PLANNING TO PREVENT CHILD MALTREATMENT: STRATEGIES TO SUPPORT AN INTEGRATED CHILD MALTREATMENT PREVENTION FRAMEWORK

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We are deeply appreciative to the many individuals who provided thoughtful perspective, suggestions, and feedback that informed the topics included in this literature review. This work is part of a larger project to develop a new framework for guiding state planning efforts to enhance state and local capacity to prevent child abuse. This project, being piloted in Colorado with support from the Office of Early Childhood and in South Carolina with support from The Children's Trust, will articulate a list of core values or pillars of practice which state leadership can use to:

- guide state and local investment decisions across multiple options to promote child safety;
- identify a common set of benchmarks to monitor the extent to which high priority interventions and policy changes substantially improve child outcomes and strengthen the ability of families to care for and protect their children; and
- outline a set of implementation strategies which state and local communities can use to move ideas into practice.

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INTRODUCTION

Child abuse and neglect prevention planning has significantly expanded over the past 40 years since the first federal reporting guidelines were authorized in 1974 under the Federal Child Abuse and Neglect Prevention and Treatment Act (Child Welfare Information Gateway [CWIG], 2011). As the field began to invest in prevention efforts two paths emerged: interventions targeting reductions in physical abuse and neglect by working with parents to alter their attitudes and behaviors and those targeting child sexual abuse by educating all children and encouraging them to reach out for help (Daro, 1988). From these two paths, a diverse continuum of interventions produced many gains but had inconsistent reach and often failed to meet the needs of those families facing the greatest challenges (Daro, 1993). By the 1990s prevention advocates had shifted their attention to programs which focused on the first few years of the parent-child relationship and were often delivered to families in their own homes (U.S. Advisory Board, 1991). Today, prevention advocates are questioning the utility of adopting one dominant framework. They are seeking a broader array of interventions that will effectively reach all new parents as well as continue to support parents beyond their child's first few years of life.

In addition to exploring new methods for structuring and delivering prevention services to individual families, the field is also seeking ways to better support evidence-based interventions. This literature review was undertaken to provide states and local communities useful guidelines for selecting specific interventions and, more importantly, building an infrastructure to support high quality implementation. The structure of our review begins with examples of promising program models that focus on strengthening individual child and parent skills and well-being and then presents promising approaches in three additional areas -- changing organizational culture and professional practice, fostering service collaboration and community efficacy, and influencing policy and legislative change. In doing so, this paper aligns with recent research suggesting that strengthening outcomes for children and their parents requires thinking beyond evidence-based programs for families (Daro, 2016). By including strategies to address some of the areas which frame discussions around child abuse and neglect prevention, this paper offers states and local communities examples of specific programmatic and policy options that can leverage their current investments in individualized services.

STRENGTHENING INDIVIDUAL CHILD AND PARENT SKILLS AND WELL-BEING

Providing child and family support, especially during early childhood, can have long-lasting positive outcomes for a child's welfare. In order to strengthen the protective factors that encourage healthy parent-child relationships the literature supports a front-load approach of services beginning during pregnancy or infancy followed by the provision of services and support as needed throughout a child's development to build upon the foundational gains of early childhood (Shonkoff & Phillips, 2000). Many programs and interventions have now been studied in multiple contexts and are the subject of various research publications. This has allowed organizations such as the California Evidence-Based Clearinghouse (CEBC) to evaluate programs and interventions based on the research available and to rate programs on various criteria.

Drawing on CEBC summaries as well as other evaluations, this section highlights specific program models that are either widely implemented across the country or represent a new component planners may wish to consider. As such, the review is not comprehensive nor does it identify all possible program models in a particular category. Those models highlighted are intended to represent a type of program state or local community planners may wish to incorporate as part of a more integrated response to prevent child maltreatment.

Building Protective Factors

Child maltreatment prevention efforts have increasingly embraced a comprehensive approach incorporating multiple theoretical perspectives on prevention (Daro, 1993; Stagner & Lansing, 2009). Accordingly, prevention strategies have expanded to address the complex causes which contribute to child maltreatment and strengthen protective factors. These protective factors include nurturing family attachment, building knowledge of parenting and child development, encouraging parental emotional resilience, boosting parental social connections, and providing concrete supports (Harper Browne, 2014). Examples of program types which include one or several evidence-based models that build these protective factors include home visiting, parent education, parent treatment, school-based programs, legal partnership, medical partnership, and two generation programs.

Home Visiting Programs

Home visiting is a widespread model being implemented by public agencies and community-based service organizations. Evaluations of home visiting programs report findings that vary

"across models, target populations, and outcome domains" (IOM & NRC, 2014a, p. 256). Nonetheless, these programs have demonstrated positive impacts in several domains, including:

- frequency of child abuse and neglect and harsh punishment (Chaffin, Hecht, Bard, Silovsky & Beasley, 2012; DuMont et al., 2010; Lowell, Carter, Godoy, Paulicin & Briggs-Gowan, 2011; Silovsky et al., 2011);
- parental capacity and positive parenting practices (Connell et al., 2008; Dishion et al., 2008; DuMont et al., 2010; LeCroy & Krysik, 2011; Nievar, Arminta, Chen, Johnson, & Dier, 2011; Olds et al., 2010; Roggman, Boyce & Cook, 2009; Zigler, Pfannenstiel & Seitz, 2008); and
- healthy child development (DuMont et al., 2010; Lowell et al., 2011; Olds, Sadler & Kitzman, 2007b; Shaw, Connell, Dishion, Wilson & Gardner, 2009).

It is important to recognize that none of these findings have been universally supported in all evaluations of a given model or across models. Indeed, comprehensive reviews of all research conducted on any given home visiting model often produce as many negative or null findings as positive findings. Impacts of any program will vary across populations and community context. The positive impacts cited for any model in this document may or may not be achieved in a particular setting. However, the likelihood of achieving positive impacts with any evidence-based program are increased when the program is carefully implemented and well supported.

Olds and colleagues are best known for publishing the seminal research showing the benefits from regular home visiting during pregnancy and early childhood. Their studies presented compelling results which has led to the widespread implementation of the model they studied: Nurse Family Partnership (NFP). The NFP "provides home visits by registered nurses to first-time, low-income mothers, beginning during pregnancy and continuing through the child's second birthday" (California Evidence-Based Clearinghouse [CEBC], n.d.). These visits typically vary in frequency from every week to every other week and provide training and support for mothers around prenatal care, child health and development, family planning, and other needs that a mother may have.

