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Creating Community Responsibility for Child Protection: Possibilities and Challenges

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Summary

Deborah Daro and Kenneth Dodge observe that efforts to prevent child abuse have historically focused on directly improving the skills of parents who are at risk for or engaged in maltreatment. But, as experts increasingly recognize that negative forces within a community can overwhelm even well-intentioned parents, attention is shifting toward creating environments that facilitate a parent's ability to do the right thing. The most sophisticated and widely used community prevention programs, say Daro and Dodge, emphasize the reciprocal interplay between individual-family behavior and broader neighborhood, community, and cultural contexts.

The authors examine five different community prevention efforts, summarizing for each both the theory of change and the empirical evidence concerning its efficacy. Each program aims to enhance community capacity by expanding formal and informal resources and establishing a normative cultural context capable of fostering collective responsibility for positive child development.

Over the past ten years, researchers have explored how neighborhoods influence child development and support parenting. Scholars are still searching for agreement on the most salient contextual factors and on how to manipulate these factors to increase the likelihood parents will seek out, find, and effectively use necessary and appropriate support.

The current evidence base for community child abuse prevention, observe Daro and Dodge, offers both encouragement and reason for caution. Although theory and empirical research suggest that intervention at the neighborhood level is likely to prevent child maltreatment, designing and implementing a high-quality, multifaceted community prevention initiative is expensive. Policy makers must consider the trade-offs in investing in strategies to alter community context and those that expand services for known high-risk individuals. The authors conclude that if the concept of community prevention is to move beyond the isolated examples examined in their article, additional conceptual and empirical work is needed to garner support from public institutions, community-based stakeholders, and local residents.

Depending on their composition and quality, neighborhoods can either foster children's healthy development or place them at significant risk for physical, psychological, or developmental harm. The National Survey on Children's Health estimates that almost 75 percent of the nation's children live in neighborhoods that their parents describe as highly or moderately supportive, while the balance live in neighborhoods judged by their parents to have either moderately low (20 percent) or very low support (6 percent).[1] Although some of this variation can be attributed to self-selection (that is, economic conditions and available options may direct high-risk families into neighborhoods that are less supportive), empirical studies indicate that neighborhoods do have an effect on family and child behaviors and outcomes, including parenting behaviors.[2]

Child abuse prevention efforts have historically focused on developing and disseminating interventions that target individual parents.[3] Early work in the field placed primary emphasis on identifying parents at risk for or engaged in abusive or neglectful behaviors. Once identified, these parents would be provided with knowledge, skill-building opportunities, and assistance to overcome their personal limitations. Such strategies were considered the most direct and efficient path to preventing maltreatment. More recently, however, attention has shifted from directly improving the skills of parents to creating environments that facilitate a parent's ability to do the right thing. It is increasingly recognized that environmental forces can overwhelm even well-intended parents, that communities can support parents in their role, and that public expenditures might be most cost-beneficial if directed toward community strategies. Some of these strategies seek to expand public services and resources available in a community by instituting new services, streamlining service delivery processes, or fostering greater collaboration among local service providers. Other strategies focus on altering the social norms that govern personal interactions among neighbors, parent-child relationships, and personal and collective responsibility for child protection. In each case, the goal is to build communities with a rich array of formal and informal resources and a normative cultural context that is capable of fostering positive child and youth development.

We begin our inquiry into community-based efforts to prevent child maltreatment by examining the theoretical frameworks of the new approach. We then explore five different community prevention efforts and summarize the empirical evidence evaluating their efficacy. Although not an exhaustive sample, these five initiatives are representative of efforts under way in many states to reduce maltreatment risk or enhance child development. After examining the unique challenges posed by community-based strategies to address abuse and neglect, we conclude by discussing key lessons learned and considering the likely financial and political benefits of embracing community-wide change to achieve measurable reductions in child maltreatment.

Why Does Community Matter if You Are Trying to Prevent Child Abuse?

The most sophisticated and widely used models in current child maltreatment policy and program development emphasize the continuous interaction and reciprocal interplay among such diverse domains as environmental forces, caregiver and familial characteristics, and child characteristics.[4] Uri Bronfenbrenner's ecological model frames individual-family behavior as being embedded in broader neighborhood, community, and cultural contexts. Although the most frequently cited risk and protective factors for maltreatment reflect parents' individual functioning and capacity, community factors can influence parent-child interactions in myriad ways. Community norms frame what parents may view as appropriate or essential ways to interact with their children and set the standards as to when and how parents should seek help from others.[5] Context can increase or reduce parental stress by influencing perceptions of personal safety—that is, by creating a sense of support or reconfirming feelings of isolation. Community resources can offer temporary respite from parental responsibility. Community professional services can improve parents' mental health and capacity to take on the role of parenting. Although many scholars agree on the need to cast a broad net in examining how the vulnerable infant becomes the responsible adult, few can agree on the most salient contextual factors and, most important for our purpose, how to manipulate these factors to increase the likelihood parents will seek out, find, and effectively use necessary and appropriate support.

A series of reports issued by the U.S. Advisory Board on Child Abuse and Neglect between 1990 and 1993 explicitly recognized the continuous interplay between individual and community environment in addressing the problem of child maltreatment.[6] Frank Barry

explains this interplay using four basic assertions, based on theory and empirical findings.[7] First, child abuse and neglect result in part from stress and social isolation. