally, participating families reported access to 91 percent of their desired services, while the services as usual group only had access to 33 percent of services they wanted. Significant positive effects were measured as a result of both the system of care component and the parent-child interaction therapy component. These results have good implications for the future of the program (Lowell, Carter, Godoy, Paulicin, & Briggs-Gowan, 2011).

Several studies have been recently published on Early Head Start and Parents as Teachers (PAT), two of the model programs chosen by HomVEE focused on cognitive development and school readiness. Early Head Start is a home-based early learning program designed to develop attachment and cognitive development in infants and toddlers. Roggman, Boyce, and Cook published findings from a randomized control trial of an Early Head Start program serving low-income families in Utah and Idaho (2009). Two hundred families were randomly assigned into the Early Head Start group or a comparison group when mothers were pregnant or children were under 10 months old. Child assessments and parent interviews were conducted at different intervals when children were between 10 and 36 months old. Results of the study showed that children exhibited increased attachment and cognitive development when compared with the control group, and for low-income mothers, attachment ratings in children were even higher (Roggman, Boyce, & Cook, 2009).

Parents as Teachers (PAT) is a home visiting program designed to teach parents about child development and provide them with support. Services include home visits, group meetings, developmental screenings, and other family resources. PAT serves families with children from birth to kindergarten. A randomized control trial was conducted to evaluate a new PAT curriculum, Born to Learn (BTL) with 256 parents in the treatment group and 271 in the control group. Outcomes were measured along a variety of developmental measures. The BTL group showed higher task completion rates at 36 months and greater effects for children from low-income families than from high-income families. Other measures yielded no significant effects (Drotar, Robinson, Jeavons, & Lester Kirchner, 2009).

In 2008, Zigler, Pfannenstiel, and Seitz published a longitudinal study that followed students in Missouri enrolled in the PAT program between 1998 and 2000. The study is a replication of an earlier study (Pfannenstiel, Seitz, & Zigler, 2003), but utilizes a larger sample (5,721 participants), uses a better poverty status measure, and includes a 3rd-grade achievement measure. Findings show that the PAT program improved school readiness through direct effect (better parenting) and indirect effects (reading to children at home, enrolling children in a preschool program, etc.) (Zigler, Pfannenstiel, & Seitz, 2008). Additionally, children from low-income households enrolled in PAT and a quality preschool program demonstrated similar school readiness scores to more affluent children. By third grade affluent children had surpassed the same low-income cohort in scores, demonstrating that over time the benefits of early intervention may be insufficient to sustain continued academic growth and development for children who remain in economically difficult circumstances (Zigler, Pfannenstiel, & Seitz, 2008).

In 2010, Bugental, Schwartz, and Lynch published findings from a randomized control trial testing a cognitively based home visiting program (treatment) against a program based on the Healthy Start model. Participants were mothers and babies who were born "medically at risk." Results showed lower cortisol

levels in the treatment group as infants, and at age 3, the treatment group measured higher verbal short-term memory (an indicator of later educational outcomes). These findings indicate that home visiting programs with a cognitive development component may be more effective than those without (Bugental, Schwartz, & Lynch, 2010). Lastly, two recent studies address cultural adaptation in the HIPPY model. The authors of a qualitative study of low-income African American families make recommendations to improve responsiveness to the needs of the population served and to better evaluate parent-home visitor relationships (Woolfolk & Unger, 2009). A quasi-experimental design shows positive measurements for Spanish-speaking Latino families in the Southwest participating in a HIPPY program. Results indicated better home environments, more competent parenting, and higher achievement in math for children at the third grade level for parents enrolled in HIPPY than those in the comparison group (Nievar, Arminta, Qi, Ursula, & Shannon, 2011).

In addition to the home visiting models supported under MIECHV, other home visiting models have demonstrated significant impacts on their target populations. For example, SafeCare is a home visiting model focused on providing aid to families at risk of maltreatment or families already reported to child protective services. Supports provided to families include infant and child health care, parent-child interaction training, and home safety. A 2011 study showed SafeCare to have increased enrollment and decreased attrition when compared with a standard community care program (Damashek, Doughty, Ware, & Silovsky, 2011). A randomized control trial was conducted using a high-risk rural population of 105 parents in Oklahoma. Participants were randomly assigned to either SafeCare or home-based mental health services as usual. While parents in SafeCare were more likely to enroll, complete the program, and had fewer child welfare reports during receipt of services, few significant sustained program effects were observed (Silovsky et al., 2011). Results from a large-scale controlled effectiveness trial of SafeCare were published in March of 2012. The study was again conducted in Oklahoma, where SafeCare was adopted statewide for families who have been reported to Child Protective Services (CPS) for neglect or who are at high risk for neglect. The trial compared SafeCare home-based services to home-based services as usual (case management and social support) (Edwards & Lutzker, 2008). Participants included 219 home visitors and 2,175 parents previously reported for maltreatment. Findings indicate that SafeCare significantly reduces maltreatment recidivism as compared to services as usual (Chaffin, Hecht, Bard, Silovsky, & Beasley, 2012).

Aside from the obvious trend in home-visiting programs, new literature exists regarding a number of other promising programs based outside the home. The American Academy of Pediatrics recommends that pediatricians and other child health professionals address psychosocial risk factors that can lead to child maltreatment (e.g., family stress, intimate partner violence, maternal depression, and substance

abuse) (Dubowitz et al., 2011). While the traditional checkup appointment provides an excellent opportunity to address such issues, barriers exist that have prevented health professionals from taking up this responsibility. Doctors are often uncomfortable discussing sensitive issues, and they lack the training to instigate such conversations and the ability to recognize key warning signs. Additionally, adequate and comprehensive screening tools have not been made available to all primary care providers (Dubowitz, Feigelman, Lane, & Kim, 2009). In response to this concern, the Commonwealth Fund developed, tested and disseminated Healthy Steps, a MIECHV approved evidence-based model that placed child development specialists within selected pediatric practices. Currently available in 17 states, this model has demonstrated consistent positive impacts on child health, child development, school readiness, and positive parenting practices.[12]

More recently, the Safe Environment for Every Kid (SEEK) model has been developed to help health professionals address risk factors for maltreatment through a training course, the introduction of a Parent Screening Questionnaire, and the addition of an in-house social worker team to work with families. Two studies were recently conducted to test existing SEEK programs: one to determine outcomes for children and families and one to measure effects on the health professionals participating in the intervention (Dubowitz et al., 2009). The first was a randomized trial conducted between 2002 and 2005 in resident clinics in Baltimore, Maryland. Of the 1,118 parents with children between the ages of 0 and 5 who were approached to participate, 729 (65%) agreed. Of those who agreed to participate, 558 (77%) completed the study protocol. The clinics were randomized by day; two days were randomly assigned into the treatment group clinics (SEEK model), and a different two days were randomly assigned to the control group clinics (standard pediatric primary care). Child abuse and neglect was measured by the number of child protective services reports, medical documentation of potential maltreatment, or parent reports of harsh parenting techniques. Data were collected at three time points: the date of birth of the first child in the study, at the onset of the study (2002), and within 6 months of when sampling ended (2005–2006).

Those families enrolled in the SEEK treatment group showed significantly lower rates of maltreatment across all measures (Dubowitz et al., 2009). Two years later, a second study was conducted to determine how the SEEK model impacts primary care pediatricians. Researchers wanted to know if SEEK changed doctor attitudes, behaviors, and competence in addressing child maltreatment in their patients (Dubowitz et al., 2011). Eighteen private practice primary care clinics participated in a cluster randomized control trial. The pediatricians from the SEEK group significantly improved in their abilities to address substance use, intimate partner violence, depression, and stress, and they reported higher levels of comfort and

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[12] The Home Visiting Evidence of Effectiveness (HomVEE) review included nine eligible studies and found positive primary and secondary outcome measures: http://homvee.acf.hhs.gov/document.aspx?sid=12&rid=1&mid=1.

perceived competence (Dubowitz et al., 2011). Both studies show promise in the SEEK model as an effective intervention that could help fill the void of primary care pediatricians comfortable and able to work with families at high risk for child abuse and neglect.

The recent literature also reflected a focus on parenting and parenting interventions over the last several years. In 2009, Richard Barth published a paper outlining the parental risk factors associated with child abuse and neglect: substance abuse, mental illness, domestic violence, and child conduct problems. He discussed the parenting programs commonly used before 2009, but noted that few have been proven to produce positive outcomes. Finally, he recommended more parenting programs be rigorously evaluated through effectiveness trials and encouraged public support for greater investments in this area (Barth, 2009). A 2011 review of 46 randomized control trial evaluations of parenting programs focuses on long-term outcomes across multiple developmental periods, and finds that existing programs show a variety of positive effects up to 20 years after the intervention occurred (Sandler, Schoenfelder, Wolchik, & MacKinnon, 2011). Specific parenting program evaluations were conducted on The Incredible Years, an evidence-based parenting program that treats child conduct problems (Letarte, Normandeau, & Allard, 2010; Marcynyszyn, Maher, & Corwin, 2011; Webster-Stratton, Rinaldi, & Reid, 2011), and Parents Anonymous, a mutual self-help group (Polinsky, Pion-Berlin, Williams, Long, & Wolf, 2010).

Trend #6: Implementation science offers program managers effective research frameworks to monitor and strengthen the service delivery process and to improve the odds of replicating model programs with fidelity and quality.

In May of 2010, then-president of Dartmouth College and physician, Jim Yong Kim wrote a column with James Weinstein, the president and chief executive officer of the Dartmouth-Hancock Health System, in *The Washington Post.* They thoughtfully addressed the need for an improved system for delivering "value-based and high-quality" health care. They cite the U.S. health care system as the most expensive in the industrialized world, with the worst outcomes, and call for "improving quality while bending the unsustainable cost curve." In order to achieve this goal, they argue for the expansion of the field of "delivery science" because no aspect of the health care system (government, insurance companies, physicians, etc.) can solve the complex problem alone. Instead, they believe a multidisciplinary approach must be used that will engage experts in the diverse fields of management, systems, engineering, sociology, anthropology, environmental science, economics, medicine, health policy, and more. Kim and Weinstein call for the marriage of research and implementation to improve the health care service delivery system (2010).

The same union is necessary for service delivery in the field of child abuse and neglect prevention. While it is not a new idea that comprehensive data should be collected at every part of the implementation process, we still are not able to execute this process well. Data collection is needed to tell a story about: (1) the strategy and chain of decisions that go into choosing a target community or model program; (2) the selection, training, and continued support of program staff, (3) the screening and assessment process of potential participants; (4) the services provided to participants; (5) the fidelity of individual programs and ongoing implementation; (6) immediate and distant impacts on program participants; (7) efforts to reach out and engage the local community and the general public; and (8) connections to other services and intervention efforts across agencies. Today we have a growing body of research to draw upon that tells us what families need, but far less clarity on how to adequately build and operate effective systems to deliver promising interventions.