Studies of the NFP model, summarized by the CEBC, report the following findings:

- fewer reports of child abuse and neglect and fewer arrests in general over time (Olds, Henderson, Chamberlin, & Tatelbaum, 1986; Olds et al, 1997);
- fewer emergency room visits, physician visits for accidents, poisoning (Olds et al., 1986; Olds, Henderson, & Kitzman, 1994);

- fewer maternal deaths and fewer early deaths (prior to 18 years of age) among children served (Olds et al., 2007a; Olds et al., 2014);
- fewer language delays and higher cognitive functioning (Olds et al., 2004; Sidora-Arcoleo et al., 2010);
- fewer instances of domestic violence and longer relationships with intimate partners (Olds et al., 2004; Olds et al., 2007a);
- fewer and wider-spaced pregnancies (Olds et al., 2004; Olds et al., 2007a); and
- fewer months using welfare and food stamps (Olds et al., 2007b).

Healthy Families America (HFA) is another home visiting model which is being widely implemented in communities across the United States. HFA seeks to enroll high risk families either prenatally or within three months after birth and continue home visits until the child is at least three years of age or up to five years of age (CEBC, n.d.). The HFA model includes screenings and assessments to determine risk for child maltreatment, adverse childhood experiences, child developmental delays, and maternal depression and utilizes home visits to encourage positive parent-child relationships through reflective practice. HFA sites often offer services beyond home visiting that include parent support groups and father involvement programs.

Studies of the HFA model, summarized by the CEBC, report the following findings:

- fewer self-reports of aggression and neglect (Duggan et al., 2004; DuMont et al., 2008; LeCroy & Krysik, 2011);
- positive changes on parental behavior and attitudes and child's emotional and social competence (Cullen, Ownbey & Ownbey, 2010; Rodriguez, Dumont, Mitchell-Herzfeld, Walden, & Greene, 2010; LeCroy & Krysik, 2011);
- significant increases in parent knowledge and maternal involvement (Barlow et al., 2006);
- reduction in domestic violence, and maternal stress and alcohol use (Duggan et al., 2004; Green, Tarte, Harrison, Nygren & Sanders, 2014; Bair-Merritt et al., 2010); and
- positive change in parental provision in developmentally supportive activities (Green et al., 2014; Caldera, et al., 2007).

Parents as Teachers (PAT) is a third home visiting model that has been widely implemented and studied. The PAT curriculum combines early childhood parent education, general family support, and school readiness into the home visiting model targeted to expectant mothers or parents of children up to five years of age. The goal of PAT is to increase parent knowledge of child development, provide early detection of developmental and health issues, prevent child maltreatment, and increase children's school readiness (CEBC, n.d.).

Studies of the PAT model, summarized by the CEBC, report the following findings:

- higher parent knowledge of child development (Pfannenstiel & Seltzer, 1989);
- higher child scores on measures of child development and school readiness (Drotar, Robinson, Jeavons & Kirchner, 2009; Pfannenstiel & Seltzer, 1989);
- more frequent reports of reading and preschool enrollment (Albritton, Klotz, & Roberson, 2004; Pfannenstiel, Seitz, & Zigler, 2002; Wagner, Spiker, & Linn, 2002; Zigler, Pfannenstiel, & Seitz, 2008);
- greater acceptance of child behavior (Wagner, Spiker, & Linn, 2002); and
- increased involvement in school activities (Albritton, Klotz, & Roberson, 2004).

Parenting Education Programs

Parenting education programs are considered a strong theoretical and practical approach to reducing risk and strengthening protective factors (Barth et al., 2005; Johnson et al., 2008, IOM & NRC, 2014a). These programs are often designed to increase knowledge of child development, enhance care, promote positive parent-child interaction and emotional sensitivity, and address child discipline and behavior management. Parenting education programs associated with the most positive outcomes include:

- teaching parents emotional communication skills;
- helping them acquire positive parent-child interaction skills; and
- giving them opportunities to demonstrate and practice these skills while observed by a service provider (CWIG, 2011; IOM & NRC, 2014a; Kaminski, Valle, Filene, & Boyle, 2008).

The Incredible Years (IY) model for parent education seeks to prevent child maltreatment by parents of high-risk children aged four to eight who exhibit recognized behavior problems. The IY offers a series of programs for parents, teachers, and children. The IY Basic Parent Training Program for prevention populations is offered for a duration of 14 weeks. It includes a

homework component to reinforce the principles taught during the two hour weekly classroom sessions (CEBC, n.d.).

Studies of The IY model, summarized by the CEBC, report the following findings:

- greater consistency and positivity in parenting (Kim, Cain, & Webster-Stratton, 2008; Reid, Webster-Stratton, & Beauchaine, 2001);
- decrease in scores on measures of harsh/negative parenting (Baydar, Reid, & Webster-Stratton, 2003);
- reduction in parental stress and depression and foster caregiver depression (Bywater et al., 2009, Bywater et al., 2011); and
- significant reduction in child problem behavior, sustained over time (Bywater et al., 2011; Drugli, Larsson, Fossum, & Morch, 2010; Reid, Webster-Stratton, & Hammond, 2003).

Triple P - Positive Parenting Program (Triple P) is another popular parenting education program for caregivers of children from birth to age 16. Triple P offers multiple program levels in group, one-on-one, and online formats (CEBC, n.d.). Multiple randomized controlled trials of the model have found that, regardless of cultural context, the model has positive impacts on parent-reported child behavior problems, reduces dysfunctional parenting and improves parental competence (Bor, Sanders, & Markie-Dadds, 2002; Leung, Sanders, Leung, Mak, & Lau, 2003; Martin and Sanders, 2003).

Parent Treatment Programs

Parental substance abuse is a recognized risk factor for child maltreatment and child welfare involvement (IOM & NRC, 2014a). The National Survey of Child and Adolescent Well-Being (NSCAW) found that among the birth families of children entering out-of-home care in the sample, 61 percent of infants and 41 percent of older children have a primary or secondary caregiver with active substance abuse (Wulczyn, Ernst, & Fisher, 2011).

For caregivers involved in the foster care system, research suggests that assignment to individual counselors or “recovery coaches” who are experts in the area of substance abuse results in better outcomes. Caregivers assigned to individual counselors begin services more quickly; have decreased alcohol and drug use, fewer physical and mental health problems, and better social function; and a five percent increase in family reunification (McLellan et al., 1998; Ryan, Marsh, Testa, & Louderman, 2006).

Family Drug Courts (FDCs) are another strategy for improving parent and caregiver outcomes for those involved in the foster care system in need of substance abuse treatment. FDCs coordinate substance abuse treatment with child protective services (CPS). By emphasizing frequent status hearings, the FDC structure allows for more efficient progress that helps CPS meet statutory obligations around permanency (Marlowe & Carey, 2012). The FDC model is effective at improving outcomes for substance abuse treatment and promoting family reunification with marginally better outcomes for caregivers with a co-occurrence of mental health problems and other demographic risk factors (Marlowe & Carey, 2012; Worcel, Furrer, Green, Burrus, & Finigan, 2008).

Additionally, FDCs offer an average net cost savings ranging from $5,000 to $13,000 per family, which are mostly realized through savings that result from reduced use of foster care (Marlowe & Carey, 2012).

School-Based Programs

School-Based Programs offer unique opportunities to build protective factors for families. Children's social and emotional competences are developed through "children's relationships, the activities they have opportunities to engage in, and the places in which they live, learn, and play" (Center on the Developing Child at Harvard University, n.d., p. 1). All of these elements affecting the development of a child's social and emotional competence are found at a child's school.

School-Based Programs frequently address violence and bullying or sexual assault prevention. A randomized controlled trial of a violence prevention program delivered to a whole-school by classroom teachers reported the following findings:

- decreased trend in peer-reported victimization;
- reduced trend of self-reported aggression;
- decreased trend of aggressive bystanding;
- increased empathy; and
- decreased the percentage of children victimized (Fonagy et al., 2009).

Similarly, a study of playground interactions following random-assignment to a bullying prevention program found:

- declines in bullying and argumentative behavior;

- increases in agreeable interactions;
- enhanced bystander responsibility;
- reduced destructive bystander behaviors;
- greater perceived adult responsiveness; and
- less acceptance of bullying/aggression (Frey et al., 2005).

School-based sexual abuse prevention programs have also been successful. A systematic review of 24 studies on school-based sexual abuse prevention training for children found an increase in protective behaviors and knowledge among the children who were exposed to the programs. The review also found some evidence that participation may increase odds of disclosure of sexual abuse (Walsh, Zwi, Woolfenden, & Shlonsky, 2015).

One common sexual abuse prevention program is Stewards of Children (Stewards). This program aims to educate adults in effective practices to prevent and recognize child sexual abuse. Stewards is designed to train child care professionals and educators and has demonstrated positive impacts on knowledge, attitudes, and preventive behaviors (Rheingold et al., 2015). There is also some evidence of increased reporting of child sexual abuse in communities where adults received the training, but more research is needed (Letourneau, Nietert, & Rheingold, 2016; Townsend & Haviland, 2016).

Legal and Medical Partnership Programs

As pediatric primary care continues to integrate more services into the pediatric setting, programs that build protective factors for the prevention of child abuse and neglect have taken advantage of the move towards greater integration with health care providers. Safe Environment for Every Kid (SEEK) and Medical-Legal Partnership (MLP) are two programs that take advantage of the healthcare setting to screen families for areas of need and provide necessary support either directly or through referrals.

The SEEK program trains both medical professionals and social workers to screen for risk factors for child maltreatment and briefly address problems or make a referral to a community resource. Studies of the SEEK program, summarized by the CEBC, indicate that SEEK results in:

- fewer CPS reports (Dubowitz, Feigelman, Lane & Kim, 2009);
- increased medical treatment compliance (Dubowitz et al., 2009);
- decreased harsh punishment (Dubowitz et al., 2009; Dubowitz, Lane, Semiatin, & Magder, 2012);

- fewer delays in immunizations (Dubowitz et al., 2009);
- improvement in addressing parental depression, stress, substance abuse, and intimate partner violence (Dubowitz et al., 2011); and
- improvement in medical professionals comfort with and screening of risk factors for child maltreatment (Dubowitz et al., 2011; Feigelman, Dubowitz, Lane, Grube, & Kim, 2011).

Similarly, the MLP program combines training of medical professionals with the presence of legal professionals on-site in health care settings. The legal professionals screen for health-harming social conditions and work collaboratively with medical providers to respond to family needs. While the MLP model is not specifically targeted to the prevention of child maltreatment, it does reduce parental stressors and increase access to concrete supports by addressing patients' needs. According to Williams, Costa, Odunlami, and Mohammed (2008), "The MLP [model] has enhanced the ability of the healthcare team to address patients' stressors in the areas of housing, immigration, income support, health insurance, education access, disability and family law" (p. 5).

A randomized controlled trial of the Development Understanding and Legal Collaboration for Everyone (DULCE) intervention, which incorporates a family specialist using the Healthy Steps model (Minkovitz et al., 2003) with a MLP model found several positive outcomes for families who received the intervention. DULCE families were more likely to complete their immunizations on schedule, more likely to schedule and attend preventative care visits, less likely to visit the emergency department, and were able to more quickly access needed concrete supports (Sege et al., 2015).

Two-Generation Programs

The early history of child abuse and neglect prevention efforts started with services which placed primary emphasis on targeting parent needs and shortcomings including parenting education classes, support groups, and crisis services (CWIG, 2011). Few of these interventions included a comprehensive assessment of a child's needs nor did they carefully monitor child development. The underlying logic of these early prevention programs was that improved parental capacity would result in improved child outcomes.

As prevention efforts have grown to reflect new public policies and services, programs emerged that developed unique service components which focused on the developmental needs of children. This created a historical tension in the balance of child abuse and neglect planning between investing in programs which focused their programmatic efforts on parents and those

which placed primary emphasis on working with children. Many of these single-focus programs have been successful in achieving targeted outcomes, but may fail to address the multi-generational nature of the risk factors for child abuse and neglect (St. Pierre, Layzer, & Barnes, 1995). In response to this concern, two-generation programs were developed and implemented in the late 1980s and 1990s to address risk factors for child abuse and neglect from multiple directions (Chase-Lansdale & Brooks-Gunn, 2014; Smith, 1991). Two-generation programs are characterized by a desire to build human capital across generations through the integration of parenting education, early childhood education, and adult education or job training under a single strategy (Chase-Lansdale & Brooks-Gunn, 2014; St. Pierre, Layzer, & Barnes, 1995).

Many of the two-generation programs implemented in the late 20th century had disappointing findings and began to fade away during the work-first policy dialogue that dominated welfare reform in the late 1990s (Chase-Lansdale & Brooks-Gunn, 2014; Shaw, Goldrick-Rab, Mazzeo, & Jacobs, 2006). Philanthropies are one of the driving forces behind the recent surge of interest in two-generation programs. Organizations like the Annie E. Casey Foundation are embracing two-generation programs to amplify the impact of interventions on families and extend that impact to influence system-level change (Gruendel, 2014).

Working with families to build the human capital they need to escape the cycle of poverty is a popular component of two-generation programs. The Mobility Mentoring program model being implemented in Boston is one example. The program brings a family together for individualized case mentoring to work towards increased family stability, well-being, education and training, financial management, and employment and career management (Babcock, 2012). The program has shown success in helping families achieve their goals and move towards self-sufficiency (Babcock & Ruiz De Luzuriaga, 2016) but more research is needed on this and similar program models in order to more fully understand the most appropriate target population and methods as well as short and long term impacts.

Organizing Effective Programs and Interventions

As discussed above, studies to determine the effectiveness of programs aiming to prevent child abuse and neglect often report mixed outcomes. Despite the need for additional research into specific programs across varying demographic and practice contexts, there are several well-researched findings and strategies that can be applied in many different program models to improve effectiveness. Strategies that include parent training and education, especially those including role-playing exercises, are associated with higher effect sizes (Euser et al., 2015; Casillas, Fauchier, Derkash, & Garrido, 2016). Programs with a moderate number of sessions (16-30) are significantly more effective than those with fewer or more sessions, this also is true for program duration, with moderately long programs being significantly more effective (6-12

months) (Euser et al., 2015). A 2009 systematic review of reviews by the World Health Organizations found that home visiting, parent education, abusive head trauma, and multi-component programs are most promising for prevention (Mikton & Butchart, 2009).

While no single program or intervention will lead to positive outcomes for all families, across a wide range of programs tailored interventions that meet specific family needs and are culturally relevant are more successful. It is also important that program staff are trained to view parents as equal partners in decision making. Additionally, practitioners should consider creating opportunities for parents to engage with peers and receive peer support to increase parent engagement and reduce the stigma of participation in parent training and education programs (National Academies of Sciences, 2016).

CHANGING ORGANIZATIONAL CULTURE AND PROFESSIONAL PRACTICE

Creating a context and culture supportive of high quality practice and innovation is as important for growing strong prevention programs as strong communities are for growing healthy families and children. Most prevention programs are housed within public agencies or community based organizations that can either support or complicate the service delivery process. In addition to ensuring that individual programs are robust and successful, research and innovative efforts are demonstrating ways in which organizational culture, the process of participant assessment, and methods of responding to needs can enhance program outcomes and streamline service delivery. This section addresses several strategies research has found effective in leveraging organizational change in ways supportive of stronger practice.

Applying Evidence-Based Practice

An estimated 80-90 percent of child-serving systems in the U.S. do not use evidence-based interventions. When a system does implement an evidence-based program, it is often adapted in ways which may result in a loss of "key ingredients critical to its effectiveness" (Arney & Scott, 2013, p. 236). Encouraging evidence-based practice (EBP) in decision-making and service delivery encounters many barriers. Value-based, local, and anecdotal knowledge are identified as barriers to research evidence use (REU) in social work. To overcome these barriers, EBP must allow for ease of adaptation based on the social service worker's knowledge of their client's values and the local context (McNeill, 2006) while still retaining the critical EBP elements. One approach to encouraging appropriate adaptation to EBP practice is training practitioners in the common elements documented in the most effective protocols. This can be illustrated by the "common elements" approach to EBP which uses a distillation and matching model to incorporate elements of manualized treatments with existing organizational infrastructure (Chorpita, Becker, & Daleiden, 2007).

In policy development, EBP is identified as a slow, but inevitable and valuable process (Lomas, 2000). Environmental, organizational, and individual factors influence the process of REU at the policy/administrative level. Environmental influences include a bureaucratic and politicized field which tends toward reactive rather than proactive decision-making. In these cases, REU is often being used as a means to justify a pre-determined policy position.

In contrast, organizational influences that promote REU include:

- leadership that supports a learning culture and EBP;

- an organizational EBP champion;
- partnerships and organizational linkages with researchers; and
- access to technology.

Strategies that have demonstrated promise in altering the behaviors and attitudes of individual service providers around REU include:

- exposure to research during education;
- critical appraisal skills;
- work experience outside of their current organization context and with diverse populations;
- access to research databases; and
- a personal dedication to inquiry (Jack et al., 2010; Lomas, 2000).

Establishing Differential Response in Allocating Services

Families seeking assistance from voluntary prevention programs or those who have been directly referred to intervention services represent broad levels of risk. Some will be facing significant personal or economic challenges in meeting the needs of their children while others simply need direction to the most appropriate interventions. The model of "differential response" examined in the context of child welfare can also be applied to secondary prevention services. The concept of conducting a careful assessment of a family's needs to ensure the best and most appropriate type and intensity of assistance is applicable to many prevention services.

Within the context of child welfare, differential response (DR) changes the structure of child protective services (CPS) to allow for more than one method of initial response to reports of child abuse and neglect (CWIG, 2014). DR often attempts to assess familial circumstances and assist families in addressing issues to avoid more serious maltreatment or future reports and involvement with CPS (Lawrence, Rosanbalm, & Dodge, 2011). DR is in line with the 2010 reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA) which requires states to refer children who are "not at risk of imminent harm to a community organization or voluntary preventive service" (CAPTA, 2010, p. 19). DR thus directs low and moderate risk reports to the alternative response indicated by CPS and allows for flexibility to direct serious allegations into the traditional response system.

Evaluations of DR systems offer some insights into the impact of DR on outcomes of interest in child abuse and neglect planning. Across multiple evaluations, DR is associated with increased

service provision, fewer subsequent reports, fewer re-assessments, and fewer removals (Lawrence et al., 2011; Loman & Siegel, 2004; Loman, Filonow, & Siegel, 2010; Siegel, Filonow, & Loman, 2010; Winokur, Ellis, Drury, & Rogers, 2015). In North Carolina, Nevada, Colorado, and Ohio evaluations found no difference between the DR and traditional response models on child safety (Lawrence et al., 2011; Loman et al., 2010; Siegel et al., 2010; Winokur et al., 2015). In Minnesota, an evaluation found improved child safety among families in the DR track (Loman & Siegel, 2004). These studies indicate that DR is associated with many positive outcomes and represents no substantial risk of negative outcomes on child safety. Additionally, cost studies indicate that while DR may be more costly to implement in the short-term, over time DR becomes more cost effective and in the long term is often no more or less costly than the traditional CPS response (Lawrence et al, 2011; Loman & Siegel, 2004; Loman et al., 2010; Winokur et al., 2015).

This model of careful assessment and differential response has applicability for prevention practice. For example, most new parents will face a range of challenges in caring for their newborn. For some, their questions will be around service access such as finding appropriate well baby care, child care or assistance around breastfeeding and nutrition. Others will require more substantive assistance in managing the care of their infant and may be facing significant challenges such as maternal depression, domestic violence, or substance abuse. A system that consistently examines the specific needs facing all new parents offers communities a way to more rationally allocate services and refer families to the level of assistance most appropriate for their specific situation.

In the absence of a systematic assessment, referrals may be based solely on rather crude indicators of need such as young maternal age, single parent status, or limited income. While such characteristics may suggest the need for more intensive intervention, wide variability exists within these groups in terms of their personal resilience and resources available to manage adversity. Universal assessment strategies offer early intervention providers a tool for improving their ability to match new parents with the appropriate level of need (Daro & Dodge, 2010).

FOSTERING SERVICE COLLABORATION AND COMMUNITY EFFICACY

While changing organizational culture and professional practice can result in more effective programs and practices, encouraging service collaboration and community efficacy further ensures that more children, youth, and families can be reached, monitored, and supported with services that meet their needs. Research supports the growing trend towards integrated systems of care, information exchange, and knowledge transfer between agencies. Utilizing technology, states and local communities can enhance the delivery of services to families and link databases to better understand the experiences of the families they serve. This information is also useful for identifying and understanding the factors that result in neighborhoods that exhibit high-risk for child maltreatment. Linked data can help researchers and funders better understand the impact of programs at the community-level and support the implementation of public policies that support neighborhoods where families and children can thrive.

Implementing Integrated Care

The concept of the Medical Home where "care is accessible, continuous, comprehensive, collaborative, compassionate, culturally competent, and family-centered" (Earls, Sulik, Martini, & DeMaso, 2008, p. 220) is the most recent effort in a long history of social service reforms that have encouraged service collaboration and systems of integrated care. Multidisciplinary teams, which engage health care, child welfare, education, and mental health professionals in collectively examining the underlying causes and service needs of abused and neglected children were initially adopted in the 1950s as a way to improve service coordination between a pediatrician, nurse, and social worker (Krugman, 2013). As the concept of multidisciplinary teams became more frequently incorporated into practice, Dr. Barton Schmitt published the *Child Protection Team Handbook* in 1978 which described "how to form and organize a team, how to create reports, and how to work together in a multidisciplinary setting" (Krugman, 2013, p. 72). A similar approach is represented in child welfare reforms that promote case conferences and family group decision making in which all relevant service providers, in partnership with families, explore their options (Center for the Study of Social Policy [CSSP], 2002). In the child abuse prevention field, calls for a more coordinated response in ensuring families are referred to the most appropriate level of service is the core principle in building centralized intake systems in the area of early intervention services, such as home visiting (Maternal, Infant, and Early Childhood Home Visiting [MIECHV], 2014).

Today, healthcare service delivery, especially of preventative services, places high priority on building networks of services in a more intentional and effective manner to strengthen the supports available to parents (IOM & NRC, 2014b). The Medical Home requires dynamic relationships with community service providers that can assist families in identifying and meeting multiple needs that ultimately have an impact on child-well-being and development (Earls et al., 2008). In a 2015 meta-analysis examining integrated primary care versus treatment as usual, four out of five collaborative care trials showed significant positive effects in children who received integrated care over those children receiving usual care (Asarnow, Rozenman, Wiblin, & Zeltzer, 2015).

Integrating child and adolescent behavioral health during pediatric care would serve to enhance child well-being and lower overall costs. This is especially true when considering that the co-occurrence of mental health conditions with chronic diseases is associated with much higher costs (Melek, Norris, & Paulus, 2013). Greater recognition of mental health needs among children has led to programs which offer consults with mental health professionals either by quick phone consultations or the co-location of mental health practitioners in the pediatric medical home (Kolko & Perrin, 2014; Sarvet et al., 2010). Pediatric medical homes have also begun to incorporate staff members with knowledge of community resources to assist families in accessing the services they need (Berkowitz et al., 2015).

Integrated care is not only attractive from a child welfare perspective, but has also received some support from commercial insurance providers who advocate the breakdown of silos of care through claims and financial incentives. Traditional fee-for-service systems tend to inhibit the push for integrated care by not offering the flexibility to account for involvement in visits by multiple teams addressing different family needs (National Academies of Sciences, Engineering, and Medicine [NASEM], 2015). Continued support and flexibility from insurance providers will be important for encouraging continued integration, as many primary care clinicians complain that transformations and initiatives which support integrated care are undertaken in their practices at their own financial risk (Chesluk & Holmboe, 2010). Service systems can work towards the implementation of integrated care either by co-locating services or by training primary care providers to identify needs, advise families, and refer them to another provider or program.

Utilizing Technology

As technology continues to advance there are new opportunities to utilize hardware, software, information technologies, and other tools to improve service delivery, more easily develop and maintain standardized data collection systems, and share information and knowledge across agencies and sectors.

Service Delivery

Utilizing technology to enhance service delivery can be an efficient way to expand the reach of a program, reduce costs, and increase participant compliance and engagement. Nevertheless, technology also raises ethical and legal issues regarding confidentiality, liability, and billing that need to be considered prior to adapting the practice within standard service delivery (Myers, 2002). The field of public health has had success in utilizing communication and information technology to deliver health information and interventions and enhance the quality of dissemination. The field of child maltreatment prevention might have similar success in utilizing these technologies to improve service delivery (Self-Brown & Whitaker, 2008).

When technology has been utilized to adapt and supplement service delivery it has been shown to effectively:

- increase participation from rural families (Feil et al., 2008);
- allow for immediate reporting of data by a participant without the cost or intrusion of a worker (Power et al., 2013);
- streamline data collection to shorten home visits (O'Connor, Laszewski, Hammel, & Durkin, 2011); and
- enhance participant engagement and satisfaction (Breitenstein & Gross, 2013; Feil et al., 2008; Taylor et al., 2008; Bigelow, Carta, & Lefever, 2008; Carta, Lefever, Bigelow, Borkowski, & Warren, 2013).

Standardized Data Collection

Administrative data collection is another area where technology is being utilized to streamline processes and overcome challenges. The research and funding environments in the child maltreatment field encourage the use of administrative data but face challenges in implementing the practice including a lack of standardized variables and data collection measures across sectors and agencies. The desire for standardized data can be linked to technological advances in computer hardware and software and a demand for services to demonstrate differential effectiveness and efficiency across populations, communities, and service models (McGhee, Mitchell, Daniel, & Taylor, 2015). When linked across multiple sectors, the utility of administrative data in child welfare research and policy formulation is "geometrically greater" than the administrative data available from as single agency (Jonson-Reid & Drake, 2008, p. 392). Multisector, multilevel, and longitudinal data can answer difficult

research questions contributing knowledge to the field's understanding of evidence-based practice, potentially contributing to better outcomes for families.

Many data sources are increasingly being standardized to allow researchers and practitioners to link cases across systems and better understand the experience of multi-systems involved families. These linked datasets allow researchers to learn about referrals and services while reducing the amount of missing data and minimizing errors by checking multiple data sources (Jonson-Reid & Drake, 2008). There are still many challenges to accessing and analyzing administrative data. Data collection and reporting varies by agency so that a single variable may not match the same variable in another database. In the case of public child welfare databases, unsubstantiated reports are less likely to be well documented and often reports are not accompanied by a variable documenting who reported an event of suspected child maltreatment. Such information can be helpful for prevention advocates seeking to understand how cases are identified and referred for formal intervention (Green et al., 2015).

In order to contribute to evidence-based practice and organizational change, administrative databases must contain reliable data and be integrated into the decision-making process (English, Brandford, & Coghlan, 2000). In order to advance the collection of standardized variables across agencies, it is recommended that states make an effort to encourage the inclusion of variables of interest to policy-making and evidence-based practice in the administrative databases of programs and services which are funded by state agencies (Jonson-Reid & Drake, 2008). Agencies should also do their part by working to adopt uniform measures and definitions for variables to lend reliability to multi-state, multi-sector datasets (Green et al., 2015). In the home visiting field, the Pew Home Visiting Initiative adopted this philosophy and recommended a standardized set of outcome and process measures for states to use in documenting the efforts of all of their early home visiting programs (Pew Charitable Trust, 2015).

Knowledge Transfer

Knowledge transfer among diverse organizations and sectors is essential for social and professional networks to function effectively. Without effective information exchange, partnerships and systems that could be effective are limited in their potential to achieve a positive impact on the families they serve (Leischow et al., 2008). In a 2000 report the Committee on Integrating the Science of Early Childhood Development at the Board on Children, Youth, and Families at the Institute of Medicine recommended:

> state and local decision makers to take bold actions to design and implement coordinated, functionally effective infrastructures to reduce the long-standing fragmentation of early childhood

> policies and programs. . . [and] establish explicit and effective linkages among agencies that currently are charged with implementing the work requirements of welfare reform and those that oversee the provision of both early intervention programs and child and adult mental health services (p. 402).

The key elements that contribute to knowledge transfer among organizations include organizational culture, organizational structure and operating procedures, and fiscal, technological, and human resources (Allen, Hyde, & Leslie, 2012). Research indicates that child welfare agencies generally lack sufficient support for using their information systems consistently and effectively (Collins-Camargo, Sullivan, & Murphy, 2011). State and community early childhood systems should work to establish sustainable linkages between agencies to ensure effective, cross-agency referrals by successfully transferring knowledge. In enabling knowledge transfer, early childhood systems can avoid duplication of services and better meet the needs of the families they serve.

Understanding Community-Level Impacts

A community can be a strength or a stressor on families and children. In order to encourage strong and healthy families it is important to understand community-level impacts on child abuse and neglect. By encouraging early learning communities and implementing programs at a community-level, early childhood systems can reinforce families by reducing risk factors that contribute to a higher likelihood of maltreatment as well as strengthening the protective factors that prevent child maltreatment.

Community Effects on Child Maltreatment

Neighborhoods with a high number of children reported for maltreatment have long been observed as exhibiting low levels of social cohesion as reflected in lower levels of child supervision exchange and play between neighbor children (Garbarino & Sherman, 1980; Vinson, Bladry, & Hargreaves, 1996). These communities also demonstrate other characteristics believed to be predictive of child maltreatment including rates of neighborhood childcare burden, ethnic heterogeneity, and neighborhood violent crime (Maguire-Jack, 2014a). However, research has shown that even in communities struggling with a range of problems, increasing social cohesion is specifically associated with lower levels of reported basic needs neglect, most commonly associated with impoverished families (Maguire-Jack & Showalter, 2016).

Program Models at the Community Level

While it is difficult to isolate the effects of programs and interventions at a community level above and beyond their effects at the individual level (Maguire-Jack, 2014a), some community-level program models have successfully reduced reported rates of child abuse and injury to

young children at the county or community level (Dodge et al., 2004, Prinz et al., 2009). A study examining the impact of spending on child maltreatment prevention programs in 39 Wisconsin counties found that higher prevention spending is associated with lower rates of child maltreatment with an average of $33.66 spent across the counties per child per year (Maguire-Jack, 2014b).

Community program models that seek to reduce the frequency of child abuse and neglect include Triple P-Positive Parenting Program, Strengthening Families, the Durham Family Initiative, Strong Communities, and the Community Partnerships for Protecting Children (CPPC). As outlined by Daro and Dodge (2009):

> All of [these] initiatives have strategies to increase the odds families will have services available to them either by improving access to existing services or by generating new services…These initiatives seek to change a range of behaviors and attitudes such as mutual reciprocity among neighbors, parent-child interactions, and collective responsibility among residents for child protection and safety (p. 73).

The five interventions addressed in Daro and Dodge (2009) reflect a range of approaches, underscoring the diversity found in comprehensive interventions that seek to change the likelihood for child maltreatment at the population level. Below we have outlined some of the key characteristics of these models.

- Triple P is a multi-tiered intervention which includes strategies delivered universally to all parents and caretakers in the community; secondary prevention efforts designed to assist subgroups of parents who may face a common challenge; and tertiary prevention efforts targeting parents with significant needs or those who have already maltreated their child (Sanders, Turner, & Markie-Dadds, 2002).

- Strengthening Families Initiative (SFI), developed by the Center for Study of Social Policy, uses focused assessments, technical assistance, and collaborative ventures to enhance the capacity of child care centers to promote five core protective factors among their program participants—parental resilience, social connections, knowledge of parenting and child development, critical support in times of need, and social and emotional competence of children (CSSP, 2007).

- The Durham Family Initiative (DFI) is a population-wide effort to expand the consistency and scope of universal assessments designed to identify high-risk families or those needing prevention services and then to link them with appropriate community-based resources (Dodge et al., 2013).

- Strong Communities seeks to help the general public and local service providers within a given community understand how their individual and collective efforts can directly address the complex and often destructive web of interactions contributing to child maltreatment. The logic of the program is that once residents feel that their neighborhood is a place where families help each other and where it is expected that individuals will ask for and offer help, public demand will drive service expansion and system improvement (Kimbrough-Melton & Melton, 2015).
- The Community Partnerships for Protecting Children (CPPC) addresses the lack of coordination between the formal child welfare response and community-based prevention efforts by incorporating family support principles into the public child welfare system and elevating child safety concerns among those working in family support settings (Daro, Budde, Baker, Neesmith & Harden, 2005).

Efforts to implement standardized data collection and improve knowledge transfer as discussed in previous sections are important elements in supporting the success of community-level interventions. One model to approaching community and neighborhood-based prevention efforts is the overlay of collaboration, advocacy, resource development, education, and services (CARES). This model emphasizes the importance of multisector cooperation to strengthen families and neighborhoods, the reduction of social isolation by strengthening informal and formal support systems, and community planning and collaboration to influence service implementation and improve access (Mulroy & Shay, 1997). Models such as CARES would benefit from linked administrative databases across the systems that serve families in order to assess community-level service provision and the neighborhood indicators relevant to children such as access to child care and early education, housing conditions, access to medical care and concrete supports, and others (Coulton & Korbin, 2007).

Early Learning Communities

There are a variety of ways to establish early learning communities to assist parents in accessing appropriate information on child development and child management. For example, Maryland's Early Childhood Advisory Council (ECAC) support such communities through existing public libraries. Libraries are used to host workshops and parent cafes that reach some of the state's most high-risk and vulnerable families. Efforts like this are part of a larger movement to partner with public libraries to focus on family engagement and narrow the gap that makes parents in lower-income households less likely to "provide children with access to books, other literacy materials, and the language-rich conversations that help children prepare for school" (Lopez, Caspe, & McWilliams, 2016, pg. 10). Libraries often function as a safe space for families dealing

with the additional stressors of poverty. These families can come together informally or formally in libraries to obtain informational, emotional, and logistical support from one another. These connections with other families help to mitigate the risk of depression and social isolation, both of which are risk factors for child maltreatment (Lopez et al., 2016).

A national survey of family engagement in public libraries found that libraries provide many services for families (Caspe, Bohrer, Allen & Buitrago, 2016). Libraries often offer early childhood literacy programs and many librarians engage parents of young children about books and resources. Of the libraries surveyed, 98 percent partner with schools and 89 percent partner with early childhood programs to meet family needs. The survey found that librarians are knowledgeable about and interested in supporting early childhood development. The findings from this survey indicate that state and local planning agencies might well consider thoughtful partnerships with libraries to provide family engagement around early childhood learning and development.

The Center for the Study of Social Policy (2016) recently published a report about its efforts to work with stakeholders from nine early childhood systems to establish early learning communities. They classify these communities as including four key characteristics:

- Community leadership with the commitment and public will to make young children and families a priority.
- Existence and awareness of quality services that are easy for families to access and use.
- Safe neighborhoods with affordable housing, access to nutritious food, reliable transportation, and employment opportunities so families can thrive.
- Policies that support families such as sustainable support for early childhood services and funding for a variety of concrete supports.

INFLUENCING POLICY AND LEGISLATIVE CHANGE

Public policy decisions at multiple levels of government shape, among other factors, research funding, the availability of support for prevention and treatment programs, and the level of concrete supports available to families living in poverty. Policy makers have to allocate a finite number of resources and anticipate that their policies produce the intended outcomes. Program staff, researchers, and representatives from state agencies can influence policy and agenda setting and encourage the development of policies which offer the greatest potential to produce positive outcomes for children and their families. Being knowledgeable of research findings related to various policy dilemmas and using these findings to shape decisions can improve the likelihood that public investments will achieve the desired ends.

Impacting Policy and Agenda Setting

Policy makers often operate under tight time constraints that limit their ability to deeply study every issue. Because of this reality, policy makers rely on knowledge brokers and advocates to inform their funding and strategic decisions (Choi et al., 2005). In order to effectively inform policy and set an agenda around an issue, the information distributed to policy makers should clearly link specific policy recommendations to documented trends and real conditions (Monroe, 1995). Economic analyses presenting information on costs with a comparison of costs and outcomes of interest are especially helpful to policy makers as they seek to determine how best to allocate their scarce resources (IOM & NRC, 2014a).

It is important to note that agenda setting is impacted by more than just the format and content of emerging and established findings. Policies are often adopted during specific windows of opportunity signified by a convergence of events, public opinion, advocacy, and political interests. Examples of factors influencing agenda setting include:

- natural disasters and crisis events;
- public opinion and media coverage;
- pressure from advocacy groups;
- political interest and election cycles; and
- a clear course of action for moving forward (Monroe, 1995; Miller Updike, 2013).

For agencies interested in measuring the impact of policy and advocacy activities, Reisman, Gienapp, and Stachowiak (2007) published a report with a menu of outcomes for advocacy and policy work. They identified multiple outcomes and strategies in six main pathways:

- shifting in social norms in ways that support behavioral change;
- strengthening organizational capacity to reinforce new practice and the implementation of strategies;
- strengthening alliances across diverse partners;
- strengthening the base of public support for an idea;
- improving public policies; and
- changing areas of impact.

Each of these pathways offers new opportunities for child maltreatment prevention beyond the replication of specific interventions that target individual families, parents, or children. Reflecting many of the ecological and multi-factorial theories that have been used to explain the occurrence of child maltreatment for decades, these strategies encourage prevention advocates to consider opportunities that may exist in the broader institutional and social context that shape the choices individual organizations and families make (IOM & NRC, 2014a). These changes can either contribute to elevated risk of maltreatment or promote important protective factors (Hendrickson & Blackman, 2015).

Innovating Federal and State Funding

Across multiple sectors, innovations in federal and state funding can have a significant impact on the prevention of child abuse and neglect. These innovations include:

- flexible funding for the integration of social and educational services during medical care;
- flexible spending grants that allow states to fund prevention programs without requiring them to spend down funds available for foster care;
- funding to address barriers to medical care; and
- the provision of concrete supports to alleviate the stressors of poverty.

Flexible Use of Funds

Innovation in the prevention of child maltreatment requires flexible funding mechanisms. Screening families for early signs and symptoms of child maltreatment during routine medical care or as part of a universal assessment of all newborns and their families is an important mechanism for prevention. However, detection of child maltreatment and its risk factors is often not straightforward (Runyan et al., 2002) and financial support for practice innovations are limited. Integration of social and educational services with pediatric medical care and support for a consistent, universal assessment of all new parents is rarely funded by private insurance despite having a robust link to children's health outcomes (Dodge et al., 2013; Perrin, Boat, & Kelleher, 2016). Some private payers are experimenting with fully capitated payment systems where providers receive a fixed dollar amount for providing a full range of services (Burwell, 2015). This movement to a capitated system of reimbursement is viewed by many in the health care sector as potentially elevating an emphasis on preventive and early intervention care. This shift is particularly likely to occur when the available evidence can make a strong link between such early investments and a reduction in chronic conditions that require long term, costly intervention (Pearson, King, & Richards, 2013).

Flexible funding is also an important topic in foster care funding reform. The current system of funding distributes separate funding for prevention and foster care cases. Foster care funds, particularly those provided by the federal government, have been significantly higher than prevention funding in part because of the high per child cost of foster care and the belief that a child unable to remain with their birth family for reasons of safety should not be denied access to this service for reasons of cost. Under a flexible funding framework recently proposed in Congress, states may be allowed to shift some of the dollars allocated to foster care to prevention investments with the goal of reducing the need for foster care (H.R. 5456, 2016).

While the link between prevention and reduction in chronic conditions in health is well established in many cases, the link between prevention services such as family preservation efforts and even early home visiting on subsequent maltreatment and foster care placement is less robust (IOM & NRC, 2014a). This lack of clear evidence has made the shift between foster care dollars to prevention more problematic. States can gamble on their foster care caseload and accept a capitated flexible grant, but if caseloads unexpectedly rise the flexible spending grant may not cover the increase (Haskins, Currie, & Berger, 2015). As evidence for the effects of prevention efforts on subsequent maltreatment grows, changes in child welfare streams may become more common and acceptable (U.S. Government Accountability Office, 2013).

Medicaid and Accountable Care Organizations

Increasing access to medical care for poor families and their children starts by addressing barriers to care such as high co-payments, logistical difficulties, and caregivers with low child health knowledge. The Affordable Care Act (ACA) and higher income requirements for states' Children's Healthcare Insurance Programs (CHIP) have helped to insure additional children and their parents (Artiga & Cornachione, 2016). This is significant as uninsured children are less likely to receive timely preventative and acute care, which leads to additional negative effects such as children missing school due to treatable conditions (Edmunds & Coye, 1998).

Several states have implemented statewide accountable care organizations (ACOs) to enroll all Medicaid managed children and adults into provider networks that take clinical and financial risk for their patients (Lloyd, Houston, McGinnis, 2015). In a number of states these ACOs have incentivized practice innovations such as care coordination, behavioral health integration and chronic care management (Harvey, Summers, & Inama, 2015). The strategies implemented by ACOs have worked well for specific populations that have traditionally used large amounts of healthcare services, achieving modest quality improvements and lower expenses in a period of 18-36 months (Christensen & Payne, 2016; Kelleher et al., 2015; Powers & Chaguturu, 2016).

Providing Concrete Supports

Poverty is a reliable and substantial predictor of child maltreatment, particularly child neglect (Millett, Lanier, & Drake, 2011; Pelton, 2015). The material hardships that are the reality of poverty can lead to parental stress and depression as well as heightened environmental risk of unintentional injuries (Pelton, 2015). Children of unemployed parents experience two to three times higher rates of abuse and neglect (Sedlak et al., 2010). By providing concrete supports to assist families living in poverty, state and federal agencies can indirectly prevent child maltreatment.

The nation's core economic security programs are highly effective in reducing poverty, especially for children. Refundable tax credits reduce overall poverty by 3.1 percentage points and child poverty by 7.1. The Supplemental Nutrition Assistance Program (SNAP) reduced overall poverty by 1.5 percentage points and child poverty by 2.8 (Golden, 2016). Emergency cash assistance as well as the provision of concrete supplies such as clothing and furniture are associated with reduced risk of child foster care placement (Pelton, 2015). In contrast, state-level studies show that child maltreatment investigations and foster care caseloads increase when welfare benefits are reduced (Ward, Sanders, Gardner, Mikton, & Dawes, 2016). This evidence suggests that prevention advocates may be well served by proactively working to increase the funding levels and reach of these programs as one component of a comprehensive strategy to improve family

resources, particularly when children are young. Research has found that even a modest increase in household income during a child's first five years of life can have measurable impacts on later school performance and life time earnings (Duncan, Kalil & Ziol-Guest, 2013).

While the research into the effects of poverty on child abuse and neglect indicates that poverty is a key risk factor for child maltreatment and that such investment may improve child outcomes, Jonson-Reid, Drake, & Kohl (2009) aptly noted:

> It is, however, critical that policy debate not confuse the need to prevent poverty with the prevention of negative behaviors (like abuse and neglect)…With so many children reported for child abuse and neglect each year, we cannot afford to abandon current work with affected children and families while searching for a long-term resolution to poverty (p. 427).

CONCLUSION

Child maltreatment prevention advocates and program developers have implemented an impressive array of services over the past 50 years. Since Henry Kempe's publication of his landmark article on the "battered child" in 1962 (Kempe, Silverman, Steele, Droegemueller, & Silver, 2013), the public is more aware of the problem and individuals are taking action both on their own and in partnership with others to reduce the number of children experiencing maltreatment. More importantly, prevention efforts are increasingly designed to not only avoid the most negative outcomes for children but also to ensure that each child achieves his or her full potential. The multiple factors that contribute to an elevated risk of child abuse or neglect and support healthy development underscore the reality that no single intervention, no matter how well researched, can provide parents the support they need to successfully meet their children's physical, cognitive and emotional needs. Equally true is the fact that more individual services operating in isolation of each other will not offer a pathway to success.

Moving forward, states and local communities will need to address both the quality and availability of high quality, evidence-based programs and ensure that such services are housed within an organizational, community and policy context that can maximize their collective potential. Specifically, this review suggests that states and local communities will be well served by expanding their prevention portfolio to include strategies that build the infrastructure necessary to support high quality implementation. The reach and effectiveness of evidence-based prevention services targeting parents, children and families can be expanded by investing in efforts to make organizational culture and standard professional practice more hospitable to these programs. Beyond individual services and organizations, prevention efforts will be strengthened when they work in collaboration with each other at both the state and community level. Finally, public policy reforms to advance the prevention mission are found in many domains. In addition to the child welfare system, public welfare, public health, and early education policies offer important opportunities to increase the quality and availability of basic supports to children living in impoverished, low resourced, or violent communities. While poverty is not the sole predictor of child maltreatment, ensuring children and their families have access to high quality health care, nutrition, housing, safety and early education opportunities creates a strong foundation for optimal child development and reduced parental stress.

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