Child Maltreatment Prevention: Toward an Evidence-Based Approach

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November 1, 2009

Dear Reader:

The Department of Children and Families would like to thank University of Wisconsin-Madison School of Social Work Professor Kristen Shook Slack, Ph.D., Social Work doctoral students, Katie Maguire Jack and Leah Gjertson, graduate students from the course, Child Abuse and Neglect, and the Institute for Research on Poverty for researching, writing, and editing, "Child Maltreatment Prevention: Toward an Evidence-Based Approach."

On July 1, 2008, the Department of Children and Families opened its doors to the children and families as Wisconsin's first cabinet agency devoted exclusively to helping and protecting kids and families of the state. The Department of Children and Families reflects Governor Doyle's desire and commitment to ensure that all Wisconsin children grow up safe, healthy, and with the support of strong families.

Child maltreatment is a significant public health problem in Wisconsin. In 2007, there were 55,895 reports of alleged child abuse or neglect and 25,632 child victims of substantiated child abuse or neglect in Wisconsin. Child maltreatment imposes an enormous toll on society and results in costs associated with utilization of administrative services and systems (e.g., child protective services, foster care, judicial system), child treatment services (e.g., health care, mental health, educational systems), long-term impact (e.g., psychological and health problems in adulthood), and next generation victimization.

An increasing number of policymakers and practitioners are turning toward the field of prevention of child maltreatment to provide solutions. Limited resources are currently allocated to the prevention of maltreatment in Wisconsin, but more needs to be done in order to make significant impacts statewide. The Department of Children and Families will work to enhance prevention and early intervention efforts across Wisconsin and will use the findings of this publication to assist us in making informed choices about what works best for children and families.

Sincerely,

Reggie Bicha
Secretary
Department of Children and Families

Contents

INTRODUCTION 1
Kristen Shook Slack, Ph.D.

CHAPTER 1: CENTER-BASED PARENTING INTERVENTIONS 5
Jenna Guensburg, Kara Kratowicz, and Brianne Nillisen

CHAPTER 2: SOCIAL SUPPORT INTERVENTIONS 11
Hannah Anderson and Sara Harrison Fisk

CHAPTER 3: PUBLIC AWARENESS CAMPAIGNS 17
Yonah Drazen, Lindsey Guenther, and Jenny Hansen

CHAPTER 4: NURSE HOME VISITING INTERVENTIONS 23
Tracy Braunreiter, Leah Brody, and Abby Lyon

CHAPTER 5: HOME VISITING: THE HEALTHY FAMILIES AMERICA MODEL 31
Melissa King, Brooke Ramsey, and Lacy Schneider

CHAPTER 6: INTERVENTIONS IN SCHOOLS AND EARLY LEARNING PROGRAMS 41
Maja Christiansen, Amanda Dees, and Crystal Ikanih

CHAPTER 7: DIFFERENTIAL RESPONSE 47
Deanna Kelley, Rachel Konopka, and Christopher Baker

CHAPTER 8: JUVENILE SEX OFFENDER PROGRAMS 53
Tara Hoff, Rachel Singer, and Julie Wesenberg

INTRODUCTION

This publication represents an effort to address the following question: What is the state of the evidence base on child maltreatment prevention? Three avenues were pursued to address this question. First, child welfare experts were targeted and asked to identify the most common types of child maltreatment universal and selective prevention strategies[1] currently in practice throughout the United States. Second, systematic literature reviews were conducted within each of these prevention areas to identify studies that met a set of inclusion criteria, to include studies of universal or selective prevention programs or initiatives, studies with designs that involved comparison groups or pre-post intervention measures, and studies that measured child maltreatment outcomes with either official records or validated child maltreatment risk scales. Third, child welfare researchers were asked to review the chapter drafts in order to identify potential omissions of relevant studies. The final document was also compared to several recently released reviews of child maltreatment prevention to ensure that pertinent research had not been overlooked.

This project was motivated, in part, by administrative staff of the Wisconsin Department of Children and Families (DCF), who requested information from the University of Wisconsin–Madison School of Social Work about "what works" in the field of child maltreatment prevention. This request was brought to students in a graduate course on Child Abuse and Neglect, who elected to take on the task of addressing the DCF request. Under the supervision of the instructor (Kristen Shook Slack, Ph.D.), and with the assistance of Social Work doctoral students (Katie Maguire Jack and Leah Gjertson) and the editorial staff of the Institute for Research on Poverty (IRP; Deborah Johnson and Dawn Duren)[2], as well as support from the Doris Duke Charitable Foundation, students conducted literature reviews in six prevention areas identified by child welfare experts:

1. Center-Based Parent Education
2. Social Support Interventions (Respite Care, Family Group Conferences, Support Groups)
3. Public Awareness Campaigns
4. Nurse Home Visiting Programs
5. Healthy Families America (HFA) Home Visiting Programs[3]
6. Interventions in Schools and Early Learning Programs

In addition to the above prevention areas, research on two other types of prevention strategies was reviewed given expressed interests of Wisconsin DCF staff:

7. Differential Response CPS Reforms
8. Interventions with Juvenile Sex Offenders

These two prevention areas are generally considered "indicated" in nature (Self-Brown & Whitaker, 2008), in that the intended target populations are typically children and families already involved in child protective services (CPS) systems, or who are provided prevention services as a result of a child maltreatment report. Thus, the child maltreatment outcome of interest is often the recurrence of maltreatment. There are many other types of indicated child maltreatment interventions that are not covered in this review, but which can be found elsewhere (e.g., Lee, Aos, & Miller, 2008).

Recently released and published reviews on evidence-based prevention programs have tended to focus on program evaluations that meet the highest standard of rigor, that is, reliance on randomized or statistically matched treatment and control groups (see, e.g., Lee, Aos, & Miller, 2008; MacMillan, Wathen, Barlow, Fergusson, Leventhal, & Taussig, 2009; Reynolds, Mathieson, & Topitzes, 2009). It was determined that limiting the response to studies that achieve this standard would be both redundant as well as under-inclusive, given that a larger body of evaluation research exists

[1]Universal prevention programs are directed at the population at large, regardless of individual levels of risk. Selective prevention programs are directed at populations at risk for child maltreatment (Self-Brown & Whitaker, 2008).

[2]The editors would also like to thank Jennifer Jones, Anne Medeiros, and Cailin O'Connor for their helpful comments on drafts of this publication.

[3]Multiple models of home visitation have proliferated throughout the United States. In the context of this exercise, it was not deemed feasible to review the research evidence on all of these models. Throughout Wisconsin, key elements of the HFA model heavily inform a large number of home visiting programs, and there is expressed interest among Wisconsin service providers in tracking research on the effectiveness of HFA. For this reason, the scope of chapter 5 was limited to HFA and its predecessor, Healthy Start. Additional discussion of another popular model in Wisconsin, the Parents as Teachers (PAT) model, is also provided in chapter 5.

with respect to child maltreatment prevention.[4] Furthermore, reviews of evidence-based prevention programs typically highlight studies that rely on a wide range of outcomes, some of which are only indirectly related to child maltreatment. Our goal was to focus on the general quality of the knowledge base across several prevention areas, focusing on evaluations that assessed more direct measures of child maltreatment (e.g., child protection system involvement) or validated measures of child maltreatment risk. Finally, the authors of this review felt that there is an important benefit to be gained from an enhanced understanding of the general or overall quality of child maltreatment prevention research.

Each chapter is organized in a similar manner. A brief description of the prevention program area is offered, followed by a brief statement of effectiveness summarizing the results of the reviewed literature. Next, sections are presented describing the interventions selected for review, the methodological quality of the reviewed studies, and a review of findings. The chapters end with a brief discussion of the prevention area, and a table that details more information about each reviewed study.

The eight groups of students who worked on the chapters for this review used a similar search strategy. The terms "child maltreatment," "child neglect," and "child abuse"[5] were each searched in conjunction with chapter-specific terms identified through a preliminary search process that yielded a set of commonly used words and phrases within a given prevention program area. This preliminary search process also gave students a sense of the start date to use for their formal search process. Every group searched literature from the mid-1980s through September 2008, but some groups searched back farther in time if warranted. Sources for students' searches included Google Scholar, ProQuest, PsycInfo, Web of Knowledge, Academic Search, and Medline. Students also searched the following four journals, specifically, given their focus on child maltreatment: *The International Journal of Child Abuse & Neglect*, *Children and Youth Services Review*, *Child Welfare*, and *Child Maltreatment*. The Child Welfare Information Gateway (maintained by the Children's Bureau) was also searched, as was the main Google search engine, in order to identify any Web-based reports that may not have been identified through searches of academic databases. Students were also asked to search organizational Web sites of relevance to their prevention areas, to post inquiries to the Child Maltreatment listserv maintained by Cornell University, and to directly correspond with identified experts in their particular area for guidance on unpublished or "non-mainstream" sources of information. So-called "grey literature" sites were not uniformly searched, although some groups did explore this option. Several elements of these search strategies were not verifiable by the instructor, and it is possible that complete fidelity to the process was not achieved by all student groups. Doctoral students assisting with the later stages of the project were asked to do a final (albeit more cursory) literature search of just the academic search engines. Several other publications deemed relevant to include were identified in this last stage.

Excluded from the review were studies that relied on only retrospective assessments of program participants, studies that did not use validated measures of maltreatment or maltreatment risk, or non-empirical studies. Studies with small sample sizes were retained for the review, but may lack sufficient statistical power to generate evidence of program impact. Another important consideration is that the categories of prevention programming reviewed for this exercise were predetermined by a relatively small group of individuals. Some categories of prevention programming may have been overlooked. Similarly, prevention programs that involved multiple modes of intervention could not be easily categorized into the prevention areas that were predefined. Instead of excluding such studies, they are discussed in the text of one or more chapters. However, a "comprehensive prevention" category was not reviewed, and thus some important research may have been missed as a result. Meta-analyses, where they existed, were incorporated in the text of chapter reviews, but were not included in the chapter tables.

As with any effort to conduct a comprehensive literature search, relevant studies may be overlooked if, for example, the search terms employed are too broad or inconsistent with descriptions provided by authors. Also, some relevant research may be published after the time period of the manual literature search. In the present review, students conducted searches through September 2008. Some studies "in press" at that time were later retrieved in their published forms, but research published or released for the first time after September 2008 was not included in this exercise. This is noteworthy, in part, because the editors of *The Future of Children* journal

[4]In a recent review of universal (or primary) prevention strategies, gaps in the prevention knowledge base are highlighted, including promising practices that have not yet been evaluated (Klevens & Whitaker, 2007).

[5]For chapters on school-based interventions and juvenile sex offender programs, the search term "child sexual abuse" was also used.

(see www.futureofchildren.org) were in the process of developing an issue on "Preventing Child Maltreatment," which was subsequently released in Fall 2009.

There are several take-away messages from this exercise. First, there is a critical need for a greater number and more rigorous evaluations of child maltreatment prevention activities. The field has had some notable contributions to the prevention knowledge base, but the vast number of evaluation studies related to child maltreatment prevention lack sufficient scientific rigor for making a meaningful contribution to an understanding of "what works." Many child maltreatment researchers acknowledge barriers to conducting evaluation research stemming from the reluctance of service providers to "withhold" treatment from some families. The reality, however, is that even prevention efforts widely assumed to be effective in reducing child maltreatment have very little research to support this claim, or inconsistent, and even nonexistent, evidence of impact, at least vis-à-vis more direct measures of child maltreatment outcomes. This review demonstrates that there are manageable ways to engage in randomized experimental evaluations (e.g., most experimental evaluations involve control groups that receive some type of service intervention), or to conduct quasi-experimental evaluations with reasonably comparable control groups. Both strategies can be effectively supplemented with pre-post measures of child maltreatment risk, process and implementation evaluations, and qualitative research on participants' experiences.

Second, this exercise helped illuminate the need for more systematic reviews of the literature on child maltreatment prevention. Many, if not most, of the literature reviews embedded in the empirical research are highly selective and rarely transparent in method. With the proliferation of research on child maltreatment over multiple decades, highly focused, comprehensive reviews are needed that span both the published and unpublished literature. Methods for conducting such reviews have been promulgated by efforts such as the Cochrane and Campbell Collaborations, and the child maltreatment prevention field could benefit from more reviews that follow such rigorous standards.

Finally, during the course of this exercise, it became evident that there was little existing literature on the role of economic support as a strategy for reducing child maltreatment. Thus, the editors of this review conducted their own systematic search specifically around economic assistance interventions. Despite decades of evidence that poverty is one of the strongest correlates of child maltreatment and CPS system involvement, there are currently no identifiable evaluations of whether economic assistance interventions prevent child maltreatment. Although many prevention programs include economic support components, they are usually tangential to the key program elements, or are not singled out in evaluation efforts for their preventive impact. This is a major gap in the prevention literature that deserves critical attention.

It is hoped that the knowledge summarized in this document will serve as motivation to the field to engage in evaluation research and improve upon evaluation strategies already in place. The expansion of funding opportunities at the federal level as well as through private foundations has grown meaningfully in recent years, and many funders now require rigorous evaluation designs. This trend should further push researchers, policymakers, and practitioners to actively engage in efforts to improve the evidence base for child maltreatment prevention. With greater attention to "what works," exciting and critical accomplishments are undoubtedly on the way.

References

Klevens, J., & Whitaker, D. J. (2007). Primary prevention of child physical abuse and neglect: Gaps and promising directions. *Child Maltreatment, 12*, 364–377.

Lee, S., Aos, S., & Miller, M. (2008). Evidence-based programs to prevent children from entering and remaining in the child welfare system: Benefits and costs for Washington. Olympia, WA: Washington State Institute for Public Policy, Document No. 08-07-3901.

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

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

Self-Brown, S., & Whitaker, D. J. (2008). Parent-focused child maltreatment prevention: Improving assessment, intervention, and dissemination with technology. *Child Maltreatment, 13*, 400–416.

CHAPTER 1: CENTER-BASED PARENTING INTERVENTIONS

Jenna Guensburg, Kara Kratowicz, and Brianne Nillisen

Description of Prevention Program Area

Over the last several decades, center- and clinic-based parenting interventions[6] have expanded across the United States in an effort to prevent child abuse and neglect. In general, these programs are short-term efforts emphasizing structured learning on topics related to parenting attitudes, skills, and knowledge of children's developmental needs. Parents who are at high risk for child maltreatment are often the target of this type of intervention. High-risk populations targeted have included parents who are or have been involved with child protective services (CPS), those with inadequate support systems, parents of children with significant behavior or health problems, those under financial stress, teen and single parents, homeless parents, parents who are incarcerated, parents with substance abuse problems, parents with limited education, and those with limited knowledge of child development.

For this review, we focused on only those studies that tracked child maltreatment outcomes, including CPS or medical reports of child maltreatment and validated measures of child maltreatment risk. This chapter includes reviews of interventions that target populations before they are formally involved in the CPS system. However, we did include two studies (Fennel & Fishel, 1998; Sanders et al., 2004) involving parenting education aimed at an array of target populations, including families referred from CPS. Evaluations of parenting education programs that exclusively target CPS-involved clients are not addressed.

Brief Statement of Effectiveness

The studies reviewed suggest that center-based parenting education has a positive impact on preventing child maltreatment, although studies have typically focused on outcomes such as parental stress and parenting attitudes, rather than more direct indicators of child maltreatment (e.g., CPS reports, reports of abusive head injuries). Also, the samples for included studies tend to be quite small, with nonrandomized sample selection methods. Additional research, with more direct measures of child maltreatment, and larger, more representative samples, is needed to provide a better understanding of the preventive impact of center-based parenting education. Experimental evidence, in particular, is needed across a range of program models and with differing demographic populations to aid more informed decisions about program planning for populations at risk of child maltreatment.

Description of Interventions Reviewed

The studies of center-based parenting interventions included in this review involved classroom- or hospital-based programming on a variety of topics related to parenting. Program duration ranged from a few days (e.g., a single intervention during a labor and delivery hospitalization) to 24 weeks. Sessions typically occurred once per week and ranged from 1 to 2 ½ hours. All sessions were held in community settings, and all but one program (Dias et al., 2005) evaluated a universal intervention targeted at moderate- to high-risk populations. Most programs served voluntary participants (Britner & Repucci, 1997; Dias et al.; Gorzka, 1999; Palusci, Crum, Bliss, & Bavolek, 2008; Wolfe & Hirsch, 2003), while others included both voluntary participants and mandated participants referred from CPS (Fennell & Fishel, 1998; Huebner, 2002; Sanders et al., 2004).

The studies focused on several common parenting topics. For instance, all interventions touched on communication and discipline with children. Several interventions additionally emphasized parent-child interaction and child development (Britner & Repucci, 1997; Gorzka, 1999; Huebner, 2002; Sanders et al., 2004; Weinman, Schreiber, & Robinson, 1992; Wolfe & Hirsch, 2003). Select interventions focused on responsible parenting and safety measures (Britner & Repucci; Palusci et al., 2008); conflict resolution/problem solving (Devall, 2004; Huebner; Palusci et al.); and avoiding substance abuse (Devall; Britner & Repucci). Two of the most frequently evaluated curricula are *Nurturing Parents* and *Systematic Training for Effective Parents* (*STEP*). Objectives of these curricula are comparable in that both aim for improvement in parenting attitudes, decreased parental stress, increased knowledge of child development, and enhanced parenting skills.

Content was delivered through varying modes, including lectures and group discussion (Britner & Repucci, 1997; Devall, 2004; Fennell & Fishel, 1998; Gorzka, 1999; Huebner, 2002; Palusci et al., 2008; Sanders et al., 2004;

[6]This chapter focuses on parenting interventions that are not home-based (e.g., center- or clinic-based group or individualized education); home visiting programs are covered in chapters 4 and 5.

Weinman et al., 1992; Wolfe & Hirsch, 2003); print material (Dias et al., 2005); videos (Devall; Dias et al.; Fennel & Fishel; Huebner; Gorzka); assignments (Devall; Huebner; Sanders et al.; Wolfe & Hirsch); and practice of parent-child interaction during sessions (Devall; Weinman et al.).

Methodological Quality of Studies

Several studies drew from racially and ethnically diverse populations (Britner & Repucci, 1997; Devall, 2004; Dias et al., 2005; Fennell & Fishel, 1998; Gorzka, 1999; Huebner, 2002; Palusci et al., 2008; Weinman, Schreiber, & Robinson, 1992; Wolfe & Hirsch, 2003). Four studies utilized nonrandomized control groups as sources of comparison (Britner & Repucci; Dias et al.; Fennell & Fishel; Wolfe & Hirsch). The outcome measures used for assessing program effectiveness included scales that have been shown to be associated with other more direct measures of child maltreatment (e.g., CPS involvement). Such measures included the Adult-Adolescent Parenting Inventory (AAPI; Bavolek, 1984; Bavolek, Comstock, & McLaughlin, 1996); the AAPI-2 (Bavolek & Keene, 2001); the Child Abuse Potential Inventory (CAPI; Milner, 1986; Milner, 1994); and the Parenting Stress Index (PSI; Abidin, 1995). One study (Dias et al.) relied on case counts of substantiated abusive head injuries in young children. Sample sizes varied across studies ranging from 6 participants to well over 50,000 participants. The smaller sample sizes lack sufficient statistical power for detecting program effects. Self-selection through voluntary participation may also bias the results of these studies due to the possibility that the highest-risk parents may not voluntarily participate. Furthermore, several studies had unclear or reported nonrandom sample selection methods that may limit the generalizability of evaluation findings or bias estimates of program effects. The most commonly used analysis strategy involved pre-post tests to measure knowledge attainment or changes in attitudes, beliefs, or stress. Several studies did not report attrition rates, which could bias the results of pre-post tests (e.g., more-motivated parents may be more likely to complete programs than less-motivated parents). The only study that analyzed attrition found that it was associated with individuals who were parenting their first child, unmarried, or reported no maltreatment during their own childhood (Huebner).