As we continue to grow our pool of evidence-based models in the child abuse and neglect prevention field, it will be important to improve how we introduce these models into a diverse array of community settings. Implementation responsibilities include staff training and credentialing, fidelity to protocol, engagement of community members, connection of participants to other existing services and programs, continued evaluation of program components, attrition rates, and most importantly, positive outcomes for parents and children. There is consensus across the child welfare field that prevention interventions should be assessed in terms of their capacity to achieve outcomes in the present day and in the future for children, parents, and families. That being said, there is less understanding about what aspects of our service delivery system support these outcomes, even after rigorous evaluations prove a model's overall effectiveness. We have a growing list of models proven to elicit positive outcomes, but far fewer evaluations have been done testing the actual process of implementation and dissemination (Mildon & Shlonsky, 2011). Implementation research has been defined in the medical field as the "scientific study of methods to promote the systematic uptake of clinical research findings and other evidence-based practices into routine practice and, hence, to improve the quality and effectiveness of health care" (Graham et al., 2006, p. 17), and has since been expanded to include the realm of child welfare (Mildon & Shlonsky, 2011).

The implementation process is challenging, and usually fraught with complications. While there is an existing body of literature on the subject (Durlak& DuPre, 2008), its interdisciplinary nature makes it difficult to generalize as researchers do not share a common language, and each field must confront unique hurdles. The National Implementation Research Network published a valuable step-wise process for program implementation in 2005 (Fixsen, Naoon, Blase, Friedman, & Wallace), and Damschroder et al. published a consolidated framework for implementation research for the healthcare field by

aggregating available literature, creating a common terminology, and identifying common themes (2009). Aarons, Hurlburt, and Horwitz produced the first implementation model for child welfare practice in four parts: Exploration, Adoption/Preparation, Implementation, and Sustainment (2011). This piece provides a strong conceptual framework for child welfare practitioners, and it draws in much of the existing literature in the field of implementation science. The authors note that their model provides "heuristic value" (Aarons, Hurlburt, & Horwitz, 2011, p. 17), but rigorous evaluations of the different implementation processes or phases are scarce (Mildon & Shlonsky, 2011).

Just as implementation evaluations are close to nonexistent in the child welfare literature, few evaluations have identified the specific components that can be used to determine program fidelity. Gearing et al. provide a recent review of the past 30 years of fidelity research in which four core components of the process are defined and explained: design, training, monitoring of intervention delivery, and intervention receipt (2011). In 2009, the National Evidence-Based Practices (EBP) Project published findings on a study in which five psychosocial interventions for adults with severe mental illness were evaluated for their use of a new implementation model that utilized fidelity feedback reports. The main takeaways regarding fidelity can be generalized to inform the prevention field. Among the critical factors they identified: strong on-site leadership committed to high-fidelity outcomes; effective educational trainings and materials provided to as killed and competent workforce; ongoing technical assistance; and routine feedback to providers on the clinical aspects of their work. In this case, regular fidelity reviews were used as a mechanism to change provider behavior, but without management buy-in to this process, high-fidelity ratings were not likely to be sustained. Other barriers to strong fidelity included disengaged or unconcerned leadership, a lack of actionable recommendations from reviewers, review consultants that did not provide feedback on time, or a lack of space created for discussion and learning. Up front, the National EBP Project recommends that in order to have high fidelity with implementation, it is important to set goals to give focus to the process, provide a clear and pragmatic framework to leaders and practitioners, give leaders the power to make changes, and offer validation through positive reinforcement to successful teams (Bond, Drake, McHugo, Rapp, & Whitley, 2009).

Kaye and Osteen (2011) address some of the challenges in measuring fidelity in child welfare systems in an examination of one state's attempt to define fidelity criteria and measure fidelity in a child safety program. They propose that child welfare agencies are often motivated to implement changes to their programming as a result of a crisis or new regulations. The lack of policy and procedure within interventions for addressing these changes require protocols be developed that calculate specific fidelity measures. While some measures of fidelity (e.g., frequency and dosage) are easily quantified, others are more subjective and rely on the practitioner's professional judgment (Kaye & Osteen, 2011, p. 2). In the

study of the state program implementation process, Kaye and Osteen describe how model developers and local practitioners worked together to establish both fidelity instruments and measurement instruments. A panel was created to determine the consistency and fairness of those evaluating the program's implementation. The authors believe the observed model was successful in part because it was inclusive and built capacity amongst stakeholders, and it could be replicated in other sites in the future (Kaye & Osteen, 2011).

How do we effectively implement evidence-based programs with high fidelity, but also with adaptability to cultural, socioeconomic, and demographic difference? Those involved in the successful implementation of Triple P initiatives in different settings have offered findings from evaluations of such efforts (Mazzucchelli & Sanders, 2010). They conclude that strict adherence to manualized treatment does not necessarily lead to the best outcomes, and believe it is possible to train practitioners to adapt to the circumstances of their work without moving outside the evidence base. Mazzucchelli and Sanders observe that "safeguarding fidelity" in interventions requires high-quality training programs, an evidence base that is easily understood by practitioners and includes outcomes for interventions with diverse participants, and staff that are experienced in a number of different protocols. Additionally, clear and comprehensive program materials are essential, clinical outcome data should be collected, and staff should be both evaluated and supported at all steps of the process. With regard to "promoting flexibility," the authors recommend that interventions should be segmented into separate components that can easily be omitted if necessary, different potential scenarios should be practiced by staff so that they are prepared to make evidence-supported adaptations, and finally, a communication flow should be created between researchers and practitioners so that each group can learn from the others' expertise and experience (Mazzucchelli & Sanders, 2010). Forehand, Dorsey, Jones, Long, and McMahon present an argument based on Mazzucchelli and Sanders's work for requiring evaluations to answer questions about implementation as we move forward so that we can build the evidence base in implementation and dissemination science (Forehand, Dorsey, Jones, Long, & McMahon, 2010).

As we study the process of implementation, the role of the service provider must be highlighted. Most of the services provided in prevention interventions are delivered through nonprofit organizations, a sector that has faced difficulties during the recession. Nonprofits are generally funded by federal and state government, charitable foundations, or by fees for services provided. While many charities experience declines in contributions during a recession, giving trends are different for each type of charity. The greatest decline in the current recession has been to entities that fund human welfare organizations (Sherlock & Gravelle, 2009). Between 2007 and 2008, the overall decline in giving was 6 percent, but for human services-related organizations the decline was 16 percent (Sherlock & Gravelle, 2009, p. 30).

Unfortunately, such organizations see an increase in demand for their services as people fall on hard times. While charities saw a decrease in contributions, the decline in assets led to major depletion of many foundations' endowments. In the public sector, reduced budgets forced federal and state governments to cut services, directly affecting the grants and contracts available to nonprofits (Sherlock & Gravelle, 2009).

Despite the dire economic trends, the cutting edge of the nonprofit sector has made extensive investments in imposing frameworks that enforce benchmarks to ensure accountability, higher quality, and goal attainment. The management and governance of nonprofits has changed drastically over the last decade. There has been a shift in operations to increase accountability, formalize structure, solidify long-term goals, measure outcomes, create successful marketing campaigns, manage funds efficiently and responsibly, and work collaboratively with other nonprofits and government entities across silos. In 2002, the Sarbanes-Oxley Act was passed as a reaction to corporate scandals undermining investor confidence (e.g., Enron, WorldCom). The Act has 11 sections that add new corporate board responsibilities, additional penalties, and requires the Securities Exchange Commission to enforce compliance with the law. The effects of Sarbanes-Oxley reached beyond the for-profit sector, and shaped the future of nonprofit practices. Since 2002, it has become necessary for nonprofits to have a strategic plan, to measure outcomes, engage in mission alignment, and create standards by which decisions about funding are made. Mission Measurement, a consulting firm based in Chicago, specializes in helping nonprofit organizations "measure social impact." The firm carefully works on projects that advance a nonprofit's specific mission by defining goals that are quantifiable and measurable and by developing sophisticated marketing strategies for publicizing their efforts. While nonprofits grapple with the increasingly competitive environment and the scarcity of funding opportunities, agencies and larger systems of care also struggle to improve efficiency and collaboration.

Trend #7: Maximizing population-level change requires new understanding of how to construct and sustain effective state systems, local community collaboration, and robust community-based organizations.

All stakeholders in the child welfare system, from those involved in prevention to those providing therapeutic services to victims, agree that greater focus must be paid to increasing collaboration between and across agencies, between academics and government institutions, and between policy and practice. As discussed previously, researchers are committed to increasing the knowledge base around program implementation and fidelity, yet it is much more difficult to address the large and complex issues that exist when social service agencies and other institutions interact in human service delivery systems. In the current economic climate, pressure mounts to provide effective and efficient systems of care. Tseng, Liu, and Wang describe previous research efforts in the area of agency collaboration as predominantly descriptive, and they provide a summary and history of relevant research on the topic (2011). They attempt to create a multi-dimensional framework to be used to evaluate influential factors in interagency interactions. That is, they use existing research to create a three-stage framework to answer the following questions: (1) What is the scope of influential factors—operational or structural? (2) Will the influential

factors have a lasting or temporary impact on collaboration? (3) What stage of development is the collaboration in (i.e., implementation, development, conceptualization, formation) (Tseng, Liu, & Wang, 2011). The scope of the influential factors in a collaboration is important to determine because it speaks to the nature of the change; structural changes affect the arrangement of the system overall, whereas an operational change is made to the common interworking of the collaborative's delivery of services. The "influential factors" identified and categorized in stage one speak to whether the impact of the change will be short- or long-term (Tseng, Liu, & Wang, 2011, p. 800). Tseng et al. claim that structural change generally has a longer-term effect because such changes are hard to reverse, and long-term impacts are clearly more important than short-term impacts. The developmental stage of the system is important because different factors are crucial to the success of a collaborative at different times throughout the process. For example, in the formation stage, communication between member parties is essential as roles and responsibilities are assigned and an overall system of operation is established. In the stage of conceptualization, the identity of the group takes precedence as a mission statement is created, goals and strategies are set, and so on. The authors believe that their framework provides a more analytical approach to studying interagency collaboration, and they claim that its use will lead to a better understanding of the process (Tseng et al., 2011). Through the collection and categorization of data from successful collaborative systems, researchers will be able to determine which aspects of the process are essential to positive outcomes, and thus will have the basic tools with which to improve social service systems overall.

System-building efforts require a firm and well-researched overall framework, but they also require attention to both individual organizations and the people that are employed there. Current work in organizational theory can provide useful guidance for establishing an organizational environment that is not only open to change, but one that fosters innovation. Choi and Ruona discuss the implementation of successful "change strategies" (2011). Through a review of relevant literature, they make the assertion that individuals are more likely to go along with change within their organization if they have been trained in the new procedures and policies in advance of implementation and when they feel they are working in an environment with a "learning culture" (Choi & Ruona, 2011). First, employees must be made to feel that the impending change is not only necessary, but likely to be successful. Therefore, investing in informing and training the entire organization about new upcoming initiatives is essential to the process (pp. 47–49). Second, contextual factors like environment and leadership are highly influential. As a result, a culture of learning must be established early, so that all members of an organization buy in to the idea that learning is a perpetual process and the best organizations are able to adapt easily to new improvements (p. 60). In a 2011 paper, Iestyn Williams complicates the notion of innovation promotion in organizations by claiming that an innovative organizational climate can only be developed

incrementally over time. In the field of health care, Williams believes that innovation can be fostered through the provision of incentives, effort to increase coordination and collaboration within organizations, and the development of an "innovation infrastructure." In order for an organization to become "innovation ready," Williams recommends the adoption of several key elements that will lead to the development and implementation of inventive new strategies: the creation of a steering committee of experienced and diverse membership to guide changes; dedicated time to and support of innovation development from senior management; the management of new projects by expert staff; technical support systems maintaining new efforts; the development of conflict resolution procedures with facilitators on hand; staff training programs regarding a new innovative work environment and specific trainings on all new interventions; and the implementation of new quality management systems (2011). While theoretical research on the topic of organizational change is published in abundance, evaluations that test the concept of "readiness" at the individual or organizational level are scant. That said, practice-based observations have been published regarding the training of professionals, organizational readiness, interagency collaboration, and system building.

Aarons, Sommerfeld, and Walrath-Greene conducted a study to determine if organization type (public vs. private) or organizational support influence the attitudes of providers towards the use of evidence-based programs (2009). Consistent with their hypothesis, study results indicate that providers working within private, for-profit organizations have more positive attitudes toward innovations like evidence-based programming and are more open to implementing evidence-based interventions. Currently, a movement is underway to make government organizations and agencies more efficient by becoming more responsive to the needs of their client and changes in the environment (Daniels & Sandler, 2008). The findings of Aarons et al. suggest that while a movement to redesign government with private business models in mind exists, there is still a long way to go before public agencies are as deft and open to the implementation of cutting-edge programming. In the meantime, Aarons et al. suggest that additional resources and attention should be paid to public institutions implementing new evidence-based programming. One way in which public child welfare government agencies are adapting to changes in the field is through an increase in social service privatization and performance contracting (Collins-Camargo, McBeath, & Ensign, 2011). The Children's Bureau funded the Quality Improvement Center on the Privatization of Child Welfare Services (QICPCW) to collect information on the increasing number of public/private partnerships. Collins-Camargo et al. published a paper reporting on the best practices identified through interviews with public agency administrators conducted by the QICPCW. Administrators identified networking and shared decision making, communication, performance measurement, and integration of data and research as the four areas most essential to successful public/private organization collaboration (Collins-Camargo et al., 2011).

Data sharing is another important issue facing agencies that work together to benefit children and families. A 2011 study on data sharing in a hospital setting for the purpose of quality improvement showed findings similar to those indicated as important to overall system building efforts. In order for a hospital to excel in data-sharing efforts, it should have strong organizational leadership, organizational reverence for the data, a strong vision for organizational goal attainment, data to track service quality and program outcomes, and staff who share an understanding of the importance of the collaborative effort (Korst, Aydin, Signer, & Fink, 2011). These findings can be easily applied to data sharing to promote child maltreatment prevention. In fact, a 2011 GAO report found that strengthening the national data on child fatalities could aid future prevention efforts. The federal National Child Abuse and Neglect Data System (NCANDS) does not require inclusion of all available information regarding the circumstances of child deaths, and it is likely that a number of child deaths are not counted in NCANDS at all. Challenges in data collection at the local level are caused by inconsistent interpretations by law enforcement, medical examiners, and child welfare workers. At the state level, coordination efforts across jurisdictions and state agencies can fail due to confidentiality issues. The GAO recommends that HHS invest in strengthening data quality, expanding available fatality information, and improving information sharing (Brown, 2011). Government recognition of the issues surrounding data-collection and sharing efforts should begin to bring attention to the topic, but new technological advances have also been cited by researchers as creating new movement around the development of data sharing systems and collaborations (Duncan, Kum, Caplick Weigensberg, Flair, & Stewart, 2008). Researchers call attention to the potential new technologies provide for developing much needed longitudinal, multi-sector, multi-dimensional administrative data bases (Jonson-Reid & Drake, 2008). Collins-Camargo et al. conducted an exploratory study to examine the way public and private sector practitioners use data or evidence-informed practice to inform the process or success of their own work (2010). They found statistically significant differences between public and private agency staff. Private staff found their data to be more adequate and were more likely to use their data routinely than their public sector counterparts (Collins-Camargo et al., p. 333).

So far, we have predominantly focused on the literature addressing organizational culture and readiness for change and interfacing agencies. However, Sanders and Murphy-Brennan, leaders in the dissemination of the Positive Parenting Program (Triple P), provide a more comprehensive picture of implementing a large-scale, evidence-based system (2010). As outlined by the authors, significant challenges associated with systematic reforms can emerge at the organizational, structural, and systemic levels. Their strongest message is that translational research is undervalued, but essential to the process of large-scale service delivery because successful interventions rely on service-based research that recognizes organizational variables and can influence policymakers (p. 34). Next, Sanders and Murphy-Brennan outline how a "systems-contextual approach" to professional training can be disseminated on a

large scale with positive results. In their own efforts, they found that an accessible, standardized, and multidisciplinary system of training is optimal, and it is best supported through quality organizational leadership (i.e., managers that communicate with and invest in their staff's development), investment in infrastructure support (i.e., budget allowances for mission training and reorientation of the workforce), avoidance of program drift (by requiring trainers to be employed by the training organization only), and high program fidelity and quality maintenance (provided through ongoing technical assistance). The synthesis and sharing of experiences learned through large-scale dissemination of evidence-based systems are essential to the success of new collaborative systems and the adaptation of existing social service systems to provide better outcomes for children and families.

Some recent studies have provided examples of collaborative, interagency efforts. North Carolina, under the oversight of a statewide taskforce of governmental and nongovernmental leaders and funding sources, has coordinated a variety of child maltreatment prevention interventions to establish an effective and universal system that can meet the needs of the entire population. The programming chosen for implementation was largely evidence-based, and some promising universal interventions are currently being evaluated to determine efficacy (Rosanbalm et al., 2010). Teixeira de Melo and Alarcão describe a multi-systemic, collaborative intervention in Portugal designed to work with children in the home through an integration of clinical, educational, social, and community approaches (2011). In New York City, three child welfare agencies banded together to develop a collaborative fundraising arm to support all agencies. Goldkind and Pardasani interviewed stakeholders from all agencies about the model implemented and offer some analysis of successful characteristics (2012). Faculty at the University of British Columbia partnered with community health, education, and child welfare practitioners to create an inter-professional learning environment for nurses, social workers, and educators. Gillespie, Whiteley, Watts, Dattolo, and Jones provide a descriptive account of the initiative (2010). Smaller efforts at interagency collaboration are occurring in single interventions—e.g., SAFE4Kids in Texas (Clettenberg, Lau, & Bonsu, 2010). While all of these papers present illuminating case studies of promising and diverse approaches to interagency collaboration and successful system building, there is very little evidence to support positive participant or system outcomes as a direct result of these efforts. Further research is needed to better understand this topic through evaluation of existing system-based interventions.

Finally, in recent years, the business community has worked to adapt for-profit principles to solve problems that plague society, in a movement usually referred to as "social innovation." This perspective is eloquently expressed by Kania and Kramer, as they discuss they their notion of *collective impact*: "the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem" (2010). Kania and Kramer argue that five conditions are necessary to achieve

collective impact: (1) a common agenda defined by a shared vision to unify multiple organizations working as part of a system; (2) shared measurement systems to increase accountability across organizations; (3) assignment of responsibilities so that each stakeholder's strengths are drawn upon; (4) a shared vocabulary to increase dialogue and improve regular and consistent communication aided by technology; and (5) the existence of an independent oversight organization to address tasks and challenges that arise from the creation of a new system and to oversee the overall direction of the collaborative enterprise. These guidelines provide broad and valuable insight into building comprehensive systems of support for families. They also reinforce many of the concepts that come out of the multidisciplinary contributions to both theory and practice that are currently informing the movement toward collaborative systems building in the field of child maltreatment prevention.

Trend #8: New technologies offer important, cost-effective opportunities for advancing our reach into new populations and supporting direct service providers.

An innovation in technology played a central role in the birth of child abuse prevention. The invention of the x-ray machine gave doctors the ability to view and diagnose injuries to children that might have been the result of physical abuse. Armed with this tool, radiologists and pediatricians were able to present more convincing evidence supporting the incidence of maltreatment and contributed to the development of Kempe's seminal paper, "The Battered-child Syndrome" (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962; Self-Brown & Whitaker, 2008). Over the past 10 years, the advent of the internet has revolutionized the communications field. New technologies have allowed scientists to make staggering discoveries and inventions to aid human life and inform the human condition. In the child abuse and neglect prevention field, technology is currently in limited use, but has exciting potential to improve existing interventions, inspire new programs, and make universal prevention efforts a real possibility.

Most basically, computers are used for screening in the identification of child maltreatment in both home and clinical settings. Technology has also been utilized in a wide variety of prevention interventions. Television and radio have been effective tools for disseminating public service announcements, and "entertainment education" has been used to inform families about public health issues, including breast

cancer, family planning, substance abuse, and violence prevention (Self-Brown & Whitaker, 2008). Self-Brown and Whitaker provide a thorough overview of the use of the computer, internet, video, telephone, and video games to aid in prevention efforts both broadly and specific to child maltreatment prevention in the late 1990s and early 2000s.

Currently, some home visiting interventions are being augmented by technology to aid staff and clients, and to enhance communication. The SafeCare model was adapted for three families; they were trained to use iPhones to record video of rooms in their home and communicate with their home visitors to prevent potentially harmful situations (Jabaley, Lutzker, Whitaker, & Self-Brown, 2011). A very limited study of the model showed a reduction in home hazards and a reduction in face-to-face time between home visitors and families. The Early Years Home Visitation Outcomes Project of Wisconsin is taking a different tack, and using laptops to monitor home visiting quality through data collection in six different home visiting model programs in the state (O'Connor, Laszewski, Hammel, & Durkin, 2011). New software was created to record and upload data from client screenings to state public health databases. When compared to paper and pencil data collection efforts, the computerized interventions resulted in significant cost savings by shortening visits anywhere from 9 to 63 minutes, and increasing the likelihood of screening completion. On the other hand, home visitors in the study did not feel laptops made the data collection process easier or improved their client interactions (O'Connor et al., 2011).

Parenting programs are also being adapted and augmented to take advantage of phone, television, internet and computer use. A parent-child engagement intervention, Planned Activities Training (PAT), is producing promising results about added text and phone call features (Bigelow, Carta, & Burke Lefever, 2008). An educational television program on parenting, *Driving Mum and Dad Mad*, was demonstrated to be effective in a randomized control trial for families who received augmented web-based services as compared to those who simply watched the series. Positive outcomes were measured in child's behavior, dysfunctional parenting, parental anger, depression, and self-efficacy (Calam, Sanders, Miller, Sadhnani, & Carmont, 2008). Service delivery efforts can be greatly supplemented by creating online versions of parenting programs, so that poor families, particularly those in rural areas, can participate. Feil et al. (2008) present case studies of a parent-infant interaction intervention, Playing and Learning Strategies (PALS), that was altered for internet delivery with a program enhancement that allows participants to make videos of their interactions with their children. PALS staff can then give personalized feedback. Initial observations from the study indicate that the internet may be a viable and effective service delivery tool (Feil et al., 2008, p. 343). A paper by Funderburk, Ware, Altshuler, and Chaffin explore the potential benefits and challenges of providing live, mentored online training to program staff for evidence-based

Parent-Child Interaction Therapy (PCIT) in order to increase intervention fidelity and result in better outcomes for participant families (2008).

New interventions are currently being designed around the use of cell phones, computers, and the internet. A text messaging intervention called Text4Baby.org was founded by the nonprofit organization, National Healthy Mothers, Healthy Babies Coalition (NHMHB). Expecting mothers can sign up, give their due date, and receive timed texts from the prenatal period through the 1st year of life. The service is free and designed to promote healthy outcomes for mother and baby. Another nonprofit, the National Campaign to Prevent Teen and Unplanned Pregnancy, created a website, www.bedsider.org, to provide anonymous and free information to girls and women regarding birth control and reproductive health. The site offers information on all major forms of birth control, publishes testimonials, answers frequently asked questions, and provides a reminder service for doctor's appointments and birth control.

Technological advances in other fields can inform child maltreatment prevention efforts. Leaders in education have embraced the use of computers, the internet, educational video games, and other software as tools in the classroom. Government support for the use of technology in the classroom has come in the form of grants from the U.S. Department of Education. In fiscal year 2009, $650 million was distributed through the Enhancing Education through Technology (E2T2) program (Cheung & Slavin, 2011). A meta-analytic review by Cheung and Slavin of supplemental educational technology programs in the classroom indicates that incorporation may be beneficial (2011). Public health officials have found creative ways to harness the power of the internet to go beyond providing passive information via email and website (Self-Brown & Whitaker, 2008). Professionals in the field of sexual health created an online community where people can ask questions of public health experts in chat rooms, receive referrals, and listen to interactive presentations about HIV/AIDS and other sexually transmitted diseases (McFarlane, Kachur, Klausner, Roland, & Cohen, 2005). In a 2005 paper, psychologist Albert Bandura argues for the creation of a "self-management system" that uses interactive media to enable individuals to adopt healthier lifestyles through the growth of personal motivational and self-regulatory skills (Bandura, 2005). These tools are already provided by many doctor's offices to increase patient involvement in the management of their health and prevention efforts (Silvestre, Sue, & Allen, 2009). However, a larger system that could reach a wider population has the potential to decrease health care costs in the long term through successful preventative strategies (Bandura, 2005). Consider the ubiquitous WebMD. People use this resource frequently and without hesitation because it is a private, instantaneous way to gain insight into one's health and potential ailments.

Privacy and autonomy are themes not only critical to the field of public health—they are issues central to the success of any maltreatment prevention program designed to improve the lives of children and

families. Parents can become weary of letting outsiders into their homes or allowing them access to their lives to see how they care for and interact with their children. Therefore, a universal, interactive online community featuring information on parenting and child development could be a valuable resource for parents. Khanacademy.org is a widely popular website that was created by a man who excelled as a math and science tutor. Today, Khan Academy is a nonprofit organization that runs and manages the website, featuring thousands of videos to teach students the basics of subjects like math, science, and history through a variety of methods. A similar resource of how-to videos directed at parents and accessible to anyone may add to a universal prevention initiative. As social media sites like Facebook and Twitter become more prevalent in the everyday lives of Americans, efforts to harness the power of such effective tools of mass communication become more important in the design of new programming, community initiatives, and system-building efforts.