Review of Findings

Most studies demonstrated positive impact as evidenced by statistically significant changes in one or more outcomes, including parenting attitudes, behaviors, and/or stress related to parenting. Short-term changes in parental attitudes were measured using pre-post tests of the AAPI (Britner & Repucci, 1997; Gorzka, 1999; Weinman et al., 1992); the AAPI-2 (Devall, 2004; Palusci et al., 2008); the CAPI (Fennell & Fishel, 1998; Palusci et al.; Sanders et al., 2004); and the PSI (Huebner, 2002; Wolfe & Hirsch, 2003). As expected, several studies showed an improvement in parenting attitudes towards children (Britner & Repucci; Devall; Fennell & Fishel; Gorzka). For example, post-intervention, or compared to a control group, parents had more positive perceptions of their children, more realistic expectations of their children, increased empathy, decreased belief in corporal punishment, and decreased behaviors and attitudes associated with parent-child role reversal (Britner & Repucci; Fennell & Fishel; Gorzka; Devall). Fennel and Fishel showed that participants were less potentially physically abusive than nonparticipants. Britner and Repucci showed that parents who participated in parenting education were less likely to have substantiated reports of child maltreatment, despite the fact that the comparison group was initially evaluated to have a lower level of risk overall. Dias and colleagues (2005) assessed trends in abusive head injuries in children 0–36 months of age and found reductions in the number and incidence of injury during the intervention period compared to the 6 years that preceded it, and compared to a demographically similar control region during the intervention period. Two studies (Gorzka; Huebner) measured pre-post changes in reports of parenting stress, and both showed positive results (i.e., reduced parenting stress). Wolfe and Hirsch (2003) found lower levels of stress in the treatment group compared to a wait-listed control group.

Discussion

In addition to the studies included in this review, there exists a substantial amount of research on parenting education programs that measure an array of outcomes potentially predictive of child maltreatment, but that do not, in and of themselves, constitute widely validated measures of maltreatment risk. Several such studies were reviewed, but ultimately excluded, because they did not include outcome measures that have been shown to have concurrent or predictive validity vis-à-vis child maltreatment. Additional research is needed analyzing the effects of parenting education as it relates specifically to child maltreatment outcomes.

More studies are also needed that assess longer-term results (e.g., comparing treatment and control groups on child maltreatment outcomes over several subsequent years following the intervention). Only two studies included in this review looked at substantiated abuse reports over a several year period (Britner & Repucci,

1997; Dias et al., 2005). Because most of the existing research incorporates short-term follow-up periods, it is unknown whether participants retain knowledge from these programs and maintain positive parenting attitudes and behaviors over time.

It is clear that research incorporating larger, randomly selected samples and experimental designs is needed to shore up an understanding of the effectiveness of center- and clinic- or hospital-based parenting education programs. Three studies included in this review used control groups of at-risk or demographically similar populations; however, the groups were not derived through random assignment (Britner & Repucci, 1997; Dias et al., 2005; Fennell & Fishel, 1998; Wolfe & Hirsch, 2003). Thus, demonstrated outcomes cannot be reliably attributed to the intervention.

Despite shortcomings in research design, studies included in this review offer suggestive (albeit descriptive) evidence of short-term benefits of center-based parenting education programs, including increased knowledge of child development and alternatives to physical discipline, improvements in parenting attitudes, and reductions in parenting stress. Complementing these findings, a recent meta-analysis of parent training interventions finds that within populations at risk of child maltreatment, such interventions have moderate and significant effects (Lundhal, Nimer, & Parsons, 2006). If short-term outcomes can be shown to have long-sustaining effects, there is a strong case to be made that parenting education can prevent child maltreatment with populations external to the CPS system.

Search Terms

The search terms used to generate the studies reviewed include combinations of the following: parent, education/parent instruction/parent class, AND child abuse/child neglect/child maltreatment.

References

Abidin, R. R. (1995). *Parenting stress index: Professional manual* (3rd ed.). Odessa, FL: Psychological Assessment Resources, Inc.

Bavolek, S. J. (1984). *Adult-adolescent inventory*. Eau Claire, WI: Family Development Resources.

Bavolek, S. J., Comstock, C. M., & McLaughlin, J. A. (1996). The nurturing program: A validated approach for reducing dysfunctional family interactions. In S. J. Bavolek (Ed.), *Research and validation report of the nurturing programs* (pp. 11–21). Eau Claire, WI: Family Development Resources.

Bavolek, S. J., & Keene, R. G. (2001). *Adult-adolescent parenting inventory AAPI-2: Administration and development handbook*. Park City UT: Family Development Resources, Inc.

Britner, P. A., & Repucci, N. D. (1997). Prevention of child maltreatment: Evaluation of a parent education program for teen mothers. *Journal of Child and Family Studies, 6*(2), 165–175.

Devall, E. L. (2004). Positive parenting for high-risk families. *Journal of Family and Consumer Sciences, 96*(4), 22–28.

Dias, M. S., Smith, K., deGuehery, K., Mazur, P., Li, V., & Shaffer, M.L. (2005). Preventing abusive head-trauma among infants and young children: A hospital-based parent education program. *Pediatrics, 115*, e470–e477.

Fennell, D. C., & Fishel, A. H. (1998). Parent education: An evaluation of STEP on abusive parents' perceptions and abuse potential. *Journal of Child and Adolescent Psychiatric Nursing, 11*(3), 107–120.

Gorzka, P. A. (1999). Homeless parents: Parenting education to prevent abusive behaviors. *Journal of Child and Adolescent Psychiatric Nursing, 12*(3), 101–109.

Huebner, C. (2002). Evaluation of a clinic-based parent education program to reduce the risk of infant and toddler maltreatment. *Public Health Nursing, 19*(5), 377–389.

Lundhal, B., Nimer, J., & Parsons, B. (2006). Preventing child abuse: A meta-analysis of parent training programs. *Research on Social Work Practice, 16*, 251–262.

Milner, J. S. (1986). *The child abuse potential inventory: Manual* (2nd ed.). DeKalb, IL: Psytec Inc.

Milner, J. S. (1994). Assessing physical child abuse risk: The child abuse potential inventory. *Clinical Psychology Review, 14*, 547–583.

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

Sanders, M., Pidgeon, A., Gravestock, F., Connors, M., Brown, S., & Young R. (2004). Does parental attributional retraining and anger management enhance the effects of the Triple P—Positive Parenting Program with parents at risk of child maltreatment? *Behavior Therapy, 35*, 513–535.

Weinman, M. L., Schreiber, N. B., & Robinson, M. (1992). Adolescent mothers: Were there any gains in a parent education program? *Family and Community Health, 15*(3), 1–10.

Wolfe, R., & Hirsch, B. (2003). Outcomes of parent education programs based on reevaluation counseling. *Journal of Child and Family Studies, 12*(1), 61–76.

Table 1. Studies Included for Review of Center-Based Parenting Education

Author/Year	Program Name	Program Description	Sample Characteristics	CM Outcome Measure(s)	Study Design	Main Findings
Britner & Repucci, 1997	(No name provided)	12 weeks of classes (no information on frequency/duration)	Treatment group: N=125 high-risk teen mothers Control groups: N=314 mothers in hospital (no treatment); N=96 mothers who received 1 home visit	Adult-Adolescent Parenting Inventory (AAPI); substantiated CPS reports	Quasi-experimental (nonrandomized treatment and control groups); pre-post test	Mothers in program less likely to have substantiated CPS reports than controls; gains in parenting attitudes and knowledge of child development (AAPI)
Dias, Smith, deGuerhery, Mazur, Li, & Shaffer, 2005	Prevent Shaken Baby Syndrome!	Trained nursing staff distributed educational material and collected signed "commitment statements" from parents acknowledging receipt and understanding of material and a pledge to avoid shaking their babies.	All parents of newborns, born during a 66-month period beginning in 1998, in 8 western New York counties	Cases of substantiated abusive head injury in children 0–36 months of age	Trend analysis; Quasi-experimental (non-randomized control group: Commonwealth of Pennsylvania, cases of substantiated abusive head injury between 1996 and 2002)	The incidence of abusive head injuries in young children was reduced by over 50% during the study period, compared to the 6 years prior to the onset of the program; no similar trend occurred in the comparison region.
Devall, 2004	Nurturing Parent (NP) Program	Weekly classes (2.5 hrs) for 9–24 weeks	N=323 parents (e.g., teen, single, foster, abusive, substance-affected, incarcerated); no information provided on selection methods	Adult-Adolescent Parenting Inventory (AAPI)	Pre-post test	Decreases in AAPI subscales: unrealistic expectations, belief in corporal punishment, role reversal, and oppression of power; increase in empathy
Fennel & Fishel, 1998	Systematic Training for Effective Parents (STEP)	9-week parent training program; 90-minute sessions, once per week	N=18 (10 treatment; 8 control); self-referred, all high-risk for abuse	Child Abuse Potential Inventory (CAPI)	Quasi-experimental (nonrandomized treatment and control groups); Pre-post test	Treatment group CAPI scores declined
Gorzka, 1999	(No name provided; Nurturing Parent Program curriculum used)	Weekly 1-hour classes for 3 weeks	N=19 parents who sought shelter at an emergency homeless shelter	Adult-Adolescent Parenting Inventory (AAPI); Parenting Stress Index (PSI)	Pre-post test	Short-term reductions in child domain scores of PSI; reductions in unrealistic expectations of the child (AAPI subscale)
Huebner, 2002	(No name provided; community health clinic-based; used Systematic Training for Effective Parenting)	Eight weekly 2-hour sessions	N=199 at-risk primary caregivers of children 1 to 36 months of age from two community samples and one residential drug treatment sample (sizes of subgroups not provided)	Parenting Stress Index, Short Form (PSI-SF)	Pre-post test	Decreases in parenting stress

Author/Year	Program Name	Program Description	Sample Characteristics	CM Outcome Measure(s)	Study Design	Main Findings
Palusci, Crum, Bliss, & Bavolek, 2008	Helping Your Child Succeed (based on Family Nurturing Program)	Class frequency and duration varied by subgroup from 8 weekly classes to a 3-day camp in which sessions varied in length	N=184 community participants; N=446 jail participants; N=38 participants from a batterers intervention program; N=74 participants from substance abuse rehabilitation programs; N=39 individuals who attended a 3-day camp	Adult-Adolescent Parenting Inventory-2 (AAPI-2); Child Abuse Potential Inventory (CAPI)	Pre-post test	Decreased lack of empathy and belief in corporal punishment; males had greater decreases than females, particularly in subscales measuring attitudes toward corporal punishment
Sanders, Pidgeon, Gravestock, Connors, Brown, & Young, 2004	Standard Group Behavioral Family Intervention (SBFI) and Enhanced Group Behavioral Family Intervention (EBFI) based on Triple P Program model	SBFI: Four 2-hour group sessions followed by 4 individual phone consultations over 8 weeks; EBFI: Four 2-hour group sessions, 4 individual phone consultations, 4 additional group sessions focusing on addressing child abuse and neglect risk factors over 12 weeks	N=39 in SBFI; N=35 in EBFI	Child Abuse Potential Inventory (CAPI)	Pre-post test	Short-term: Parents in both SBFI and EBFI showed significant improvements in CPI scores; EBFI parents had greater improvements (compared to SBFI parents) in CAPI scores; Long-term: No significant difference observed between groups at 6-month follow-up
Weinman, Schreiber, & Robinson, 1992	Parent Education Program	Teen mothers attend classes for 7 hours per day, 3 days per week, for 8 weeks	N=73 teen mothers from nine different sessions	Adult-Adolescent Parenting Inventory (AAPI)	Pre-post test	Improvements in all parenting constructs within the AAPI; differences maintained 8 weeks after program completion with the exception of inappropriate expectations
Wolfe & Hirsch, 2003	Listening to Children	8 weekly meetings lasting 2.5 hours; Study 1: Targeted middle-income married mothers with at least one child younger than age 5; Study 2: Targeted African American mothers with children enrolled in Head Start	Study 1: N=11 treatment; N=14 control Study 2: N=6 treatment; N=6 control	Parenting Stress Index, Short Form (PSI-SF)	Quasi-experimental (nonrandomized treatment and control groups); Pre-post test	Study 1: Treatment group reported less stress and less problematic child perceptions than control group on post-tests; Study 2: Treatment group mothers reported less depression, social isolation, and overall stress, and greater satisfaction from interaction with their children than control group on post-tests.

CHAPTER 2: SOCIAL SUPPORT INTERVENTIONS

Hannah Anderson and Sara Harrison Fisk

Description of Prevention Program Area

Social support has been identified as a critical component of interventions for families at risk for child abuse or neglect. Such interventions can involve both formal (e.g., agency-based) as well as informal social support, characterized as "systematic activities designed to change the existing quality, level, or function of an individual's personal social network or to create new networks and relationships for families through the use of volunteers and peer group experiences" (Budde & Schene, 2004, p. 342). Social support interventions are typically designed to assist families in meeting immediate needs, increase parental protective factors, strengthen families, and reduce child maltreatment. Social support interventions tend to target caregivers perceived to have a higher risk of child maltreatment. Examples of characteristics that have been associated with higher risk levels have included: elevated parental stress, poverty, unemployment, presence of a child with behavior problems or special needs, caregiver mental health issues, lack of a support system, substance abuse issues, single parenthood, large family size, and/or the presence of domestic violence in the family home (Cowen, 1998). Generally, high-risk families experience more than one of these risk factors.

Specific social support interventions reviewed for this chapter include respite care, mutual support programs, and family group conferences (also referred to as family team meetings) targeted primarily to parents and families who do not yet have formal involvement with child protective services (CPS). While such programs are quite common, there is little empirical research regarding their effectiveness in preventing child maltreatment with families outside of the CPS system.

Respite care (RC) provides families with temporary, comprehensive, often overnight child care in a licensed family home or day care facility or in a family's own home. It is intended to provide parents with a temporary "break" from their caregiving duties due to an emergency situation or high stress. Respite care programs are typically designed to have a crisis component (e.g., a parent is unable to provide appropriate care due to an emergency situation) or as a pre-arranged protective measure (e.g., a caregiver to a high-needs child may use respite twice a month to reduce parental stress). Group-based mutual support programs (MSP), such as those offered through Parents Anonymous©, are prevalent, but few have been rigorously evaluated. Such programs are typically voluntary, are partially led or directed by participants, and many involve anonymous membership. Family Group Decision Making (FGDM) is a practice strategy that originated in New Zealand, where it is now a mandatory component of child welfare services (Hassall, 1996). FGDM is often used to prepare children and families for reunification at the close of a foster care spell or with families with open child welfare cases. FGDM centers on bringing family and social support networks together to determine a plan for child safety and well-being, with facilitation by professional staff. Research on the efficacy of FGDM with families outside of CPS is nonexistent.

For the present review, we included only those evaluations that focused on the particular types of interventions described above. We did not include evaluations of programs that offer multiple services in addition to social support elements if evaluation findings could not be reasonably linked to the social support component(s). We also did not review evaluations that included outcome measures not previously validated vis-à-vis child maltreatment, or that relied primarily on measures of participant satisfaction or other retrospective assessments by participants.

Brief Statement of Effectiveness

An extensive review of available literature regarding the effectiveness of social support interventions in reducing child maltreatment yielded a limited amount of evaluation research. The studies reviewed suggest mixed impact on child maltreatment prevention. While MSP programs, specifically Parents Anonymous©, evidenced declines in child maltreatment measures over time, evaluations of RC and FGDM were mixed, with some evidence of higher rates of child maltreatment in treatment groups, compared to both nonrandom and randomized control groups. However, it is difficult to draw broad-based conclusions about the effectiveness of social support programs due to the scant attention that has been paid to this preventive strategy and its associated impact on more direct measures of child maltreatment.

Description of Interventions

The three evaluations of respite care included in this review (i.e., ARCH National Respite Network, 2007; Bruns & Burchard, 2000; Cowen, 1998) involved

programs designed to provide emergency child care for families experiencing crisis (including risk of child abuse and/or neglect). Length of respite placement varied in duration ranging from less than 1 day to 30 days. While these programs involved additional components (e.g., referrals to community resources, parenting information), respite services were the central component of the programs. Some respite programs also involved requirements that parents visit children daily and participate in case management services (ARCH National Respite Network).

The only evaluation of a mutual support program that met review criteria involved the program Parents Anonymous© (National Council on Crime and Delinquency, 2007). Parents Anonymous© programs aim to eliminate risk factors associated with child maltreatment and to increase support for parents struggling with their children. The key principles of these programs are mutual support, parent leadership, shared leadership, anonymity, and confidentiality. Although primarily a voluntary intervention, some parents who participate are mandated to do so by CPS (National Council on Crime and Delinquency).

Unlike RC and MSP interventions, which seek to change the structure of a family's social support resources through the use of peer networks and volunteers, family group conferences are intended to change the quality and intensity of existing social networks (Budde & Schene, 2004). This is addressed in FGDM by bringing together family members, friends, community members, and social service providers (to include CPS staff) who are vested in promoting safety and well-being for the target family's child(ren). The conference or meeting requires extensive outreach and planning, is typically several hours in duration, and may involve an assessment phase that includes formal service providers, as well as time dedicated to a private meeting of informal members of the social support network.

Methodological Quality of Studies

All three evaluations of RC were quasi-experimental in design, involving nonrandom comparison groups. RC participating families were a select group (those who agreed to participate, and in some studies, those who completed a follow-up survey in addition to a baseline assessment), and as such were not representative of the larger target population in each study. Two of the evaluations (Bruns & Burchard, 2000; Cowen, 1998) involved relatively small samples (e.g., 50–75 participants). Some families using RC received additional services and resources such as baby supplies, day care referrals, and housing information. In addition, parents participating in RCs from the ARCH network had requirements to meet with a caseworker to address family needs. These additional aspects of the RC interventions pose some limits on understanding of the effectiveness of respite care alone as a prevention strategy.

The evaluation of an MSP prevention program—Parents Anonymous©—involved repeated assessments (baseline, 1 month, and 6 months) of a number of measures associated with child maltreatment (National Council on Crime and Delinquency). Like the RC evaluations, the Parents Anonymous© sample was not representative of the larger population of participants. However, the sample size was reasonable for conducting repeated measures analyses, an array of validated measures associated with child maltreatment were included in the evaluation, and careful attention was paid by the research team to the role of sample attrition.

Review of Findings

Evaluations of RC produced mixed results, but it is likely that some of the inconsistencies are driven by differences in study design. The Bruns and Burchard (2000) and Cowen (1998) studies both found evidence of declines in CPS involvement, and Cowen found evidence of reductions in parenting stress, associated with respite care use. Both studies employed quasi-experimental designs (e.g., nonrandom comparison groups) and pre-post tests on measures associated with child maltreatment. They also both relied on small sample sizes, and Cowen's findings on a pre-post measure of parenting stress suffered from significant attrition. The larger scale study conducted by the ARCH National Respite Network (2007) found higher rates of CPS involvement among respite-using families compared to demographically matched, CPS-identified families from counties lacking respite care services. This finding was attributed to a possible "scrutiny effect" for the respite care families, although it is not clear why families from the control group would not also face higher scrutiny due to their involvement with CPS.

The only evaluation of an MSP intervention that was identified for the present review was a repeated-outcomes analysis of Parents Anonymous© participants (National Council on Crime and Delinquency, 2007). This evaluation did identify improvements in a number of validated measures associated with child maltreatment, including reductions in subscales of the Child Abuse Potential Inventory (Milner, 1986), the Parent-Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998), and the Parenting Stress Index-Short Form (Abidin, 1995). One important

caveat is that the baseline scores on such measures tended to be low, suggesting that a lower-risk group of families may be selecting into this type of intervention.

The review of studies evaluating FGDM interventions did not yield any evaluations involving families outside of the CPS system. Three evaluations were identified involving families who had CPS contact that did not result in a foster care placement for one or more children. While this group of families cannot be characterized as a "voluntary" population, since in many cases CPS continued to monitor them and provide other in-home services, we include evaluations of FGDM with this target population when measures of child maltreatment (e.g., re-reports to CPS) were included as key outcomes. The findings from these studies did not offer strong evidence of reductions in child maltreatment. Indeed, the results of one experimental evaluation (Berzin, 2006) demonstrated higher rates of child maltreatment reports for the treatment group compared to the control group. This effect also emerged for a quasi-experimental evaluation of multiple FGDM sites in Sweden (Sundell & Vinnerljung, 2004), and in addition, this study found evidence of higher rates of foster and residential care placement and lower rates of case closure in the treatment group compared to the nonrandomized control group. The only FGDM study to show reductions in child maltreatment reports (Pennell & Burford, 2000) involved a small sample (N=63) and a quasi-experimental design with limited information on how the "CPS-identified" control group was selected.

Discussion

While it might be assumed, due to the sheer number of social service programs that include a social support component, that such interventions have been proven to be effective in preventing child maltreatment, astonishingly little research supports this conclusion. Social support-based interventions are often perceived by families and social service practitioners alike as valuable. The available literature has supported social support interventions as reducing parental stress, maltreatment potential, harsh discipline, and involvement in child protection systems. However, due to the limited amount of rigorous research to date, it is premature to conclude that such services are effective in reducing child maltreatment. Given the growing popularity of family group conferencing, and the prevalence of mutual support and respite care interventions across the country, this lack of evidence should serve as compelling motivation to the field to engage in rigorous research that can more clearly demonstrate the preventive benefits of social support services.

Search Terms

The search terms used to generate the studies reviewed include combinations of the following: family support, parent support, mutual support, self-help, social support, respite care, crisis care, crisis nursery, family group conference, family team meeting AND child abuse/child neglect/child maltreatment.

References

Abidin, R. R. (1995). *Parenting stress index: Professional manual* (3rd ed.). Odessa, FL: Psychological Assessment Resources, Inc.

ARCH National Respite Network. (2007). Crisis respite: Evaluating outcomes for children and families receiving crisis nursery services. http://www.archrespite.org/CN_Final_Revised.pdf (Accessed February 15, 2009).

Berzin, S. C. (2006). Using sibling data to understand the impact of family group decision-making on child welfare outcomes. *Children and Youth Services Review, 28*, 1449–1458.

Bruns, E. J., & Burchard, J. D. (2000). Impact of respite care services for families with children experiencing emotional and behavioral problems. *Children's Services: Social Policy, Research, and Practice, 3*(1), 39–61.

Budde, S., & Schene, P. (2004). Informal social support interventions and their role in violence prevention: An agenda for future evaluation. *Journal of Interpersonal Violence, 19*(3), 341–355.

Cowen, P. S. (1998). Crisis child care: An intervention for at-risk families. *Issues in Comprehensive Pediatric Nursing, 21*, 147–158.

Hassall, I. (1996). Origin and development of family group conferences. In J. Hudson, A. Morris, G. Maxwell, & B. Galaway (Eds.), *Family group conferences: Perspectives on policy and practice* (pp. 17–36). Monsey, NY: Willow Tree Press.

Milner, J. S. (1986). *The child abuse potential inventory: Manual* (2nd ed.). DeKalb, IL: Psytec, Inc.

National Council on Crime and Delinquency. (2007). *Outcome evaluation of parents anonymous.* Oakland, CA: Author.

Pennell, J., & Burford, G. (2000). Family group decision making: Protecting women and children. *Child Welfare, 79*(2), 131–157.

Straus, M. A., Hamby, S. L., Finkelhor, D., Moore, D. W., & Runyan, D. (1998). Identification of child maltreatment with the Parent-Child Conflict Tactics Scales: Development and pyschometric data for a national sample of American parents. *Child Abuse & Neglect, 22*(4), 249–270.

Sundell, K., & Vinnerljung, B. (2004). Outcomes of family group conferencing in Sweden: A 3-year follow-up. *Child Abuse & Neglect, 28*, 267–287.

Table 2. Studies Included for Review of Social Support Interventions

Author/Year	Program Name	Program Description	Sample Characteristics	Key Outcome Measure(s)	Study Design	Main Findings
RESPITE PROGRAM EVALUATIONS						
ARCH National Respite Network, 2006 (Revised 2007)	Crisis Respite	24-hour crisis nursery care (up to 30 days) for children ranging from infancy to age 5, coupled with case management services to address family needs; most families self-referred to services, but were considered at risk for child maltreatment	Families from 4 Midwest counties (N=96 families without current, but with prior, CPS involvement; N=58 families without current or prior CPS involvement;[a] and N=468 matched control families identified by CPS in counties without crisis respite)	CPS reports; substantiated CPS reports; number of days in out-of-home placement (OHP)	Quasi-experimental (non-randomized treatment and control groups)	Families using respite care (RC) had more CPS reports but fewer substantiated reports compared to non-CPS involved control group; results on OHP inconclusive
Bruns & Burchard, 2000	Vermont Department of Developmental and Mental Health Services Respite Care	In-home, out-of-home, and overnight respite services for caregivers of children and adolescents with emotional and behavioral problems	N=73 families (of N=94) who applied for respite services, and who agreed to participate in the study; (N=33 received 50+ hours of RC; N=28 waitlisted families received no RC; N=12 families received 1–12 hours of RC)	OHP; additional crisis intervention services	Quasi-experimental (non-randomized treatment and control groups); pre-post tests	High-use group had a reduction in OHP while in RC compared to an increase in OHP for waitlist comparison group
Cowen, 1998	Crisis Child Care	Short-term (up to 24 hours) crisis RC for children ranging from infancy to age 13	Families using RC in 4 rural Iowa counties; N=51 parents (23% response rate)	Parenting Stress Index-Short Form (PSI-SF); CPS report rates	Pre-post tests; comparison of 12-month CPS report rate changes in crisis care counties compared to counties not using crisis care	Reduced levels of parenting stress; CPS referrals decreased by 2% in counties where crisis care was implemented; no decline in other counties
MUTUAL SUPPORT PROGRAM EVALUATIONS						
National Council on Crime and Delinquency, 2007	Parents Anonymous©	Anonymous mutual support groups co-led by a professionally trained facilitator and a group participant; group meetings offered weekly	N=188 parents, in groups from 19 states, who attended multiple meetings over a 6-month time period; 29% mandated to attend	Subscales of Child Abuse Potential Inventory (CAP-I); subscales of Parent-Child Conflict Tactics Scale (P-C CTS); Parenting Stress Index-Short Form (PSI-SF)	Repeated measures analysis	Statistically significant reductions in CAP-I and one P-C CTS subscale at both 1 and 6 months; reductions in other P-C CTS subscale and in PSI-SF were not statistically significant

Author/Year	Program Name	Program Description	Sample Characteristics	Key Outcome Measure(s)	Study Design	Main Findings
FAMLY GROUP CONFERENCE EVALUATIONS						
Berzin, 2006	California's FGDM Title IV-E Waiver Demonstration	Single family conference within a 6-month period for intact CPS-involved families with children from infancy to age 18	N=110 children whose families received FGDM; N=74 children whose families received traditional in-home CPS services[b]	CPS reports of maltreatment; removal of a child from the home	Experimental evaluation	Higher rate of child maltreatment reports for treatment group compared to control group; incidence of child removals small (N=2 in treatment group only)
Pennell & Burford, 2000	Family Group Decision Making Project	Family group conferences facilitated by a professionally trained coordinator; conferences averaged 5.5 hours in duration	N=32 (primarily intact) families referred from CPS in eastern Canada who received FG conferences; N=31 control group families identified by CPS	CPS events: maltreatment reports, substantiated reports, number of reports, and emergency visits to home related to a maltreatment report	Quasi-experimental (non-randomized treatment and control groups); pre-post tests	Reduction in CPS events for FGDM families during study period and increase in CPS events in control group
Sundell & Vinnerljung, 2004	Family Group Conferences	No information provided on nature of FGDM intervention; families referred for FGDM had to have at least one child under 17 years of age	N=97 children participating in 66 FG conferences in 10 Swedish regions; control group of (N=142) randomly selected children involved in 104 traditional CPS investigations	CPS events: maltreatment reports, substantiated reports, service provision, case closure	Quasi-experimental (non-randomized treatment and control groups)	FGDM group had higher rate of re-reports and substantiated reports to CPS, a higher rate of foster/residential care placement, and more open cases than control group by the end of the 3-year observation period

[a]For the purposes of this review, which focuses on universal or selective prevention efforts, we did not include in the table results involving 468 families with open CPS cases who used crisis respite services during the study period, although the authors report on this group in the evaluation.
[b]Riverside County was also included in the California IV-E Waiver Demonstration, but findings from the Riverside sample were excluded because that site targeted children in foster care or relative care, with the primary outcome being placement stability.

CHAPTER 3: PUBLIC AWARENESS CAMPAIGNS

Yonah Drazen, Lindsey Guenther, and Jenny Hansen

Description of Prevention Program Area

Public awareness campaigns involve focused messages delivered through various forms of media, with the expressed intent to increase knowledge and awareness of child maltreatment, which in turn may influence behaviors that elevate child maltreatment risk. Child maltreatment prevention media campaigns may involve television advertisements, radio advertisements, bulletin boards, educational materials, posters, brochures, and newsletters. These components may occur in different combinations, and may be targeted to specific groups (e.g., parents of newborns) or to a more general population, such as a geographic region.

Brief Statement of Effectiveness

All studies reviewed for this chapter demonstrated some degree of effectiveness, most commonly through pre-post test analyses of measures of parenting dysfunction or maltreatment-related knowledge and/or changes in trends around maltreatment reporting or other markers of child maltreatment (e.g., abandoned infants, hospitalizations for maltreatment-related injuries). Studies that tracked rates of child maltreatment reports attributed increased reporting to improved awareness of maltreatment (Andrews, McLeese, & Curran, 1995; Hoefnagels & Baartman, 1997).

Description of Interventions Reviewed

The studies reviewed evaluated the effectiveness of public awareness campaigns to increase knowledge about child sexual abuse (Rheingold et al., 2007); shaken baby syndrome (Deyo, Skybo, & Carroll, 2008); safe haven programs (California Department of Social Services, 2005); child abuse (Pietrodangelo, 1983; Hoefnagels & Baartman, 1997); the connection between substance abuse and child abuse (Andrews et al., 1995); and positive parenting practices (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009; Calam, Sanders, Miller, Sadhnani, & Carmont, 2008; Waterston et al., 2009).

Media strategies used by the various campaigns included 10-second or 30-second television public service announcements, radio public service announcements, billboards, posters, Web sites, public service announcements in movie theaters, print advertisements in magazines as well as newspapers, press releases, brochures, wallet cards, report card inserts, logos, information packets, newsletters, documentaries and other short films, training sessions and other informational materials for educators, and educational booklets.

Methodological Quality of Studies

One of the more rigorously designed evaluations of a public awareness campaign involved counties randomly assigned to receive universal media and communication strategies, professional training and knowledge dissemination, and different types of targeted interventions for parents (Prinz et al., 2009). These counties were compared to control counties that did not engage in the initiative. Although treatment counties demonstrated more successful outcomes than control counties, it is not known whether observed outcomes were the result of the media campaign, specifically, or additional prevention components put into place simultaneously (e.g., provider training, service integration strategies), or any combination of the above. Nonetheless, this comprehensive prevention strategy represents a new and promising wave of prevention initiatives involving multiple facets and community-level targets of change, as touted by child maltreatment prevention experts (Daro & Dodge, 2009).

Some studies recruited volunteers to participate in research studies and randomly assigned individuals to either view media content or not (Calam et al., 2008; Rheingold et al., 2007; Waterston et al., 2009). Although these studies employed random assignment, individuals first had to express interest in participating, leading to potential selection bias in observed results. It is not possible to know whether this intervention would have the same effect on individuals who would not typically volunteer for such a study. These studies recruited individuals in ways that further limit the generalizability of the findings. One study recruited individuals from shopping malls (Rheingold et al., 2007) and another targeted individuals who were already participating in a family support program (Calam et al., 2008).

The majority of the studies assessed effectiveness by tracking the incidence rates of the behaviors targeted in the intervention, such as maltreatment reports, abandoned infants, or phone calls to hotlines. Correlations between the timing of the media campaigns and the frequency of outcomes were analyzed. However,

such correlations do not allow researchers to assert a causal impact of the media campaigns.

Review of Findings

The experimental study by Prinz and colleagues (2009) showed a statistically significant decrease in child maltreatment outcomes in counties exposed to the media campaign compared to control counties. Three studies found an increase in reports of child abuse and neglect after public awareness campaigns had been implemented, suggesting increased awareness of child maltreatment and knowledge of where to report (Andrews et al., 1995; Pietrodangelo, 1983; Hoefnagels & Baartman, 1997). Pietrodangelo found an increase in the print media's coverage of issues of child abuse and neglect during the public awareness campaign. Some parents reported learning and retaining new information as a result of a shaken baby campaign (Deyo et al., 2008). Other parents reported improved parenting skills and behaviors (Calam et al., 2008; California Department of Social Services, 2005; Rheingold et al., 2007; Waterston et al., 2009). One study (Andrews et al.) concluded that a high number of respondents had been exposed to the campaign, measured in terms of the number of calls to a hotline advertised as part of the campaign. Several studies were excluded from this review because they examined only post-test measures, and thus did not afford an assessment of campaign impact.

Discussion

There is a great need to invest in evaluations of public awareness campaigns to prevent child maltreatment. The existing evaluation research is limited in its rigor. By and large, intervention effects are determined using correlational designs and not through experimental designs that allow researchers to estimate causal effects. More recent research by Prinz et al. (2009) and Waterston et al. (2009) offer examples of how rigorous research can be implemented to assess the impact of public awareness strategies. The existing evidence suggests that public awareness campaigns may be an effective means of increasing awareness about child maltreatment prevention, and there is some evidence that public awareness campaigns may influence parenting behaviors, but further study is required to more accurately assess the unique contribution of this prevention strategy.

Another related type of prevention effort involves community- or region-wide initiatives to address child maltreatment using a multi-faceted approach. Components of this type of prevention strategy may include training initiatives for service providers, agency and system innovations to improve service delivery, community events, and programs for parents with varying levels of maltreatment risk—all of which may occur in the context of a broader public awareness campaign.

Search Terms

The search terms used to generate the studies reviewed include combinations of the following: public awareness, campaign, media, public service announcement, public education, AND child abuse/child neglect/child maltreatment.

References

Andrews, A. B., McLeese, D. G., & Curran, S. (1995). The impact of a media campaign on public action to help maltreated children in addictive families. *Child Abuse & Neglect, 19*, 921–932.

Calam, R., Sanders, M., Miller, C., Sadhnani, V., & Carmont, S. (2008). Can technology and the media help reduce dysfunctional parenting and increase engagement with preventative parenting interventions? *Child Maltreatment, 13*(4), 347–361.

California Department of Social Services. (2005). *Report to the legislature on the Safely Surrendered Baby Law*. Sacramento, CA.

Daro, D. & Dodge, K. A. (2009). Creating community responsibility for child protection: Possibilities and challenges. *Future of Children, 19*(2), 67–94.

Deyo, G., Skybo, T., & Carroll, A. (2008). Secondary analysis of the "Love me…never shake me" SBS education program. *Child Abuse & Neglect, 32*, 1017–1025.

Hoefnagels, C, & Baartman, H.E.M. (1997). On the threshold of disclosure—The effects of a mass media field experiment. *Child Abuse & Neglect, 21*, 557–574.

Pietrodangelo, D. (1983). Child abuse: Making the public aware. *Public Welfare, 41*(4), 31–35.

Prinz, R., Sanders, M., Shapiro, C., Whitaker, D., & Lutzker, J. (2009). Population-based prevention of child maltreatment: The U.S. Triple P System Population Trial. *Prevention Science*. Published online: January 22, 2009.

Rheingold, A., Campbell, C., Self-Brown, S., Arellano, M., Resnick, H., & Kilpatrick, D. (2007). Prevention of child sexual abuse: Evaluation of a community media campaign. *Child Maltreatment, 12,* 352–363.

Waterston, T., Welsh, B., Keane, B., Cook, M., Hammal, D., Parker, L., et al. (2009). Improving early relationships: A randomized, controlled trial of an age-paced parenting newsletter. *Pediatrics, 123,* 241–247.

Table 3. Studies Included for Review of Public Awareness Campaigns

Author/Year	Program Name	Program Description	Sample Characteristics	Key Outcome Measure(s)	Study Design	Main Findings
Andrews, McCleese, & Curran, 1995	No name provided	Saturation media campaign via TV, billboards and posted signs with logos, catch phrases, phone numbers, and instructions. Campaign focused on link between substance abuse and child maltreatment	Residents of South Carolina	Number and content of calls to toll-free child maltreatment information line	Trend data	The number of calls regarding substance abuse concerns and children at risk increased by 61.9% over a 10-month period after the campaign began.
Calam, Sanders, Miller, Sadhnani, & Carmont, 2008	Driving Mum and Dad Mad	Parents watched a television series called "Driving Mum and Dad Mad," which provided education about parenting. Individuals in an enhanced treatment condition also received a self-help workbook and Web-based support on positive parenting.	N=723 families randomized into two groups: N=360 in standard treatment (control) and N=363 in enhanced (treatment) group	Parenting Scale (measured dysfunctional discipline styles) Parental Anger Inventory	Experimental evaluation; pre-post tests	Statistically significant declines in measures of dysfunctional parenting
California Department of Social Services, 2005	Safely Surrendered Baby Public Awareness Campaign	3,900+ paid announcements on network and cable stations; 7,500 public service announcements (PSA); PSAs in movie theaters; Print ads in college and statewide newspapers	Residents of California	Count of surrendered and abandoned babies	Trend data	Significant decrease in number of abandoned infants and abandoned, deceased infants over a period beginning 3 years prior to the campaign through the end of the campaign
Deyo, Skybo, & Carroll, 2008	Love Me, Never Shake Me	After giving birth, parents took a pre-test, received Shaken Baby Syndrome educational materials, watched a short video, responded to a post-test measure, and signed a written pledge to not shake their babies.	N=7,051 biological mothers at least 18 years of age who completed the program from 2002 to 2005 in one of 5 hospitals in central Ohio	Quiz on the effects of Shaken Baby Syndrome	Pre-post tests	Statistically significant increase in knowledge that it is okay to let an infant cry

Author/Year	Program Name	Program Description	Sample Characteristics	Key Outcome Measure(s)	Study Design	Main Findings
Hoefnagels & Baartman, 1997	No name provided	Media campaign aimed at children's disclosure of abuse; Targeted children ages 8–15 as well as "safe" adults in contact with these children; Multiple media outlets including television, radio, posters, newspaper and magazine articles, school publications; Training sessions for teachers	Dutch children ages 8–15; Teachers or other adults in contact with children in the above age group	Count of abuse reports during and after the campaign	Pre-post tests	Disclosures of physical child abuse increased during the campaign, and declined to the pre-intervention level after the campaign ended.
Pietrodangelo 1983	Florida Department of Health and Rehabilitative Services Public Awareness Campaign	Two different 30-second television public service announcements (PSAs); two different 10-second television PSAs; two different 30-second radio PSAs; and one print advertisement	Residents of Florida	Incidence of child maltreatment-related articles in print media, and number of CPS reports	Trend data	Saw an increase in the number of print media stories related to child maltreatment. CPS reporting also significantly increased during the campaign.
Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009	Triple P Positive Parenting Program	Professional training for existing service providers; improved service and system coordination; and a universal media and communication campaign including positive parenting newspaper articles, newspaper stories, and press releases related to Triple P dissemination; newsletters to parents, radio public service announcements, and community events	18 counties with population sizes between 50,000 and 175,000, randomized into treatment and control groups. Targeted families with at least one child under the age of 8.	Child maltreatment substantiations Child out of home placements Child hospitalizations and emergency room visits due to maltreatment-related injuries	Experimental evaluation	Statistically significant declines in child maltreatment substantiations, out-of-home placements, and hospitalizations and emergency room visits for maltreatment-related injuries in target counties compared to control counties.

Author/Year	Program Name	Program Description	Sample Characteristics	Key Outcome Measure(s)	Study Design	Main Findings
Rheingold, Campbell, Self-Brown, Arellano, Resnick, & Kilpatrick, 2007	Darkness to Light	Videos and educational pamphlets on child sexual abuse	N=200 parents with children under age 18 residing in the home were recruited in shopping malls in Philadelphia, Boston, Tampa, Memphis, Detroit, Kansas City, Tacoma, and Phoenix. Volunteers were randomized into four conditions: video public service announcements (N=49), educational pamphlets (N=52), video public service announcements (PSAs) and educational pamphlets (N=49), and no media (N=50).	Sexual Abuse Trauma Screen Child sexual abuse quiz Child Sexual Abuse Myth Scale	Experimental evaluation; pre-post tests	Individuals who received combined video PSAs and pamphlets had greater knowledge of child sexual abuse than those with no media exposure. Observed differences between groups were no longer significant at the one-month follow-up. Individuals who received either the video PSA only or pamphlet only did not have different levels of child sexual abuse knowledge from those in the control group.
Waterston, Welsh, Keane, Cook, Hammal, Parker, & McConachie, 2009	Baby Express	Monthly parenting newsletter sent directly to the home in the first year of life	Parents of first infants born in North East England District General Hospital between February and October of 2003 were randomized into either a treatment group (n=94) who received the newsletter or control group (n=91), who did not receive the newsletter.	Adult-Adolescent Parenting Inventory (AAPI)	Experimental evaluation; pre-post tests	Statistically significant difference from pre- to post test between the treatment and control groups on one dimension of the AAPI, inappropriate expectations

CHAPTER 4: NURSE HOME VISITING INTERVENTIONS

Tracy Braunreiter, Leah Brody, and Abby Lyon

Description of Prevention Program Area

Nurse home visiting programs were designed to improve the well-being of vulnerable mothers and their young children. The eligibility requirements for participation vary across programs; however, the primary target population is often young or first-time mothers from low-income households. Initial contact with the mother is typically made during pregnancy. As home visitors, nurses work closely with mothers during weekly visits to: (1) improve pregnancy outcomes by addressing health-related behaviors, (2) improve child health and development by strengthening parenting skills, and (3) address maternal life course outcomes, such as education, employment, and family planning (Isaacs, 2008; Kitzman, Cole, Yoos, & Olds, 1997; Child Trends, 2003**)**. Nurses also provide referrals to additional services, help develop mother's problem-solving skills, and strengthen family support networks (Olds et al., 1997). Generally, families receive home visits during pregnancy and through the first 2 years of the child's life, but several programs conclude visits sooner.

Nurse home visiting programs exist nationwide. The most widely utilized model is the Nurse-Family Partnership (NFP), currently implemented in 28 states in the United States. (Nurse-Family Partnership, 2008). The NFP is a nonprofit organization that provides communities with support services for implementing and maintaining a nurse home visiting program that follows this specified model. Participating agencies must adhere to the model elements, which are based on research conducted by Olds and colleagues (1997).

Nurse home visiting programs are considered distinct from programs using paraprofessional home visitors, or home visitors from different professional backgrounds (e.g., social work). Nurse home visiting programs have been evaluated for a host of outcomes related to such things as child health and development, parenting, employment, linkages to public benefits, and maternal life course outcomes (Olds et al., 1997; Olds et al., 1999; Fergusson, Hildegard, Horwood, & Ridder, 2005; Fraser, Armstrong, Morris, & Dadds, 2000). This review is limited to the impact of nurse home visiting programs on outcomes related to child abuse or neglect, including substantiated reports of child maltreatment, validated parental report measures, and medical records of clinic and hospital visits for accidents and injuries. Nurse home visiting programs that target families after an incident of child maltreatment has occurred were excluded, given that the emphasis of our review is on primary and secondary prevention strategies.

Brief Statement of Effectiveness

Overall, the evidence indicates that nurse home visiting programs are associated with reduced levels of child maltreatment outcomes, in the short-term as well as the long-term. The positive impact of nurse visitation on child maltreatment may be moderated when additional risk factors such as domestic violence are present in the home (Eckenrode et al., 2000). At least one study found that nurse visiting failed to have a significant impact on maternal reports of child abuse potential (Black et al., 1994). Nurse home visiting programs have also been shown to produce positive effects on numerous aspects of family functioning and child well-being; however, this chapter focuses on the programs' effects on child maltreatment outcomes. Findings from the initial experimental study of nurse home visiting indicated that first-time mothers with the most risk factors (i.e., young, unmarried, and low-income) benefited the most from the intervention (Olds et al., 1997). As a result of this finding, many programs have focused the intervention on first-time mothers who have at least one of these risk factors. It is believed that by targeting at-risk populations, nurse home visiting can have a more substantial, cost-effective impact on children and families.

Description of Interventions Reviewed

Two studies involved interventions targeting first-time mothers who were also under the age of 19, unmarried, and/or of low socioeconomic status (Olds et al.; 1997; 1999), and one involved a target population of substance-using women (Black et al., 1994). The remaining studies involved interventions with at-risk families, variously defined (Fraser et al., 2000; Fergusson et al., 2005). Treatment groups typically received nurse home visiting services that began during pregnancy or immediately following child birth, and that lasted between 18 and 36 months. Control groups received one or more of the following services: child development screenings, free transportation to child medical appointments, referrals to standard community health services, and/or compensation for interview time.

The first randomized trial of a nurse home visiting program began recruitment in 1978, and was conducted

by Olds and colleagues (Olds et al., 1997). The 400 study participants were from Elmira, New York—a semirural community composed of primarily Caucasian residents (Olds et al., 1997). The long-term effects of nurse visiting on the frequency of child abuse and neglect were assessed by searching state records of substantiated reports of child maltreatment over a 15-year period. The Elmira study found lower rates of maltreatment reports in the treatment group than the control group. A follow-up study of the same program site by Eckenrode and colleagues (2000) found that higher numbers of domestic violence incidents limited the effectiveness of the intervention. The NFP program model was also used in a trial conducted with a primarily African American population in the urban area of Memphis, Tennessee (Olds et al., 1999). Participants in the Memphis program were enrolled in 1990 and 1991. This study did not measure child maltreatment reports, but did measure a potential proxy for child maltreatment—the number of children's health care encounters during the first 2 years of life resulting from injuries or ingestions. The exact study location and enrollment dates for the program evaluated by Black et al. (1994) were not provided. These researchers reported that the recruitment took place in the prenatal clinics of a large, metropolitan teaching hospital. Members of the treatment group received biweekly visits from nurses.

The final two studies were conducted in New Zealand (Fergusson et al., 2005) and Australia (Fraser et al., 2000). One study followed the Early Start program model, typically viewed as a paraprofessional home visiting program (Fergusson et al., 2005); however, this New Zealand intervention employed professional home visitors that had either nursing or social work qualifications. Participants were enrolled in 2000 and 2001. Child maltreatment was measured with the Child Abuse Potential Inventory (CAPI; Milner, Gold, & Wimberley, 1986), and assessed through parental self-report of child protective services (CPS) contacts. The Australian study did not follow an established home visiting program model, but program goals and procedures were similar to those of the Nurse-Family Partnership model (Fraser et al., 2000). After enrolling mothers in 1996, the study measured child maltreatment with repeated measures of the CAPI.

Methodological Quality of Studies

Overall, the study design characteristics for evaluations of nurse home visiting programs are quite rigorous. Most of the studies involved reasonable sample sizes and the use of randomly assigned treatment and control groups, making it possible to assess the causal impact of nurse home visiting on child maltreatment outcomes. These studies have been conducted in several geographical areas and there is some diversity within and across the participant populations. Among the studies, outcomes were often measured at several time points, for example, during program participation, shortly after program completion, and in one instance, many years after the conclusion of program involvement.

There are benefits and limitations inherent in the different methods of measuring child maltreatment that should be considered when interpreting study results. Two of the five studies included in this review measured child maltreatment rates through information gathered from social services records (substantiated CPS reports). This measure of child maltreatment does not capture any instances of child maltreatment that do not come to the attention of CPS. Medical records of accidental child injuries and ingestions as an outcome measure of child maltreatment are both over-inclusive and under-inclusive. For example, some portion of the injuries and ingestions that occurred were not likely the result of child abuse and neglect. Conversely, many instances of child maltreatment do not necessarily result in a trip to the clinic or hospital. However, both state CPS records and medical records are free of the social desirability bias that may be present in self-report data. The remaining three studies use parental self-report data to capture child maltreatment outcomes. Fergusson et al. (2005) measure child maltreatment with parental reports of contact with CPS and the physical assault subscale of the Parent-Child Conflict Tactics Scale (PC-CTS; Straus et al., 1998). Fraser and colleagues (2000) and Black and colleagues (1994) examined the impact of nurse home visiting with the CAPI (Milner et al., 1986). Although there are limitations to each method of measurement, the fact that multiple measures across program models yield evidence about the impact of nurse home visiting on reducing the occurrence of child maltreatment provides strong support for the effectiveness of this prevention strategy.

Review of Findings

Collectively, these studies suggest that nurse home visiting programs are successful in reducing child maltreatment, primarily in at-risk populations. The results from the Elmira study show that mothers who received nurse home visiting had a significant decrease in the number of substantiated child abuse or neglect reports (Olds et al., 1997). Specifically, mothers participating in the program had 80% fewer cases of substantiated child abuse reports than mothers in the control group. The effect of the program on child maltreatment reports was greater for mothers that were unmarried and from low-income households. The NFP

program was replicated in Memphis, Tennessee (Olds et al., 1999). This study used medical records to measure potentially abusive or neglectful parenting. Results indicate that families who participated in the program had fewer child visits to medical clinics for injuries and ingestions than families in the control group. It was also found that children of families receiving nurse visits also spent fewer days in the hospital related to injuries or ingestions. These results were concentrated in families where the mother had low psychological resources at baseline. Furthermore, in measurements taken when the child was 2 years old, nurse-visited mothers reported fewer child-rearing beliefs associated with child maltreatment.

Research on nurse home visiting programs conducted outside the United States. did not replicate the NFP model, but results of these studies still indicate that nurse home visiting programs can decrease child maltreatment outcomes. The Early Start program in New Zealand (which employed both nurse and social work professionals) found that participating families reported significantly lower rates of severe physical assault than the control group (Fergusson et al., 2005). However, the study found no difference between nurse-visited families and comparison families in parent-reported rates of contact with CPS. In Australia, mothers that received nurse home visits showed a greater reduction in CAPI scores than families receiving only standard community health services (Fraser et al., 2000). The impact of nurse home visiting in this study was shown to vary based on whether the participant was a first-time mother or had multiple children.

The research conducted by Black and colleagues (1994) was the only study in this review that failed to find that nurse visitation had an impact on a measure of child maltreatment. The CAPI was administered to study participants prenatally and again 18 months later. Women in the control group had more elevated CAPI scores at follow-up, but the effect was not statistically significant. Given the small sample size, however, there may have been insufficient statistical power to detect significant group differences. This study also did not use an established protocol to administer the nurse home visits, although the description of program activities indicate that it was likely quite similar to others included in the review.

Discussion

Results from the literature review suggest nurse home visiting programs are a viable method of child maltreatment prevention. Nurse home visiting has demonstrated both short-term and long-term benefits vis-à-vis child maltreatment outcomes. Other studies of home visiting programs that utilized a combination of professional (e.g., nurse, social worker, mental health professional) and paraprofessional staff further support the role of home visiting in the child maltreatment prevention continuum (see Huxley & Warner, 1993; Velasquez, Christensen, & Schommer, 1984). Evaluations of these programs have shown that groups receiving home visits have fewer instances of confirmed child abuse and neglect, and fewer out-of-home placements, compared to those that do not receive the intervention.

The research reviewed for this chapter suggests that targeting the nurse home visiting intervention to at-risk populations may result in the greatest impact. The NFP is a pervasive model in the United States, and is supported by rigorous evidence. Future evaluations of this model would benefit from additional attention to moderating factors, as in the case of domestic violence (Eckenrode et al., 2002). Although a number of rigorous studies of nurse home visiting programs have been conducted, only a limited number of studies explicitly examine impacts on child abuse and neglect outcomes such as CPS involvement or validated measures of child maltreatment risk. Additional research, incorporating such outcomes and targeting diverse populations, is still needed.

Search Terms

The search terms used to generate the studies reviewed included combinations of the following: nurse home visit, home visit AND child abuse/child neglect/child maltreatment.

References

Black, M. M., Nair, P., Kight, C., Wachtel, R., Roby, P., Schuler, M. (1994). Parenting and early development among children of drug-abusing women: Effects of home intervention. *Pediatrics, 94*(4), 440–448.

Child Trends. (2003). *Guide to effective programs for children and youth: Nurse-Family Partnership*. Retrieved November 24, 2008, from http://www.childtrends.org/Lifecourse/programs/NurseHomeVisitingProgram.htm.

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

Fraser, J. A., Armstrong, K. L., Morris, J. P., & Dadds, M. R. (2000). Home visiting intervention for vulnerable families with newborns: Follow-up results of a randomized controlled trial. *Child Abuse & Neglect, 24*, 1399–1429.

Fergusson, D. M., Hildegard, G. L., Horwood, J. H., & Ridder, E. M. (2005). Randomized trial of the early start program of home visitation. *Pediatrics, 116*, 803–309.

Huxley, P., & Warner, R. (1993). Primary prevention of parenting dysfunction in high-risk cases. *American Journal of Orthopsychiatry, 63*(4), 582–588.

Isaacs, J. (2008). Nurse home visiting. *Impacts of Early Childhood Programs*. Retrieved November 24, 2008 from http://www.firstfocus.net/Download/Brief5.pdf.

Kitzman, H. J., Cole, R., Yoos, H. L., & Olds, D. L. (1997). Challenges experienced by home visitors: A qualitative study of program implementation. *Journal of Community Psychology, 25*(1), 95–109.

Milner, J. S., Gold R. G., & Wimberley, R. C. (1986). Prediction and explanation of child abuse: Cross-validation of the child abuse potential inventory. *Journal of Consulting and Clinical Psychology, 54*, 865–866.

Nurse-Family Partnership. (2007). *Newslink: NFP National Service Office.* Retrieved May 16, 2008, from http://www.nursefamilypartnership.org/resources/files/PDF/Newsletter/Newslink9FINAL.pdf

Olds, D. L., Eckenrode, J., Henderson, C. R., Kitzman, H., Powers, J., Cole, R. et al. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect: Fifteen-year follow-up of a randomized trial. *Journal of the American Medical Association, 278*(8), 637–643.

Olds, D. L., Henderson, C. R., Kitzman, H. J. Eckenrode, J. J., Cole, R. E., & Tatelbaum, R. C. (1999). Prenatal and infancy home visitation by nurses: Recent findings. *The Future of Children, 9*, 44–65.

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

Straus, M. A., Hamby, S. L., Finkelhor, D., Moore, D. W., and Runyan, D. (1998). Identification of child maltreatment with the Parent-Child Conflict Tactics Scales: Development and psychometric data for a national sample of American parents. *Child Abuse & Neglect, 22*, 249–270.

Velasquez, J., Christensen, M., Schommer, B. (1984). Part II: Intensive services help prevent child abuse. *American Journal of Maternity and Child Nursing, 9*, 113–117.

Table 4. Studies Included for Review of Nurse Home Visiting Programs

Author/Year	Program Name	Program Description	Sample Characteristics	Key Outcome Measure(s)	Study Design	Main Findings
Olds, Eckenrod, Henderson, Kitzman, Powers, Cole, et al., 1997	Nurse-Family Partnership (NFP) (Elmira, NY)	Nurses promoted healthy behaviors during pregnancy and early childhood, quality care of children, and positive maternal life-course development. Other components of the intervention included service linkage, goal setting, problem-solving skills, and strengthening support networks.	N=400 pregnant women with no previous live births, and with at least 1 of 3 risk factors: (1) <19 years old at time of enrollment, (2) unmarried, (3) low socioeconomic status; Sample members enrolled 1978–1980	Substantiated reports of child maltreatment from state records over 15-year period	Experimental evaluation, 4 randomized groups: (1) n=94 received two child development screenings (2) n=90 received two screenings plus free transportation for medical visits (groups 1&2 = controls) (3) n=100 received screenings, transportation & prenatal nurse visits (4) n=116 same services as group 3, plus nurse visits until child 2 years of age.	Mothers receiving nurse home visiting during pregnancy and until child was age 2 had significantly fewer reports of child abuse or neglect than control group. Effect was greater for mothers who were unmarried and from low-SES households at baseline.
Black, Nair, Kight, Wachtel, Roby, & Schuler, 1994	Nurse home visitation program for drug-abusing mothers (Location not indicated)	Nurse home visits began prior to childbirth and continued on a biweekly basis until the child was 18 months old. The program was designed to provide maternal support, promote parenting and child development, and link families with formal and informal resources.	N=60 pregnant women who used cocaine and/or heroin. Most were unmarried African American mothers with low income, multiple children, and limited education.	Child Abuse Potential Inventory (CAPI).	Experimental evaluation; n=29 controls received regular medical care for infants, transportation, and compensation for evaluations; n=31 treatment group members received the same as controls plus biweekly nurse visits	Differences in the CAPI scores were not statistically significant between treatment and control groups. Both groups had elevated CAPI scores during the prenatal assessment that declined over time.

Author/Year	Program Name	Program Description	Sample Characteristics	Key Outcome Measure(s)	Study Design	Main Findings
Olds, Henderson, Tatelbaum, & Chamblin, 1986	Nurse-Family Partnership (Memphis, TN)	Elmira model of nurse home visiting was replicated with similar program elements with a primarily African American population living in a large urban area.	Pregnant women with no previous live births and having at least 2 of 3 risk factors: (1) unmarried, (2) < 12 years education, (3) unemployed. Sample members were enrolled 1990–1991.	Children's health care encounters for injuries or ingestions	Experimental evaluation, 4 randomized groups: (1) n=166 received free transportation for prenatal care (2) n=515 received free transportation for child health care & developmental screenings (groups 1&2 = controls) (3) n=230 received transportation, screenings & prenatal nurse visiting + 1 nurse visit after birth (4) n=228 received same services as group 3, and nurse home visits until child 2 years of age.	Children of families receiving nurse home visits had fewer clinic visits for injuries and ingestions and were hospitalized for fewer days related to injuries or ingestions by 2 years of age.
Fergusson, Hildegard, Horwood, & Ridder, 2005	Early Start (Christ-Church, New Zealand)	Followed Early Start program model (see Healthy Families America chapter for description of this model). Home visitors had either nurse or social work qualifications.	N=443 women recruited within 3 months of child birth following screening by community health nurses to identify at-risk families. Sample members were enrolled 2000–2001.	Parent-Child Conflict Tactics Scale (PC-CTS). Parental self-report of contacts with child protective services.	Experimental evaluation; n=220 in treatment group received home visits for up to 36 months; n=223 in control group received no program services.	Families receiving home visits reported lower rate of severe physical assault against a child than families in control group. No difference between home visited and control groups in rates of (parent-reported) child protective services involvement. Measurements taken at 6, 12, 24, & 36 months.

Author/Year	Program Name	Program Description	Sample Characteristics	Key Outcome Measure(s)	Study Design	Main Findings
Fraser, Armstrong, Morris, & Dadds, 2000	Home visiting program using Child Health Nurses (Brisbane, Australia)	Program designed to establish a relationship of trust between nurse and family and promote maternal-infant attachment, positive health behaviors and parenting practices, family support systems, and the reduction of parental stress and potential for child abuse.	N=181 women in the immediate postnatal period. Inclusion was determined by mothers' self-reports on a range of risk factors. Participants enrolled in 1996.	Child Abuse Potential Inventory (CAPI)	Experimental evaluation; N=90 in treatment group received regular nurse home visits (minimum of 18); N=91 in control group received referrals to existing community services	There was a significant reduction in CAPI abuse scores for treatment group only at 7 and 18 months. Measurements taken at baseline, 7 & 18 months.

CHAPTER 5: HOME VISITING: THE HEALTHY FAMILIES AMERICA MODEL

Melissa King, Brooke Ramsey, and Lacy Schneider

Description of Prevention Program Area

A key goal of many home visiting programs is to reduce the incidence of child abuse and neglect. Like nurse home visiting programs, other home visiting models typically target families with infants deemed to be at risk for child maltreatment, sometimes relying on hospitals or clinics to screen and identify at-risk families during the prenatal period, near the time of childbirth, or soon after childbirth. Home visits typically begin on a weekly basis and become less frequent as the family makes progress toward program goals. Examples of services that home visitors provide include parent education and skills training, safety assessments of the home, and linkages to needed community resources. Home visiting programs staffed by nurses are described in chapter 4. This chapter focuses on the Healthy Families America (HFA) program and its parent program, Healthy Start, because of the prevalence of these models in the state of Wisconsin. The HFA model often involves home visitors from professional backgrounds such as social work, persons with educational degrees in child development, and/or paraprofessionals, who typically have at least a high school diploma or an associate's or bachelor's degree, and who receive additional training specific to the home visiting intervention.

For the purpose of this review, we selected only those evaluations of HFA that included child maltreatment outcome measures, such as child protective services (CPS) involvement, or validated scales measuring child maltreatment risk. This review also summarizes the results of a recent, comprehensive review of HFA evaluations conducted by Harding, Galano, Martin, Huntington, & Schellenbach (2007), and includes some discussion of the Parents-as-Teachers (PAT) model, which is another popular home visiting model in Wisconsin. The research summary table at the end of the chapter does not include nonexperimental designs (i.e., those lacking a comparison group), multiple studies of the same state,[7] and studies for which documents were inaccessible.[8]

[7]There is one exception: for the Hampton Healthy Families program in Virginia, two separate studies are included in the table because one measures maltreatment outcomes at the family level and the other at the community level.

[8]See Harding et al. (2007) for information on unpublished HFA evaluations not included in this review.

Brief Statement of Effectiveness

Seven of the reviewed studies evaluated HFA programs and four evaluated the Healthy Start Program (HSP). Among eight studies involving outcomes of child maltreatment based on child protective services (CPS) involvement, only two showed a significant program impact (Galano, 2002; Williams, Stern, & Associates, 2005). Both employed a quasi-experimental design involving nonrandomized control groups.

Several studies established program effects related to validated measures of child abuse and neglect risk. Three studies reported significant reductions in self-reported harsh parenting behaviors using the Parent-Child Conflict Tactics Scale, PC-CTS (Bugental et al., 2002; Duggan et al., 2004; DuMont et al., 2008). Finally, two studies found that participants had significantly lower scores on the Child Abuse Potential Inventory (CAPI) compared to a control group (Chambliss & Emshoff, 1999; Milner & Crouch, 2006).

Description of Interventions Reviewed

Four studies evaluated the HSP model of home visiting (Bugental et al., 2002; Duggan et al., 2004; Harding et al., 2007; Galano et al., 2001). The HSP is grounded in family support practice, parent training, attachment theory, and ecological models of child development (Bowlby, 1969; Bronfenbrenner, 1979; Helfer, 1987). The HSP model originated in Oahu, Hawaii, during the 1980s. HSP asserts that home visiting promotes child health and development; enhances positive parenting skills; and addresses environmental risk factors with education, support, and links to community resources (Hawaii Department of Health, undated). HSP uses population-based screening and assessment to identify families at risk of child abuse and neglect. Screenings typically take place in a clinic or hospital, but prenatal care providers may also refer families. To enroll, a family must not have had CPS contact related to the target child. Identified and eligible families have the opportunity to participate in the voluntary program for a period of up to 3 to 5 years. Home visits begin on a weekly basis and progress to biweekly, monthly, and then quarterly visits based on criteria set by the HSP (Duggan et al., 2004).

Seven studies focused on the HFA model of home visiting (Davenport, 2001; Duggan et al., 2007; DuMont et al., 2008; Chambliss & Emshoff, 1999; Landsverk et

al., 2002; Milner & Crouch, 2006; Williams et al., 2005). Prevent Child Abuse (PCA) America launched HFA in the early 1990s. Like HSP, HFA strives to promote positive parenting, enhance child health and development, and prevent child abuse and neglect. The HFA model uses a standard set of 12 critical elements to guide implementation and services, but localities have flexibility to tailor the program to the local population. Home visitors offer services and make referrals, promote preventive health care, secure medical homes, establish and maintain trust with families, build upon family strengths, develop a family support plan, determine the safety of the home, teach positive parent-child interaction, and manage crisis situations. Programs must offer intensive services (i.e., at least once a week) and follow defined criteria for increasing or decreasing frequency of service over time. HFA programs currently operate in over 440 communities in the United States and Canada (Healthy Families America, 2008).

Several measures were typical of the evaluations reviewed for this chapter. The Kempe Family Stress Checklist or a similar screening tool was administered before or near the time of childbirth to identify families at risk for child maltreatment. CPS records of child abuse and neglect constituted the primary measure of child maltreatment; eight of the reviewed studies used individual-level CPS records to measure child abuse and neglect and one relied on aggregated community rates (Galano, 2002). Four of the studies reviewed measured child maltreatment risk using the Parent-Child Conflict Tactics Scale (PC-CTS; Straus, Hamby, Bonney-McCoy, & Sugarman, 1996; Straus, Hamby, Finkelhor, Moore, & Runyan, 1998), either alone or in addition to CPS data. This self-report measure has questions that reflect whether parents have engaged in neglectful, psychologically aggressive, or physically abusive behaviors (Straus et al., 1996). Two studies used the Child Abuse Potential Inventory (CAPI; Milner & Crouch, 2006). Studies by Duggan et al. (2004, 2007), DuMont et al. (2008), and Chambliss & Emshoff (1999) included both self-report measures and CPS data.

Methodological Quality of Studies

The flexibility of Healthy Families America (HFA) results in significant program variation that poses a challenge when attempting to compare results across studies (Harding et al., 2007). For example, programs choose the risk level at which families are eligible for services and whether home visiting begins prenatally or at the time of childbirth. Program duration ranges from 1 to 5 years. Some of the studies of HFA interventions track families for 1 or 2 years (DuMont et al., 2008; Bugental et al., 2002; Chambliss & Emshoff, 1999; Duggan et al., 2007). Galano & Huntington (1999) did not report on the length of time that study participants were followed. The five other studies of HFA involved follow-up periods of 3 years or longer. Sample sizes varied greatly, from only 96 families to 2,600, with the majority of the studies having samples between 300 and 1,000 families. The results of studies in this review are affected by dropout rates. DuMont et al. (2008), Duggan et al. (2007), and Chambliss & Emshoff (1999) all cited attrition rates of 50% or greater. Several studies did not provide attrition information.

Seven of the studies included in this review were experimental evaluations. These studies typically offered services as usual or limited service availability to the control group. Bugental et al. (2002) differed from the other experimental designs with the use of incremental conditions to examine program effects; control, unenhanced, and enhanced conditions. Four studies used quasi-experimental designs. Williams et al. (2005) found evidence that HFA program involvement led to a reduction in substantiated maltreatment reports. This study design involved retrospectively creating treatment groups based on the amount of home visitation services the families had received, while the control group contained parents eligible for HFA who were denied services when enrollment was at capacity. The review also included a community-level evaluation that targeted one community for the intervention, comparing rates of substantiated maltreatment reports to comparison communities. The intervention community had lower rates of substantiated reports and steeper declines in this outcome compared to the other communities. Researchers determined that given other contextual changes in the intervention community, the risk level there increased during the period of declining CPS report rates. Still, this type of quasi-experimental study design makes causal links to program impact difficult to establish, given the range of possible confounding factors that undermine regional comparability.

Review of the Findings

Harding et al. (2007) conducted a review of 33 Healthy Family America (HFA) evaluations,[9] reporting on four outcome domains: child maltreatment, child health and development, maternal life course, and parenting. The Harding et al. review concluded that HFA might improve parenting attitudes, in some cases measured with validated scales of child maltreatment risk, but

[9]It should be noted that the Harding et al. review did include several evaluations of the Healthy Start Program. HSP is the parent program of HFA and the two programs continue to be substantially similar.

there is little and mixed evidence indicating that HFA had significant impacts on child health and development or maternal life course outcomes. Harding and colleagues reported that only 1 of 6 experimental studies measured a significant reduction in substantiated maltreatment reports.[10] However, quasi-experimental and community comparison designs suggested that home visiting programs are associated with a reduction of substantiated maltreatment reports. Finally, the review concluded that modest program benefits were indicated by studies using parental self-report measures of child maltreatment risk.

The purpose of this review was to examine evaluations of HFA and HSP programs that involved experimental or quasi-experimental designs and validated child maltreatment outcomes measures. Where multiple studies were available on the same program, the most recent report was selected, unless two reports of the same program contained different maltreatment outcome measures. These criteria resulted in the inclusion of 11 studies, 8 of which were also included in the Harding et al. (2007) review (Chambliss & Emshoff, 1999; Duggan et al., 2007; Landsverk et al., 2002; Williams et al., 2005; Milner & Crouch, 2006; Duggan et al., 2004; Galano et al., 2001; Galano, 2002).

Two studies reported an association between the HFA intervention and reduced CAPI scores (Chambliss & Emshoff, 1999; Milner & Crouch, 2006). Milner & Crouch (2006) found the association only for parents at the highest level of risk. It should be noted that the sample reporting CAPI scores in Milner & Crouch (2006) was significantly smaller (N=183) than the original sample (N=2,220). The research did not contain an explanation for this large reduction in sample size. Two studies found that program HFA participation was associated with less psychological aggression (Landsverk et al., 2002) and fewer neglectful behaviors (Duggan et al., 2004), both assessed with subscales of the PC-CTS.

Three evaluations used randomized experimental designs and assessed CPS involvement (Duggan et al., 2007; Duggan et al., 2004; Galano et al., 2001). All three found no significant differences in substantiated CPS reports between control groups and groups receiving home visiting services. DuMont et al. (2008) used an experimental design to evaluate Healthy Families New York. There was no significant difference in levels of maltreatment as measured by abuse and neglect reports. However, PC-CTS results from the same study showed reductions in abusive parenting practices as measured by parent self-reports. The final study was a small experimental evaluation of the HSP that measured maltreatment with the CTS (Bugental et al., 2002). The evaluation found that only the home-visiting condition involving a cognitive appraisal component was associated with prevention of physical abuse.

Four other studies used quasi-experimental designs and assessed substantiated abuse and neglect reports. Williams and colleagues (2005) created treatment and control groups retrospectively according to the level of service that families received. Results indicated significantly fewer maltreatment reports for parents who received 3 or more years of home visiting services compared to controls. Galano (2002) evaluated the impact of HFA on community levels of substantiated abuse and neglect reports. In this instance, HFA was part of a city initiative that used multiple strategies to improve levels of healthy births and school readiness in Hampton, Virginia. Outcomes were measured over a 17-year period and compared with other communities in Virginia. The intervention community reported significantly lower rates of maltreatment reports compared to other communities. Another quasi-experimental study found no difference in rates of maltreatment reports between the treatment group, which received at least 6 months of service and more than 4 home visits, and the control group that received less than 4 home visits (Davenport, 2001).

Discussion

HFA and HSP home visiting programs are well grounded in effective prevention theories, and several evaluations of these programs show promising results; however, variable quality in evaluation design and differing evaluation strategies make comparisons across studies difficult (Harding et al., 2007). It is clear that most experimental studies found that HFA had no impact on levels of reported child abuse and neglect, although there is evidence demonstrating reductions in other measures of child maltreatment risk. One significant challenge related to evaluating such programs is attrition by program participants. High levels of program attrition interfere with the ability of these programs to meet goals related to preventing child maltreatment effectively. The review revealed several potential strategies for improving prevention outcomes, including targeting families prenatally (DuMont et al., 2008), and adding a cognitive component, such as the one used in Bugental et al. (2002).

[10] One study found a significant impact on levels of maltreatment (see Harding et al., 2007; or Daro, 1996). The Daro (1996) evaluation was excluded from this review because a more recent evaluation was available for that state (see Duggan et al., 2004).

In addition to the HFA and HSP program models, the Parents as Teachers (PAT) model of home visiting is widely used in Wisconsin. Although this model is not the focus of the present chapter, it is worth noting that two rigorous evaluations of PAT suggest that it may also be an effective prevention strategy for child maltreatment. Results of a randomized trial showed that after 3 years of program participation, adolescent mothers scored lower on the Adult-Adolescent Parenting Inventory (AAPI; Bavolek, 1984), a validated parent-report measure of child maltreatment risk, compared to control group adolescents (Wagner, Spiker, Hernandez, Song. & Gerlach-Downie, 2001). Another study demonstrated that adolescent mothers randomly assigned to participate in the PAT program were less likely to have contact with CPS than adolescent mothers in the control group (Wagner & Clayton, 1999). Although more research is clearly needed, these limited results hold promise for the PAT model.

Finally, it should be reiterated that other evaluations exist of home visiting models besides those discussed in chapters 4 and 5 of this publication. (See, for example, Howard & Brooks-Gunn, 2009, and Reynolds, Mathieson, & Topitzes, 2009 for recent reviews of evidence-based home visiting interventions.) Thus, the reviews of home visiting interventions presented in this publication should not be considered exhaustive.

Search Terms

The search terms used generate the studies reviewed included combinations of the following: home visitation/home visiting, Healthy Families America/Healthy Start AND child abuse/child neglect/child maltreatment.

References

Bavolek, S. J. (1984). *Adult-adolescent inventory*. Eau Claire, WI: Family Development Resources.

Bowlby, J. (1969). *Attachment and loss: Vol. 1: Attachment.* New York, NY: Basic Books.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Cambridge, MA: Harvard University Press.

Bugental, D., Ellerson, P., Rainey, B., Lin, E., Kokotovic, A., & O'Hara, N. (2002). A cognitive approach to child abuse prevention. *Journal of Family Psychology, 16,* 243–258.

Chambliss, J., & Emshoff, J. (1999). *The evaluation of Georgia's Healthy Families Program: Results of phase 1 and 2.* Emstar Research Inc: Atlanta, GA.

Daro, D. (1996). *Intensive home visitation: A randomized trial, follow-up, and risk assessment study of Hawaii's Healthy Start Program: Final report*. Center on Child Abuse Prevention Research, National Committee to Prevent Child Abuse, U.S. Department of Health and Human Services, Washington, D.C.

Davenport, D. (2001). *Performance audit: Healthy Families Program.* State of Arizona Office of the Auditor General: Phoenix, AZ.

Duggan, A., Caldera, D., Rodriguez, K., Burrell, L., Rohde, C., & Crowne, S. (2007). Impact of a statewide home visiting program to prevent child abuse. *Child Abuse and Neglect, 31,* 801–827.

Duggan, A., McFarlane, E., Fuddy, L., Burrell, L., Higman, S., Windham, A., & Sia, C. (2004). Randomized trial of a statewide home visiting program: Impact in preventing child abuse and neglect. *Child Abuse and Neglect, 28,* 597–622.

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

Galano, J. (2002). *FY02 Healthy Families Partnership benchmark study: Measuring community-wide impact*. Applied Social Psychology Research Institute, the College of William and Mary: Williamsburg VA.

Galano, J., Credle, W., Perry, D., Berg, S.W., Huntington, L. & Stief, E. (2001). Developing and sustaining a successful community prevention initiative: The Hampton Healthy Families Partnership. *Journal of Primary Prevention, 21*(4), 495–509.

Galano, J., & Huntington, L. (1999). *Evaluation of the Hampton, Virginia, Healthy Families Partnership: 1992–1998.* Center for Public Policy Research, The Thomas Jefferson Program for Public Policy, The College of William and Mary, Williamsburg, VA.

Harding, K., Galano, J., Martin, J., Huntington, L. & Schellenbach, C. (2007). Healthy Families America® effectiveness: A comprehensive review of outcomes. *Journal of Prevention & Intervention in the Community, 34*(1/2), 149–179.

Hawaii Department of Health. (n.d.). *Hawaii Healthy Start Program*. Retrieved from http://hawaii.gov/health/family-child-health/mchb/programs/hs.html.

Healthy Families America. About us: Overview. Retrieved February 15, 2009, from http://www.healthyfamiliesamerica.org/about_us/index.shtml.

Helfer, R. E. (1987). The developmental basis of child abuse and neglect: An epidemiological approach. In R.E. Helfer & R.S. Kempe (Eds.), *The battered child* (4th ed., pp. 60–80). Chicago, IL: The University of Chicago Press.

Howard, K.S. and Brooks-Gunn, J. (2009). The role of home-visiting programs in preventing child abuse and neglect. *Future of Children, 19(2)*, 119–146.

Landsverk, J., Carrillo, T., Connelly, C., Ganger, W., Slymen, D., Newton, R., Leslie, L. & Jones, C. (2002). *Healthy Families San Diego clinical trial: Technical report.* Child and Adolescent Services Research Center, San Diego Children's Hospital and Health Center: San Diego, CA.

LeCroy & Milligan Associates. (2006). *Healthy Families Arizona FY2006.* The Arizona Department of Economic Security, Division of Children Youth & Families, Office of Prevention & Family Support: Phoenix, AZ.

Milner, J., & Crouch, J. (2006). *Healthy Families Illinois.* Illinois Department of Human Services. Retrieved from http://www.dhs.state.il.us/page.aspx?item=31192.

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

Straus, M. A., Hamby, S. L., Finkelhor, D., Moore, D. W., & Runyan, D. (1998). Identification of child maltreatment with the Parent-Child Conflict Tactics Scales: Development and pyschometric data for a national sample of American parents. *Child Abuse & Neglect, 22*(4), 249–270.

Straus, M. A., Hamby S. L., Bonney-McCoy, S., & Sugarman, D. B., (1996). The revised conflicts tactics scale (CTS2). *Journal of Family Issues, 17*, 283–316.

Wagner, M., Spiker, D., Hernandez, F., Song, J., & Gerlach-Downie, S. (2001). *Multisite Parents as Teachers evaluation: Experiences and outcomes for children and families.* Menlo Park, CA: SRI International.

Wagner, M. & Clayton, S. (1999). The Parents as Teachers program: Results from two demonstrations. *Future of Children, 9(1)*, 91–115.

Williams, Stern, & Associates. (2005). *Healthy Families Florida evaluation report.* Miami, FL.

Table 5. Studies Included for Review of HFA/HSP Home Visiting Programs

Author/Year	Program Name	Program Description	Sample Characteristics	Key Outcome Measure(s)	Study Design	Main Findings
HEALTHY FAMILIES AMERICA EVALUATIONS (*indicates inclusion in Harding et al. review)						
Chambliss & Emshoff, 1999*	Healthy Families Georgia	Healthy Families America model	N=130 treatment (received HFA visits); N=119 control (referred to other community services); Families screened at childbirth using mother's medical records and Kempe's Family Stress Checklist. Participants enrolled from 8 program sites.	Substantiated CPS reports; Child Abuse Potential Inventory (CAPI)	Experimental evaluation	No significant differences in substantiated CPS reports between treatment and control groups after 1 year; Treatment group CAPI scores declined faster than control group CAPI scores
Davenport, 2001[a]	Healthy Families Arizona	Healthy Families America model	N=1,139 treatment (participated for ≥ 6 months and received ≥ 4 home visits); N=512 control (enrolled in program but received ≤ 4 home visits); Families screened at childbirth	Substantiated CPS reports made at least 6 months after program intake	Quasi-experimental (non-randomized treatment and control groups)	No significant differences in substantiated CPS reports between treatment and control groups after approximately 2 years
Duggan, Caldera, Rodriguez, Burrell, Rohde, & Crowne, 2007*	Healthy Families Alaska	Healthy Families America model	N=162 treatment (received HFA home visits); N=163 control (referred to other community services); Families screened at childbirth using the Kempe Family Stress Checklist; Participants were enrolled from 6 of 7 Healthy Families Alaska sites; High rates of attrition from program	Substantiated CPS reports	Experimental evaluation	No significant differences in substantiated CPS reports between treatment and control groups after 2 years

Author/Year	Program Name	Program Description	Sample Characteristics	Key Outcome Measure(s)	Study Design	Main Findings
DuMont, Mitchell-Herzfeld, Greene, Lee, Lowenfels, Rodriguez, et al., 2008	Healthy Families New York	Healthy Families America model	N=579 treatment (received HFA visits); N=594 control (referred to other community services); Families lived in at-risk communities and were screened before or after childbirth using Kempe Family Stress Checklist; Participants were enrolled from 3 sites	Substantiated CPS reports; Parent-Child Conflict Tactics Scale (PC-CTS)	Experimental evaluation	No significant difference found in substantiated CPS reports; Self-report data showed significant reductions in frequency of physical abuse acts at the conclusion of year 1 and year 2
Landsverk, Carrillo, Connelly, Ganger, Slymen, Newton et al., 2002*	Healthy Families San Diego	Healthy Families America model	N=247 treatment (received 3 years of HFA visits); N=241 control (no home visitation services); Screening at childbirth in one hospital identified high-risk families	Parent-Child Conflict Tactics Scale (PC-CTS)	Experimental evaluation	No significant differences in maltreatment behaviors; Fewer instances of psychological aggression found at the conclusion of year 2 and year 3
Milner & Crouch, 2006	Healthy Families Illinois	Healthy Families America model	Approximately 4,500 families were referred (~71% treatment & ~29% control; latter included parents screened eligible for the program who were unable to enroll due to program capacity); Services initiated prenatally or at childbirth for families screening positive for risk using Family Stress Checklist	Child Abuse Potential Inventory (CAPI)	Quasi-experimental (non-randomized treatment and control groups)	Only parents at highest level of risk had significant reductions in CAPI scores

Author/Year	Program Name	Program Description	Sample Characteristics	Key Outcome Measure(s)	Study Design	Main Findings
Williams, Stern, & Associates, 2005*	Healthy Families Florida	Healthy Families America	N=753 completers: completed entire program N=659 high fidelity: 3 years of service and >75% of expected visits N=276 comparison: < 3 months of service N=955 control: no service due to program capacity; Families screened using Healthy Families Florida Assessment Tool Study; Study included all participants of HHF 1999–2003	State CPS records of "some indication" or "verified" maltreatment	Quasi-experimental (non-randomized treatment and control groups)	Control group was 3.7 times more likely than completer group to have been a victim of maltreatment at 2 years; Comparison group was 3.2 times more likely to have been maltreated at 3 years
			HEALTHY START EVALUATIONS			
Bugental, Ellerson, Rainey, Lin, Kokotovic, & O'Hara, 2002	Healthy Start Program (HSP)	Healthy Start model with an added cognitive appraisal component for 1 group of participants	N=35 enhanced intervention (HS+cognitive appraisal); N=34 unenhanced intervention (HS only); N=27 control (information provided on other community services); Families at risk for child abuse determined by screening before or after childbirth using the Kempe Family Stress Checklist	Self-reported physical abuse using the Parent-Child Conflict Tactics Scale (PC-CTS)	Experimental evaluation	Significant difference in physical abuse between treatment and control groups after 1 year; Prevalence of physical abuse: enhanced 4%, unenhanced 23%, and control 26%
Duggan, McFarlane, Fuddy, Burrell, Higman, Windham, et al., 2004*	Hawaii Healthy Start	Healthy Start model	N=373 treatment; N=270 control; Families screened at childbirth using mother's medical records and Kempe's Family Stress Checklist; Participants enrolled from 6 sites on island of Oahu that were open for referrals	Substantiated CPS reports; Self-reports of Parent-Child Conflict Tactics Scale (PC-CTS).	Experimental evaluation	No significant difference found in substantiated CPS reports between treatment and control groups; Treatment group was less likely to self-report neglectful behaviors in all 3 years.

Author/Year	Program Name	Program Description	Sample Characteristics	Key Outcome Measure(s)	Study Design	Main Findings
Galano, Credle, Perry, Berg, Huntington, & Stief, 2001 (reporting on Galano & Huntington 1999)*	Hampton Healthy Families Partnership	Healthy Start model	N=417 treatment (participated in HS); N=197 control (services as usual from Health Department); Screening of all pregnant women served by local health department during recruitment period, 9/1992–7/1995; Families selected if at risk of child abuse and neglect	Substantiated CPS reports	Experimental evaluation	No significant difference found in substantiated CPS reports between treatment and control groups
Galano, 2002*	Hampton Healthy Families Partnership	Healthy Start model that included parent education classes, a welcome baby program, Young Family Centers, and a developmental newsletter	Population of Hampton as intervention community; populations of Hampton Roads and Greater Richmond were comparison communities	Substantiated CPS reports	Quasi-experimental design (non-randomized treatment and control groups) evaluating community-level change	Intervention community had decline in substantiated CPS reports; no significant change in the comparison communities

[a]See LeCroy & Milligan Associates, 2006, *Healthy Families Arizona FY2006*, the Arizona Department of Economic Security, Division of Children Youth & Families, Office of Prevention & Family Support: Phoenix, Arizona, for a recent evaluation with similar results on child maltreatment outcomes.

CHAPTER 6: INTERVENTIONS IN SCHOOLS AND EARLY LEARNING PROGRAMS

Maja Christiansen, Amanda Dees, and Crystal Ikanih

Description of Prevention Program Area

There are two types of child maltreatment prevention programs found in educational settings: (1) curriculum-based programs that attempt to increase children's knowledge about maltreatment and self-protection behaviors, and (2) programs that directly involve parents in their children's education and learning at school and at home. The curriculum-based programs can be broken into two areas, general maltreatment prevention and sexual abuse prevention. They include age-appropriate puppet shows, plays, role plays, videos, lectures, mentoring, support groups, and rehearsal of protective behaviors with children from preschool through high school. These types of programs have typically been studied only for their ability to increase knowledge and self-protective behaviors, not for their ability to bring about actual reductions in the incidence of maltreatment. There is currently only one school-based program that has been studied for its ability to affect the rate of child maltreatment, the Chicago Child-Parent Center (CPC) program (Reynolds & Robertson, 2003). This program provides family support services in addition to directly promoting parents' involvement in their children's education. Other promising approaches to prevention in early learning settings are being implemented throughout the United States, but they have not yet been evaluated for their impact on child maltreatment. These approaches are addressed in the discussion section of this chapter.

Two comprehensive meta-analyses on child-focused, curriculum-based sexual abuse prevention were available in the published literature. Only those studies omitted from these publications were reviewed for the present chapter. However, results from the meta-analyses are discussed.

Brief Statement of Effectiveness

The Chicago CPC program demonstrated a reduction in the rate of child maltreatment, and was the only program to examine this outcome (Reynolds & Robertson, 2003). Existing meta-analyses of sexual abuse prevention programs (Davis & Gidyez, 2000; Zwi et al., 2007) found evidence of significant improvements in measures of knowledge and protective behaviors stemming from program participation, but could not inform outcomes such as actual abuse rates (indeed, many such studies involve small sample sizes, thereby limiting the variability of outcomes such as maltreatment). Other school-based prevention programs incorporating puppet shows, lectures and plays—the Kids on the Block (KOB) program, the Children Need to Know Personal Safety (CNKPS) training program, and Project Trust (PT)—were also found to have statistically significant increases in children's knowledge of abusive situations (Dhooper & Schneider, 1995; Fryer, Kraizer, & Miyoshi, 1987; Oldfield, Hays, & Erickson Megel, 1996).

Description of Interventions

The Chicago CPC program provides preschool education for low-income children as well as a variety of family support services, including home visiting, as well as assistance with parenting skills, vocational skills, and social supports. The program begins when children are age 3 and continues for up to 3 years in a school-age component. The program was designed to enhance both family well-being and child development by promoting a stable learning environment at home and at school through a family-school partnership.

The remaining interventions included in this review are school-based (i.e., they do not involve services to families of the participating children). The KOB program incorporates a puppet show intended to increase children's knowledge about abuse so that children are better equipped to recognize abuse and interrupt or avoid abusive situations (Dhooper & Schneider, 1995). The program is delivered in a one-hour segment, and children participate in an extended question and answer period following the puppet show. The CNKPS program is an 8-day curriculum consisting of 20-minute lectures on child abuse prevention (Fryer et al., 1987). Children are taught rules that are intended to prevent them from involvement with potentially dangerous situations. Finally, PT is a play performed by high school students for elementary age students. The play lasts approximately 30 minutes and is followed by a 15-minute question and answer period. The play is intended to increase children's knowledge about abusive situations.

Methodological Quality of Studies

Of the studies included in this review, two involved a randomized experimental design, the CNKPS program (Fryer et al., 1987) and PT (Oldfield et al., 1996), allowing researchers to make causal inferences about the effectiveness of the program. Two programs were studied using a quasi-experimental design. The KOB

program was provided to children in some schools in three counties, who were compared to children from other schools in the same county that did not deliver the program (Dhooper & Schneider, 1995). The evaluation of the Chicago CPC program employed a quasi-experimental longitudinal design and compared children who received the program to children (matched on key characteristics) in alternative full-day kindergarten programs (Reynolds & Robertson, 2003).

Review of Findings

The CPC was the only program to demonstrate reductions in rates of child maltreatment; other studies did not assess maltreatment outcomes per se. The CPC program's success in reducing child maltreatment rates suggests that comprehensive, school-based early childhood programs are effective in reducing and preventing child maltreatment, and replications of this model are warranted. As with other studies that rely on CPS records of child maltreatment, one limitation of the CPC evaluation is that such measures are subject to reporting biases and represent undercounts of maltreated children.

The group of curriculum-based studies in this review consists of programs that have demonstrated an ability to increase children's maltreatment knowledge and self-protection behaviors. Two of the studies used pre-post test measures administered to both treatment and control groups (Fryer et al., 1987; Dhooper & Schneider, 1995) to assess program effectiveness. These studies showed an increase in the treatment group scores after participation in the prevention programs, whereas control group scores primarily remained the same or had insignificant changes.

In addition to the studies reviewed for this chapter, findings from two comprehensive meta-analyses offer further insight about the prevention of sexual abuse, specifically, through school-based interventions. The meta-analysis conducted by Davis & Gidyez (2000) found evidence of program impacts that was greatest for children in preschool or early elementary school (compared to later grades). They also found that programs integrating active participation by children were significantly more effective than those without such a component. The researchers also found that programs with more sessions had greater effect sizes, regardless of whether more sessions resulted in greater overall time spent in the program. Zwi and colleagues (2007) similarly reviewed the evidence of impact for school-based sexual abuse prevention programs. They also found evidence of heightened knowledge and protective behaviors through program participation, but caution that some studies also found evidence of increased child anxiety.

Discussion

Although there is some evidence to show that school-based programs are effective in increasing children's knowledge and protective behaviors related to maltreatment, only one study assessed actual child maltreatment outcomes. More studies are needed to assess whether school-based interventions are effective in reducing child maltreatment, as measured by official reports or other validated measures of child maltreatment risk. There is also a need to assess the longer-term results of school-based interventions. The majority of studies included in this review analyzed children's knowledge directly after participation in a program (Dhooper & Schneider, 1995; Fryer et al., 1987). One study analyzed children's retention of knowledge 3 months after attending the program, and found that they did retain the knowledge gained (Oldfield et al., 1996). However, little is known about whether children retain such knowledge for extended periods of time.

Finally, given the promising findings from the CPC program, there is a need for designing and testing similar models of comprehensive school-based interventions. Relevant to this mode of prevention is an initiative jointly spearheaded at the federal level by the Children's Bureau and the Office of Head Start (Children's Bureau, 2009a; 2009b). The Early Head Start/Child Welfare Service (EHS/CWS) Initiative, beginning in 2002, extended funding to over 20 sites around the country to experiment with different collaboration service models involving local EHS and CWS providers. Sites were required to target high-risk CWS families; develop logic models that addressed the goals of enhancing safety, permanency, and well-being of the children in the EHS/CWS target populations; and engage in process evaluations of the varying service models. Evaluation technical assistance was provided by James Bell Associates.

Most sites targeted families already involved in the child welfare system, but a few (approximately 3–5), involved birth to age 3 populations that were at risk for CWS involvement. Although the initiative was not intended to produce a multi-site outcome evaluation, sites engaged in data collection at multiple time points using an array of validated child maltreatment risk scales (e.g. Adult-Adolescent Parenting Inventory, Parenting Stress Index). In general the sites that describe target populations involving families at risk for CWS involvement reported declines in these measures over time (suggesting improvements in parenting skills, behaviors, beliefs,

emotions, etc.). Without the benefit of within-site control groups, it is difficult to know whether these collaborative service models serve as an effective child maltreatment prevention strategy with families not involved with CWS. However, findings from the process evaluations are promising in this regard, and warrant further and more rigorous efficacy studies.

Another model that warrants attention in this area of prevention is Strengthening Families through Early Care and Education, developed by the Center for the Study of Social Policy.[11] The Strengthening Families model is based on an extensive review of early childhood program elements that foster known protective factors associated with child maltreatment. Although the model has not been rigorously evaluated for its ability to impact child maltreatment, it has tremendous momentum within the United States, suggesting that efforts to evaluate the model are greatly needed.

Search Terms

The search terms used to generate the studies reviewed include combinations of the following: school, school-based, education AND child abuse/child neglect/child maltreatment.

References

Children's Bureau, Administration on Children, Youth, and Families, Administration for Children and Families, U.S. Department of Health and Human Services (2009a). *Early Head Start-Child Welfare Services Initiative: Final Synthesis Report, Vol. I.* Arlington, VA: James Bell Associates.

Children's Bureau, Administration on Children, Youth, and Families, Administration for Children and Families, U.S. Department of Health and Human Services (2009b). *Early Head Start-Child Welfare Services Initiative: Compendium of Grantee-Specific Findings, Vol. II.* Arlington, VA: James Bell Associates.

Davis, M. K., & Gidyez, C. A. (2000). Child sexual abuse prevention programs: A meta-analysis. *Journal of Clinical Child Psychology, 29*(2), 257–265.

Dhooper, S., Schneider, P. (1995). Evaluation of a school based child abuse prevention program. *Research on Social Work Practice, 5*(1), 36–46.

Fryer, G., Kraizer, S. & Miyoshi, T. (1987). Measuring actual reduction of risk to child abuse: A new approach. *Child Abuse and Neglect, 11*(2), 173–185.

Oldfield, D., Hays, B., Erickson Megel, M. (1996). Evaluation of the effectiveness of Project Trust: An elementary school-based victimization prevention strategy. *Child Abuse and Neglect, 20*(9), 821–832.

Reynolds, A. J., Robertson, D. L. (2003). School-based early intervention and later child maltreatment in the Chicago Longitudinal Study. *Child Development, 74*(1), 3–26.

Zwi, K. J., Woolfenden, S. R., Wheeler, D. M., O'Brien, T. A., Tait, P., & Williams, K. W. (2007). School-based education programmes for the prevention of child sexual abuse. Cochrane Database of Systematic Reviews, (3).

[11]See www.strengtheningfamilies.net.

Table 6. Studies Included for Review of Interventions in School Settings

Author/Year	Program Name	Program Description	Sample Characteristics	Key Outcome Measure(s)	Study Design	Main Findings
Dhooper & Schneider, 1995	Kids on the Block (KOB)	Puppet skits were used to teach children about child abuse and methods of prevention. The skits were followed by a question and answer period.	Delivered to N=413 children in grades 3–5 in three Kentucky counties; N=383 control group children from some schools in the same counties that did not deliver the program.	12-item questionnaire measuring 4 dimensions of child abuse: (1) general understanding of child abuse, (2) ability to discriminate between discipline and physical abuse, (3) ability to understand the difference between appropriate and inappropriate touch, and (4) proper response to physical and sexual abuse	Quasi-experimental (non-randomized treatment and control groups); pre-post tests.	The treatment group scored significantly higher than the control group on the post-test scores.
Oldfield, Hays, & Erickson Megel, 1996	Project Trust (PT)	High school students performed a 30-minute play for elementary school students. The play was followed by a 15-minute question and answer period.	N=658 students in treatment group; N=611 students in control group. Both groups selected from four schools in a Midwestern city; Control group classrooms received the play after the evaluation was complete.	Children's Knowledge of Abuse Questionnaire-Revised Maltreatment Disclosure Report Form	Experimental evaluation	Students in the treatment group were more knowledgeable about child abuse than students in the control group. Students in the treatment group showed significant gains in the knowledge of abuse assessment. Students in the treatment group showed retention of knowledge 3 months later. Students in the control group were not tested at 3-month follow-up.
Fryer, Kraizer, and Miyoshi, 1987	Children Need to Know Personal Safety Training Program (CNKPS)	8 days of 20-minute lectures teaching children rules about strangers through role-playing.	N=23 students in the treatment group; N=21 students in the control group. Children in K-2nd grade in a Denver, CO, elementary school	Children Need to Know Knowledge Attitude Test Dangerous situation simulations	Experimental evaluation; Pre-post tests	Children in the treatment group were more likely than children in the control group to pass the dangerous situation simulations in the post-test.

Author/Year	Program Name	Program Description	Sample Characteristics	Key Outcome Measure(s)	Study Design	Main Findings
Reynolds and Robertson, 2003	Chicago Child-Parent Center (CPC) Program	Preschool education for low-income children coupled with family support services, including home visiting, but with a focus on enhancing parental involvement in children's education.	N=989 treatment group children who completed preschool and kindergarten in CPCs; N=550 control group children (matched on age, participation in government programs, and family poverty status) who attended alternate full-day kindergarten (but were eligible to participate in the CPC during subsequent grades).	Substantiated CPS reports and petitions to the county juvenile court	Quasi-experimental (non-randomized treatment and control groups)	Preschool enrollment in CPC was associated with lower rates of CAN by age 17. 4 to 6 years of CPC participation was associated with substantially lower rates of CAN and significantly lower rates of child neglect than participation for fewer years.

CHAPTER 7: DIFFERENTIAL RESPONSE

Deanna Kelley, Rachel Konopka, and Christopher Baker

Description of Prevention Program Area

Differential response (also called alternative response) is a relatively recent innovation in child protection systems for responding to reports of alleged maltreatment. In the context of more traditional child protection investigation methods, families typically receive a "one-size-fits-all" approach to investigation and assessment, regardless of the severity of the maltreatment allegation or the level of risk attributed to the family's situation (Waldfogel, 1998). Furthermore, the majority of child protective services (CPS) reports are screened out, and for those cases that are screened in, most investigations result in an unsubstantiated finding (Drake, Jonson-Reid, Way & Chung, 2003; Hindley, Ramchandani, & Jones, 2006). Yet past research has shown that families with unsubstantiated reports to CPS have relatively high rates of re-reports, suggesting that risks for such families may persist or escalate over time (Drake et al., 2003; Hindley et al., 2006). In an effort to decrease the volume of CPS investigations and more appropriately serve lower risk families, several states have implemented differential response (DR) reforms. Under a DR approach, families with lower risk levels can be provided with assessments of family service needs, instead of the more traditional "investigatory" responses to child maltreatment allegations. The main goals of DR are to more appropriately serve lower risk families (although moderate and high-risk families may also be assigned to assessment tracks in some jurisdictions), reduce re-reports of abuse and neglect to CPS, and reduce demands on limited CPS resources.

DR models vary by state, but typically, workers who serve lower risk families in a DR system focus on providing or linking families with voluntary services. An assessment-oriented track often targets families whose child maltreatment reports are considered to reflect low to moderate levels of risk. Reports involving sexual abuse or egregious harm typically do not qualify for this path of service. If assessment track workers have concerns regarding children's safety, the case is referred back to the traditional CPS investigation track. DR programs do not make a formal determination of maltreatment with lower risk families because the goal is to assess family needs, rather than investigate a specific maltreatment allegation.

A recent review of state practices found that at least 29 states have implemented some form of DR (Zielewski, Macomber, Bess, & Murray, 2006). In this chapter, we review evaluations of programs that include child maltreatment as a key outcome. These evaluations are based on DR models in Alaska, Kentucky, Minnesota, Missouri, North Carolina, Virginia, and Washington.

Brief Statement of Effectiveness

The review of studies for this chapter found evidence from both experimental and quasi-experimental evaluations to suggest that DR can be effective in reducing recurrence of child abuse and neglect reports (Merkel-Holguin, Kaplan & Kwak, 2004; Institute of Applied Research, 2006; Loman & Siegel, 2004; Schene, 2005; U.S. Department of Health and Human Services, 2005). At a minimum, it appears that child safety is not compromised under DR (Institute of Applied Research; Loman & Siegel; Schene; U.S. Department of Health and Human Services).

Description of Interventions Reviewed

The DR evaluations included in this review involved various models of service. Programs varied in terms of the number of "tracks" available for families to follow, the point at which a track is assigned to families, and who provides services within particular tracks. DR programs in Alaska, Missouri, North Carolina, Virginia, and Washington have two tracks; a family is either routed to a traditional CPS investigation or to an assessment track, in which services are provided on a voluntary basis and no formal investigation of a specific allegation of maltreatment is completed (Center for Child and Family Policy, 2006; Merkel-Holguin et al., 2004; Loman & Siegel, 2004; Virginia Department of Social Services, 2005; Washington Department of Social and Health Services, 2005). Programs in Kentucky and Minnesota include a third track that is considered more prevention-focused for families who do not have any presenting safety concerns but who could potentially benefit from supportive, voluntary services (Zielewski et al., 2006; Institute of Applied Research, 2006). In Alaska, Kentucky, North Carolina, Virginia, and Washington, CPS staff provide an initial assessment and then refer families to community organizations (Merkel-Holguin et al.). In Minnesota, CPS staff conduct an assessment as well as provide direct services to the family. In Missouri, assessment-track families receive services from community-based providers in some counties and directly from CPS staff in others (Merkel-Holguin et al.; Loman & Siegel). In Alaska, families are referred immediately to the community-based provider,

who conducts both the assessment of family needs and provides services or referrals (Merkel-Holguin et al.).

Methodological Quality of Studies

The evaluation conducted on the Minnesota DR program was the only one to employ a randomized experimental design, affording causal inferences about the effectiveness of the program (Institute of Applied Research, 2006; Loman & Siegel, 2004). Other studies reviewed employed a variety of quasi-experimental methods. Studies in Arizona, Kentucky, Missouri, and Virginia compared the assessment-track families to the investigation-track families (Merkel-Holguin et al., 2004; Loman & Siegel; Virginia Department of Social Services, 2005). This type of design has inherent limitations because the families who are placed in the assessment track are presumed to have lower safety risks than the investigated families; indeed, this forms the basis for being placed into the assessment track. The evaluations in Alaska and North Carolina compared rates of families in the county in which DR was implemented to similar sites across the state (Merkel-Holguin et al.). This design is also problematic because there is no guarantee that the demographics or practices in the comparison counties are highly similar to those of the DR county, any differences in this regard undermine causal assumptions of the impact of DR. A study in Washington compared rates of families on the assessment track who accepted services to families on the assessment track who were not located or contacted (Washington Department of Social and Health Services, 2005). However, families not located or contacted are likely to have different characteristics and circumstances than families who accept DR services.

Review of Findings

The four major findings from the included studies were: (1) child safety is not compromised under the DR program (Institute of Applied Research, 2006; Loman & Siegel, 2004; Schene, 2005; U.S. Department of Health and Human Services, 2005); (2) families who receive an assessment response have fewer subsequent reports of child abuse and neglect (Merkel-Holguin et al., 2004; Institute of Applied Research; Loman & Siegel; U.S. Department of Health and Human Services); (3) families who receive an assessment response and who have subsequent reports have a longer period of time between reports (Institute of Applied Research); and (4) subsequent reports are less severe for the assessment-track group (Merkel-Holguin et al.).

Discussion

In addition to the studies included in this review, several other evaluations have been conducted that do not include an assessment of child maltreatment recurrence (California Department of Social Services, 2006; Center for Child and Family Policy, 2006; Hernandez et al., 1996; Zielewski et al., 2006). Such studies have looked at CPS worker or family satisfaction, rates of case-type openings (e.g., non-judicial case dispositions; Hernandez et al., 1996), and family connection to services (California Department of Social Services, 2006; Hernandez et al., 1996; Zielewski et al.). These studies are important for program improvement, but do not speak to our primary goal of determining whether DR programs are effective in reducing child maltreatment.

We encountered difficulty in obtaining some evaluations that have been completed on DR. Two states, specifically Texas and Iowa, are referenced as having conducted evaluations on their programs (Merkel-Holguin et al., 2004; Waldfogel, 2008). These evaluations are no longer available online, or were not provided by the authors after multiple requests. More studies are needed that assess longer-term results (e.g., comparing treatment and control groups on child maltreatment outcomes over several subsequent years following the intervention). Studies in Kentucky, Virginia, and Washington evaluated their program over a period of one year (Merkel-Holguin et al.; Virginia Department of Social Services, 2005; Washington Department of Social and Health Services, 2005). Only two studies included in this review looked at maltreatment reports over a several year period (Institute of Applied Research, 2006; Loman & Siegel, 2004). It is important to know whether the DR intervention is effective in the long-term, potentially at large cost savings to CPS systems.

Coupled with findings that families tend to be more satisfied with the assessment-oriented approach, it can be argued that DR is a preferable approach to engaging and serving some families within CPS. However, more experimental evaluations are required to determine whether DR is effective in reducing child maltreatment. Although the evaluation completed in Minnesota found promising results, there are multiple DR models in use across the country that involve variations in the referral process, services provided, and whether assessment and service provision is internal or external to CPS. For example, some states (e.g., California, Minnesota, and Wisconsin) have one service track that is external to CPS; that is, families are referred to service providers in the community who work with voluntary families, and CPS involvement is ended. Implementation evaluations

of Wisconsin's Community Response Programs (Slack, Berger, & Jack, 2009) and Minnesota's Parent Support Outreach Program (Loman, Shannon, Sapokaite, & Siegel, 2009) have been conducted, but outcome evaluations are not yet available. It is essential that more experimental research be conducted to show how variations in DR affect child maltreatment outcomes, and whether models shown to be effective retain their impact with different populations and in different regions of the country.

Search Terms

The search terms used to generate the studies reviewed include combinations of the following: alternative response/differential response/dual track/flexible response AND child abuse/child neglect/child maltreatment.

References

California Department of Social Services. (2006). *Child welfare services system improvements, 11 county pilot implementation evaluation*. California: Department of Social Services. Available at http://www.cfpic.org/children/children_003.htm.

Center for Child and Family Policy. (2006). *Multiple Response System (MRS) Evaluation Report to the North Carolina Division of Social Services (NCDSS).* Durham, NC: Duke University, Center for Child and Family Policy.

Drake, B., Jonson-Reid, M., Way, I., & Chung, S. (2003). Substantiation and recidivism. *Child Maltreatment, 8*(4), 248.

Hernandez, M., Barrett, B.A., Armstrong, M.I., Brown, E.C., Economos, T.G., Gomez, et al. (1996). *Evaluation of Florida's Family Services Response System.* Tampa, FL: University of South Florida, Florida Mental Health Institute, Department of Child and Family Studies.

Hindley, N., Ramchandani, P., & Jones, D. (2006). Risk factors for recurrence of maltreatment: A systematic review. *Archives of Disease in Childhood, 91*(9), 744–752.

Institute of Applied Research. (2006). Extended follow-up study of Minnesota's Family Assessment Response: Final report. Retrieved April 4, 2009 from http://www.iarstl.org/papers/Final MNFARReport.pdf.

Loman, T., Shannon, C., Sapokaite, L., & Siegel, G. (2009). *Minnesota Parent Support Outreach Program Evaluation: Final Report.* St. Louis, MO: Institute of Applied Research.

Loman, A. & Siegel, G. (2004). *Differential response in Missouri after five years.* Institute of Applied Research: St. Louis, MO.

Merkel-Holguin, L., Kaplan, C., & Kwak, A. (2004). *National study on differential response in child welfare.* American Humane Association and Child Welfare League of America.

Schene, P. (2005). The emergence of differential response. *Protecting Children, 20* (2&3), 4–7.

Slack, K.S., Berger, L.M., and Jack, K.M. (2009). *The Community Response Program Initiative: Interim Implementation Report to the Wisconsin Children's Trust Fund*. Madison, WI: Wisconsin Children's Trust Fund.

U.S. Department of Health and Human Services. (2005). *Alternative responses to child maltreatment: Findings from NCANDS.* Washington, DC: Department of Health and Human Services.

Virginia Department of Social Services. (2005). *Evaluation of the differential response system.* Virginia: Department of Social Services.

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

Waldfogel, J. (2008). The future of child protection-revisited. In D. Lindsey & A. Shlonsky (Eds.), *Child Welfare Research: Advances for Practice and Policy* (pp. 235–241). New York, NY: Oxford University Press.

Washington Department of Social and Health Services. (2005). *Alternative response systems program, progress report.* Washington: Department of Social and Health Services.

Zielewski, E., Macomber, J., Bess, R., & Murray, J. (2006). *Families connections to services in an alternative response system.* Washington, DC: Urban Institute Child Welfare Research Program.

Table 7. Studies Included for Review of Differential Response

Author/Year	Program Name	Program Description	Sample Size and Characteristics	Key Outcome Measure(s)	Study Design	Main Findings
Center for Child and Family Policy, 2006	Multiple Response System (MRS), North Carolina	Families with neglect reports and dependency cases assigned to a family assessment track; other families/cases referred to an investigative assessment track	N=9 pilot counties[a] that implemented MRS in 2002–2003; N=9 comparison counties that had not yet implemented MRS, matched on total and child population sizes and rates of child maltreatment reports.	Rates re-assessment, and substantiated reports of maltreatment	Quasi-experimental (non-randomized treatment and control groups); trend data	No significant differences in rates of re-assessment or substantiated reports of maltreatment.
Institute of Applied Research, 2006	Family Assessment Response (FAR), Minnesota	Families screened into CPS are placed on the traditional investigation track or the family assessment track. Families who receive traditional investigations must have allegations of egregious harm or imminent risk of harm; all other families are offered voluntary services by the county CPS.	FAR was initially implemented in 20 of Minnesota's 87 counties. This study evaluated the outcomes of N=5,733 families (3,177 treatment and 2,211 control) who were screened for FAR from the period February 2001 through December 2002.	CPS reports (as a measure of child maltreatment recurrence)	Experimental evaluation	Families who received FAR had fewer subsequent reports; families who received FAR had longer periods of time without a new report.
Merkel-Holguin, Kaplan, & Kwak, 2004	Differential Response (DR), Alaska	Families screened into CPS and deemed low-risk are screened into DR. Families are referred to a community-based provider for a safety assessment and services.	DR implemented in 3 cities: Wasilla, Anchorage, and Nome. The evaluation was performed on an unreported number of families in Wasilla during the periods June 1997 to May 1999 and June 1999 to May 2001.	CPS reports (as a measure of child maltreatment recurrence)	Quasi-experimental, comparison group from similar site without DR	Families in DR had fewer re-reports.

Author/Year	Program Name	Program Description	Sample Size and Characteristics	Key Outcome Measure(s)	Study Design	Main Findings
Merkel-Holguin, Kaplan, & Kwak, 2004	Multiple Response System (MRS), Families in Need of Service Assessment (FINSA), Kentucky	Families reported to CPS are: (1) screened out if inappropriate; (2) provided resource linkage if need services but do not meet criteria for abuse or neglect; (3) FINSA; and (4) traditional investigation. The four tracks together are considered the MRS. Under FINSA, CPS staff perform assessment and refer for community services or move family to a traditional investigation.	N=20,965 cases were examined between the period of July 2002 and March 2003. The size of the treatment and control groups was not reported.	CPS reports (as a measure of child maltreatment recurrence)	Quasi-experimental; comparison group of traditional CPS families	Cases in the investigative track were twice as likely to have a subsequent investigation when compared to FINSA families.
Loman & Siegel, 2004	Differential Response (DR), Missouri	Families screened into CPS are placed into two categories: (1) traditional CPS for severe cases and (2) DR for all other cases. CPS staff provide a safety assessment for DR families, refer to community-based organizations for voluntary services, or provide direct services.	14 small and medium sized counties across MO and in certain zip codes in St. Louis County and the City of St. Louis; the evaluation was performed on N=7,711 families (4,110 treatment and 3,601 control) involved in DR from July 1995 through June 1997 and followed through November 2002	CPS reports (as a measure of child maltreatment recurrence)	Quasi-experimental; comparison to a similar site that did not have DR	Re-reports are lower for families receiving DR.
Virginia Department of Social Services, 2005	Differential Response System (DRS), Virginia	Families screened into CPS are placed into: (1) traditional investigations or (2) differential response. Families in DR assessed by CPS staff and referred to community-based agencies, when needed.	The evaluation was performed on N=226 families (113 treatment and 113 control) who were involved with DRS during the period January 2004 through December 2004.	CPS reports (as a measure of child maltreatment recurrence)	Quasi-experimental; comparison group was comprised of traditionally served CPS families	No statistically significant difference in re-reports for families receiving DRS and traditional CPS

Author/Year	Program Name	Program Description	Sample Size and Characteristics	Key Outcome Measure(s)	Study Design	Main Findings
Washington Department of Social and Health Services, 2005	Alternative Response System (ARS), Washington	Families screened into CPS are placed into: (1) traditional investigations or (2) alternative response.	The evaluation was performed on 1,409 families (988 families who participated in services "treatment" and 536 families who were not offered services but were referred "control") who were referred to ARS between the period July 1, 2003 and June 30, 2004.	CPS reports (as a measure of child maltreatment recurrence)	Quasi-experimental; comparison between ARS families who accepted services and ARS families who were not contacted or located	Families who accepted ARS services had fewer re-reports than families who were not contacted or located.

[a]A 10th pilot county was not included in analytical comparisons with non-pilot counties because it was not able to be matched to another county on population size and rates of reported maltreatment.

CHAPTER 8: JUVENILE SEX OFFENDER PROGRAMS

Tara Hoff, Rachel Singer, and Julie Wesenberg

Description of Prevention Program Area

Interventions to prevent subsequent sexual offenses by juveniles are a critical aspect of child maltreatment prevention. Although the prevention of abuse recurrence can be thought of as a tertiary, rather than primary or secondary, prevention strategy, there is a growing need within child welfare systems to effectively address the needs of juvenile offenders. Given the paucity of research on prevention efforts with this population, the review in this chapter serves as a descriptive starting point for addressing what is a current gap in the prevention service continuum. A recent review of official records found that juveniles are responsible for approximately one-fifth of all serious sex crimes (Pastore & Maguire, 2007). Other estimates indicate that between one-third and one-half of those that commit child molestation are juveniles (Becker, Cunningham-Rathner, & Kaplan, 1986; Deisher, Wenet, Clark, & Fehrenbach, 1982), and about one-half of adult sex offenders admit to committing their first offense as a juvenile (Abel, Mittleman, & Becker, 1985; Becker & Abel, 1985). Importantly, many juvenile sex offenders have previously been the victims of child maltreatment. For example, Hendricks and Bijleveld (2008) found that in their sample of adolescent offenders, three-quarters had been neglected in some way, one-half had been sexually abused, and one-third had been physically or emotionally abused. Further, high levels of family stress, problematic parent-child relationships, and parental rejection are risk factors associated with recidivism by juvenile sex offenders (Boyd, Hagan, & Cho, 2000), and which can complicate efforts to intervene with this population.

In general, juvenile sex offender treatment programs aim to: (1) alter distorted thinking about human sexuality; (2) prepare the juvenile for age-appropriate and consensual relationships; and (3) reduce deviant sexual fantasies and sexual behaviors that reinforce those fantasies (Salter, 1988, as cited by Weinrott, Riggan, & Frothingham, 1997). A variety of theories and therapeutic practices have influenced treatment modalities, but cognitive-behavioral therapy has emerged as the preferred method of treatment for this population (Reitzel & Carbonell, 2006). However, despite the proliferation of cognitive behavioral therapy models, the efficacy of any particular form of treatment with juveniles remains somewhat unclear.

There is significant variation in the program characteristics of interventions with juvenile sex offenders. Treatment programs may be conducted in residential facilities or community settings. They may target the individual offender, the offender and their family, or a group of offenders. The participation criteria for specific treatment programs can vary based on the age and sex of the juvenile, the type of offense, the type of victim, and additional considerations of the juvenile's needs. Evaluations reviewed measure effectiveness in different ways. Such differences, coupled with differences in program characteristics, make it difficult to compare results across studies.

It should be noted that evaluations of interventions with female juvenile offenders were excluded from this review. It is believed that the issues associated with female juvenile sex offenders are qualitatively different from those of their male counterparts (Hendricks & Bijleveld, 2006). For the purpose of this review, the pragmatic reason for excluding studies of female offenders is that the small numbers of female sex offenders in existing research prevents meaningful statistical analysis of this subgroup (Waite et al., 2005).

Brief Statement of Effectiveness

The studies reviewed suggest that juvenile sex offenders are more likely to recidivate with a nonsexual offense than a sexual offense, but the ability to attribute program impact on recidivism is limited by the use of nonequivalent control groups. Findings from two experimental evaluations are suggestive of program impact on rates of problem sexual behaviors (Letourneau et al., 2009; Weinrott et al., 1997); however, neither study addressed recidivism of sexual offenses.

Description of Interventions

Two studies included in this review targeted adolescent offenders and their families (Letourneau et al., 2009; W. Seabloom, M. Seabloom, E. Seabloom, Barron, & Hendrickon, 2003); an additional two targeted only adolescent offenders (Waite, et al., 2005, Weinrott et al., 1997). One study involved youth who were incarcerated in juvenile facilities throughout the treatment period (Waite et al.); and three studies identified participants through referral processes and most of the involved youth lived in the community while undergoing treatment (Letourneau et al.; Seabloom et al., 2003; Weinrott et al.).

Across the four studies in this review, several measures were used to capture subsequent offenses or correlates of subsequent offenses. Often, evaluators measured both sexual and nonsexual offenses. Two studies relied on the recidivism rate of juvenile sex offenders as the primary outcome measure (Seabloom et al., 2003; Waite et al., 2005). The Vicarious Sensitization intervention (Weinrott et al., 1997) measured levels of deviant arousal, while the study of multisystemic therapy evaluated sexual behavior problems, problem criminal behaviors, substance abuse, mental health, and out-of-home placement of the youth (Letourneau et al., 2009).

All four interventions involved multiple components and were designed to help adolescents acquire the skills necessary to prevent re-offenses (Seabloom et al., 2003; Waite et al., 2005; Letourneau et al., 2009). Two of the interventions included a cognitive-behavioral therapy component (Letourneau et al.; Waite et al.); one involved a behavioral conditioning component (Weinrott et al., 1997); and one involved a psychotherapeutic component (Seabloom et al.).

Methodological Quality of Studies

None of the studies measuring actual rates of recidivism employed a rigorous evaluation design.

The most significant limitation to the reviewed studies is the use of nonequivalent comparison groups to assess program effectiveness (Seabloom et al., 2003; Waite et al., 2005). The lack of random assignment into treatment and control groups makes it very difficult to isolate the impact of an intervention on outcomes for participants. For example, participants who completed the Personal/Social Awareness Program had significantly different recidivism rates from those who withdrew or were referred elsewhere (Seabloom et al.). However, it is not possible to determine how much of the reduction in recidivism was due to the impact of the program or due to differences in the circumstances and characteristics of the youth (e.g., youth who completed the program may have different circumstances and characteristics than those who did not complete the program). These same characteristics may make program completers less likely to recidivate.

Only two studies used randomized treatment and control groups (Letourneau et al., 2009; Weinrott et al., 1997); however, direct measures of recidivism were not employed, and follow-up periods were relatively short (i.e., one year or less).

Two studies relied on official records of arrests and criminal convictions to measure recidivism (Waite et al., 2005; Seabloom et al., 2003). Official records provide a direct and concrete measure of subsequent offenses and avoid biases associated with self-reports. However, official records fail to capture all of the instances of subsequent offenses and therefore underestimate recidivism rates in offending behaviors. This is due to the underreporting of sex crimes and the practice of plea-bargaining wherein lesser sexual charges or nonsexual offenses become the official record (Seabloom et al., 2003; Vizard, Monck, & Misch, 2001).

Review of Findings

The ultimate aim of juvenile sex offender treatment programs is to prevent future instances of sexual abuse. Both of the programs that measured recidivism rates found that participants were more likely to commit future nonsexual offenses than sexual offenses (Seabloom et al., 2003; Waite et al., 2005). Of the youth who completed the Personal/Social Awareness program (Seabloom et al.), none committed a subsequent sexual offense within the lengthy follow-up period. This group was also less likely to have been arrested or convicted of other criminal offenses than those who failed to complete the treatment program. Juvenile sex offenders housed separately from the rest of the population who received intensive treatment and juvenile sex offenders housed within the general population who received less intensive treatment had similar recidivism rates (Waite et al.). Youth who participated in the multisystemic therapy intervention (Letourneau et al., 2009) showed a significant reduction in sexual behavior problems, delinquency, substance use, mental health concerns, and out-of-home placements compared to the youth who participated in a cognitive-behavioral treatment intervention. The Vicarious Sensitization intervention showed reductions in arousal to prepubescent girls, while not affecting arousal to teenage girls (Weinrott et al.1997). Self-reports of Vicarious Sensitization participants indicate that they experienced less deviant arousal than the wait-listed control group. It was found that program impacts were maintained for at least 3 months following the intervention (Weinrott et al.).

Discussion

A common perception among the general public and policymakers is that juvenile sex offenders pose an inordinate risk of sexual re-offense (Waite et al., 2005; Zimring, Piquero, & Jennings, 2007; Caldwell, Ziemke, & Vitacco, 2008). Actual rates of juvenile sexual recidivism appear to be quite low. Waite et al. (2005) reviewed 12 studies of recidivism of juvenile sex offenders and found that rates ranged from 2% to 14%. However, efforts to prevent sexual recidivism remain

crucial, and at present, little is known about how to effectively achieve this goal.

The studies included in this literature review indicate that the following program components may have positive impacts: individualized treatment plans (Seabloom et al., 2003); family-oriented interventions (Seabloom et al.; Letourneau et al., 2009); the inclusion of mental health and substance use assessments (Letourneau et al.); and a focus on antisocial behavior (Waite et al., 2005; Letourneau et al.; Nisbet, Wilson, & Smallbone, 2004). These components need further empirical validation, with attention to the effectiveness of different combinations of program components, including cognitive-behavioral therapy, vis-à-vis re-offense rates.

Reitzel and Carbonell (2006) conducted a recent meta-analysis of the effectiveness of sexual offender treatment for juveniles as measured by recidivism. These researchers caution that it is not always possible to compare juvenile sex offender treatment programs, even across programs that share the same theoretical orientation, because there is not a standardized curriculum for administering treatment (Reitzel & Carbonell). Individual study characteristics, such as differences in the handling of dropouts and nonequivalent follow-up periods between treatment groups, further limit comparability. Reitzel and Carbonell concluded that the programs in their meta-analysis failed to display evidence of substantial impacts.

In conclusion, juvenile sex offenders have been shown to have relatively low rates of sexual recidivism; however, the mechanisms that support this result are unknown. The research suggests that there may be benefits inherent to the treatment programs included in this review. However, it is not clear which program, if any, is the most effective at producing a reduction in subsequent sexual offenses. More research is needed, especially experimental studies, to provide additional insight into the ability of sex offender treatment programs to reduce subsequent instances of sexual abuse. It is not known whether receiving treatment in a residential facility versus receiving treatment in the community has an impact on the recidivism of youth. Finally, given recent research showing that therapists' assessments of recidivism risk are unrelated to actual recidivism (Hendriks & Bijleveld, 2008) indicates a need for heightened attention to the development of valid risk assessment tools.

Search Terms

The search terms used to generate the studies reviewed included combinations of the following: juvenile/adolescent sex offender/offense, sexual abuse prevention, and child abuse/child sexual abuse/child maltreatment.

References

Abel, F., Mittleman, M., & Becker, J. (1985). Sex offenders: Results of assessments and recommendations for treatment. In J. Ben-Aaron, S. Hucker, & C. Webster (Eds.), *Clinical criminology: Current concepts* (pp. 127–155). Toronto: M & M Graphics.

Becker, J. V. & Abel, G. (1985). Methodological and ethical issues in evaluation and treating adolescent sex offenders. In E. M. Otey & G. D. Ryan (Eds.), *Adolescent sex offenders: Issues in research and treatment* (pp. 109–129). Rockville, MD: NIMH.

Becker, J. V., Cunningham-Rathner, J., & Kaplan, M. S. (1986). Adolescent sexual offenders: Demographics, criminal and sexual histories, and recommendations for reducing future offenses. *Journal of Interpersonal Violence, 1*(4), 431–445.

Boyd, N. J., Hagan, M., & Cho, M. E. (2000). Characteristics of adolescent sex offenders: A review of the research. *Aggression and Violent behavior, 5*, 137–146.

Caldwell, M. F., Ziemke, M. H., & Vitacco, M. J. (2008). An examination of the sex offender registration and notification act as applied to juveniles. *Psychology, Public Policy, and Law, 14*(2), 89–114.

Deisher, R. W., Wenet, G. A., Clark, T. F., & Fehrenbach, P. A. (1982). Adolescent sexual offense behavior: The role of the physician. *Journal of Adolescent Health Care, 2*(4), 279–286.

Elliott, D. S., Huizinga, D., & Ageton, S. S. (1985). *Explaining delinquency and drug use*. Beverly Hills, CA: Sage.

Frierdrich, W. N., Lysne, M., Sim, L., & Shamos, S. (2004). Assessing sexual behavior in high-risk adolescents with the Adolescent Clinical Sexual Behavior Inventory (ACSBI). *Child Maltreatment, 9*, 239–250.

Hendriks, J., & Bijleveld, C. (2006). Female adolescent sex offenders—an exploratory study. *Journal of Sexual Aggression, 12,* 31–41.

Hendriks, J., & Bijleveld, C. (2008). Recidivism among juvenile sex offenders after residential treatment. *Journal of Sexual Aggression, 14*(1), 19–32.Knopp, F. H., 1985. *The youthful sex offender: The rationale & goals of early intervention & treatment.* Syracuse, NY: Safer Society Press.

Letourneau, E. J., Henggeler, S. W., Borduin, C. M., Schewe, P. A., McCart, M. R., Chapman, J. E., et al. (2009). Multisystemic therapy for juvenile sexual offenders: 1-year results from a randomized effectiveness trial. *Journal of Family Psychology*. *23*(1), 89–102.

Nisbet, I. A., Wilson, P. H., & Smallbone, S. W. (2004). A prospective longitudinal study of sexual recidivism among adolescent sex offenders. *Sex Abuse: A Journal of Research and Treatment, 16*(3), 223–234.

Pastore, A. L., & Maguire, K. (Eds.). (2007). *Sourcebook of criminal justice statistics: 31st Edition.* Retrieved from http://www.albany.edu/sourcebook/toc.html.

Prentky, R. A., Harris, B., Frizzell, K., & Righthand, S. (2000). An actual procedure for assessing risk with juvenile sex offenders. *Sexual Abuse: A Journal of Research and Treatment*, 12, 71–93.

Prentky, R., & Righthand, S. (2001). *Juvenile Sex Offender Assessment Protocol (J-SOAP)*. Bridgewater, MA: Justice Resource Institute.

Reitzel, L. R., & Carbonell, J. L. (2006). The effectiveness of sexual offender treatment for juveniles as measured by recidivism: A meta-analysis. *Sexual Abuse: A Journal of Research and Treatment, 18*, 401–422.

Salter, A. C. (1988). *Treating child sex offenders and victims.* Newbury Park, CA: Sage.

Seabloom, W., Seabloom, M. E., Seabloom, E., Barron, R., & Hendrickson, S. (2003). A 14- to 24- year longitudinal study of a comprehensive sexual health model treatment program for adolescent sex offenders: Predictors of successful completion and subsequent criminal recidivism. *International Journal of Offender Therapy and Comparative Criminology, 47*(4), 468–481.

Vizard, E., Monck, E. & Misch, P. (2001). Child and adolescent sex abuse perpetrators: A review of the literature. In R. Bull (Ed.), *Children and the law: The essential readings* (pp. 392–418). Maldern, MA: Blackwell.

Waite, D., Keller, A., McGarvey, E. L., Wieckowski, E., Pinkerton, R., & Brown, G. L. (2005). Juvenile sex offender re-arrest rates for sexual, violent nonsexual and property crimes: A 10-year follow-up. *Sexual Abuse: A Journal of Research and Treatment. 17*, 313–331.

Weinrott, M. R., Riggan M., & Frothingham S. (1997). Reducing deviant arousal in juvenile sex offenders using Vicarious Sensitization. *Journal of Interpersonal Violence. 12(*5), 704–728.

Zimring, F. E., Piquero, A. R., & Jennings, W. G. (2007). Sexual delinquency in Racine: Does early sex offending predict later sex offending in youth and young adulthood. *Criminology & Public Policy, 6*(3), 507–534.

Table 8. Studies Included for Review of Interventions Targeting Juvenile Sex Offenders

Author/Year	Program Name	Program Description	Sample Size & Characteristics	Key Outcome Measure(s)	Study Design	Main Findings
Letourneau, Henggeler, Borduin, Schewe, McCart, Chapman et al., 2009	Multisystemic Therapy (MST)	MST involved family therapy, behavioral training, and cognitive-behavioral therapy to empower adolescents to cope with problems and reduce serious antisocial behavior. MST also provided parents with skills and resources to deal with the challenges of raising youth with behavior problems.	N= 67 male juveniles received intervention N= 60 male juveniles in comparison group; Participant youth had all committed a sexual offense and were referred to sexual offender treatment as part of probation or diversion program requirements.	Problem sexual behavior measured with Adolescent Sexual Behavior Inventory[b] Criminal behavior measured by the self-report delinquency scale designed for the National Youth Survey[c]	Experimental evaluation Intervention: MST. Comparison: typical community services for juvenile sexual offenders Measurements taken pretreatment, and at 6 months & 12 months	MST group showed significant reductions in problem sexual behavior and delinquent behavior compared to group receiving services as usual
Seabloom, W., Seabloom, M., Seabloom, E., Barron, & Hendrickson, 2003	Personal/Social Awareness Program	A juvenile sexual offender program targeting adolescents and their families. Included psychotherapy groups for juveniles and parents, individual psychotherapy, family therapy, bimonthly retreats, 2-day family educational/sexual awareness seminars; participation in program dated 1977–1986.	N=122 male juveniles; Participants referred from court system, child protection system, other treatment programs, and from self-/family referrals. The participants presented a history of sexual offenses or other issues related to deviant sexual behaviors.	Recidivism of a sexual or non-sexual offense: arrest and conviction data were collected via the Minnesota Bureau of Criminal Apprehension	Longitudinal study; retroactive comparison groups based on treatment completion: (1) N=52 successful completion (2) N=18 referred to another program (3) N=52 withdrew from treatment prior to completion	No sexual offense recidivism by treatment completers; Completers were less likely than non-completers to be arrested or convicted for other types of criminal offenses
Waite, Keller, McGarvey, Wieckowski, & Brown, 2005	Virginia Department of Juvenile Justice Sex Offender Treatment Programs	Two institutional treatment programs: (1) "self-contained" separated from the general juvenile incarcerated population into specialized living units, received sex offender-specific cognitive behavioral treatment and relapse prevention; and (2) "prescriptive" remained housed within general population, also received cognitive behavioral therapy in the form of individual and group therapy sessions	N=144 male juveniles self-contained group N=112 male juveniles prescriptive group; Participants were incarcerated in Department of Juvenile Justice facilities following the commission of a sexual offense.	Recidivism of a sexual or non-sexual offense: arrest and incarceration data, length of time to re-arrest and type of offense as determined by data from the Department of Juvenile Justice Impulsive/antisocial behaviors measured using archival data to complete the Juvenile-Sex Offender Assessment Protocol[a]	Quasi-experimental (non-randomized treatment and control groups)	For both groups, actual re-arrest was most likely to be for a nonsexual offense and least likely to be for a sexual offense.

Author/Year	Program Name	Program Description	Sample Size & Characteristics	Key Outcome Measure(s)	Study Design	Main Findings
Weinrott, Riggan, & Frothingham, 1997	Vicarious Sensitization (VS)	Form of aversive conditioning that aims to reduce sexual arousal to young children. Laboratory-based intervention that administers aversive conditioning using multiple forms of media (audio, video, photographs) to portray negative social, emotional, physical, & legal consequences of sex crimes. Treatment duration of 3 months.	N=35 male juveniles Received intervention (VS) N=34 male juveniles in control condition (weekly cognitive therapy); Participants had all committed a sex offense against a child at least 4 years younger. Referred from outpatient juvenile sex offender programs, private practitioners, probation officers, and state institutions.	Phallometric data: % of full erection and seconds to 25% of full erection Self-report of deviant arousal	Experimental evaluation Intervention: VS Control: weekly cognitive therapy	VS reduced arousal to prepubescent girls (arousal to teenage girls was not reduced); Treatment gains were maintained 3 months after program completion After VS, youth reported less deviant arousal and less deviant self-stimulation.

[a]Prentky, R. A., Harris, B., Frizzell, K., & Righthand, S. (2000). An actual procedure for assessing risk with juvenile sex offenders. *Sexual Abuse: A Journal of Research and Treatment*, 12, 71–93. Prentky, R., & Righthand, S. (2001). *Juvenile Sex Offender Assessment Protocol (J-SOAP)*. Bridgewater, MA: Justice Resource Institute.
[b]Frierdrich, W. N., Lysne, M., Sim, L., & Shamos, S. (2004). Assessing sexual behavior in high-risk adolescents with the Adolescent Clinical Sexual Behavior Inventory (ACSBI). *Child Maltreatment*, 9, 239–250.
[c]Elliott, D. S., Huizinga, D., & Ageton, S. S. (1985). *Explaining delinquency and drug use*. Beverly Hills, CA: Sage.

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