Conclusion

While this paper has provided examples of exciting innovations with applications for improving child abuse and neglect prevention efforts, unanswered questions remain. For example, how can we understand and explain downtrends in negative social indicators in a variety of contexts, e.g., the reduction in teen pregnancy rates over the last decade? Can we simulate the charisma and commitment of outstanding leaders, such as Jeffrey Canada and his Harlem Children's Zone, as we implement evidence-based programs in different settings? What are concrete actions we can take to successfully aid efforts to promote agency collaboration? Each of these questions is complex and difficult to unpack, but new trends in research, policy, and practice can inform the future.

The emphasis on evidence-based programming at the federal level highlights the importance of understanding which programs have the potential to attain positive outcomes for children and families and why. While these new federal initiatives are focused on addressing the seemingly different realms of health and education, they may both have a significant impact on the future of the field of child abuse and neglect prevention and on system collaboration at the local, state, and federal levels. By modeling collaboration at the federal level, these and similar initiatives are forcing state and local agencies to jointly implement new programs and services. Additionally, by investing in home visiting and early childhood education, the federal government is able to direct investment to the earliest years of life and apply some standards for program model choice, implementation standards, and evaluation requirements. With the imposition of these regulations and guidelines, states will not only be empowered by the knowledge we already have about early childhood and parenting, but will be actively engaged in growing the library of information on strategies with the potential to successfully improve outcomes for children.

New advances in neuroscience, medicine, psychiatry and psychology increase our understanding of child development, and in turn, improve the scientific foundation of successful interventions to promote healthy families. Recent efforts towards a better comprehension of cultural context, existing social capital within

a community, and the reinforcement of protective factors will also reinforce the development of more effective programming. As community-based initiatives increase in popularity, the need to improve communication and buy-in from researchers, practitioners, policymakers, and the public becomes more critical. Additionally, community-based strategies will require a new research frame for accurate evaluation as methodologies become more complex. Multidisciplinary collaboration will be essential to building a new research paradigm. On the other hand, the forging of a new research-practitioner relationship will also benefit future research efforts. Translational research that bridges the gap between academia and practice will better serve vulnerable populations when research questions are shaped by pressing, need-to-know issues on the ground and when findings are linked to implications for policy. The future of the field will benefit from creative doers, generous communicators, interdisciplinary thinkers, and the continued promotion of a common vision to protect and promote the health and well-being of all our children.

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Appendix A: Names and affiliations of experts interviewed in 2011

Each of the following individuals participated in an interview during which time they were asked to identify emerging issues or trends in their fields over the past several years. Experts provided information about key thought leaders in their fields, promising programs showing positive outcomes for children and families, successful strategies to improve collaboration across local agencies, the impact of new technologies in their fields, and external events shaping current research.

Lisa Barrow, PhD, Senior Economist, Federal Reserve Bank of Chicago; Affiliated Scholar at Chapin Hall at the University of Chicago

Robert J. Chaskin, PhD, Associate Professor and Deputy Dean for Strategic Initiatives, School of Social Service Administration, University of Chicago; Affiliated Scholar at Chapin Hall at the University of Chicago

Mark E. Courtney, PhD, Professor, School of Social Service Administration, University of Chicago; Affiliated Scholar at Chapin Hall at the University of Chicago

Deborah Daro, PhD, Senior Research Fellow, Chapin Hall at the University of Chicago

Diane DePanfilis, PhD, Professor, Associate Dean for Research, Director, Ruth H. Young Center for Families and Children, School of Social Work, University of Maryland

Kenneth Dodge, PhD, Director of the Center for Child and Family Policy; William McDougall Professor of Public Policy, Professor of Psychology and Neuroscience, Duke University

Anne Cohn Donnelly, MA, MPH, DPH, Senior Lecturer of Social Enterprise, Kellogg School of Management, Northwestern University

Robert Goerge, PhD, Senior Research Fellow, Chapin Hall at the University of Chicago

Deborah Gorman-Smith, PhD, Professor, School of Social Service Administration, University of Chicago

Sydney Hans, PhD, Samuel Deutsch Professor, School of Social Service Administration, University of Chicago

Brenda Jones Harden, PhD, Associate Professor, Department of Human Development, University of Maryland

David Henry, PhD, Professor, Public Health and Psychology, University of Illinois at Chicago; Fellow, Institute for Health Research and Policy, President's Professor of Biomedical Research at the University of Alaska Fairbanks; Affiliated Scholar at Chapin Hall at the University of Chicago

Jill E. Korbin, PhD, Associate Dean of the College of Arts and Sciences, Professor of Anthropology, Director of the Schubert Center for Child Studies, Co-Director of the Childhood Studies Interdisciplinary Program and Minor, Case Western Reserve University

Judy Langford, MA, Associate Director and Senior Fellow, Center for the Study of Social Policy

Rhett N. Mabry, MHA, Vice President, Child Care, Duke Endowment

Harriet Meyer, MA, independent consultant, former President of Ounce of Prevention Fund, Chicago.

Ada Skyles, PhD, JD, Associate Director, Chapin Hall at the University of Chicago

Cheryl Smithgall, PhD, Research Fellow, Chapin Hall at the University of Chicago

Julie Spielberger, PhD, Research Fellow, Chapin Hall at the University of Chicago

Matthew Stagner, PhD, Executive Director, Chapin Hall at the University of Chicago

Michael Wald, JD, Jackson Eli Reynolds Professor of Law, Emeritus, Stanford University

Fred Wulczyn, PhD, Senior Research Fellow, Chapin Hall at the University of Chicago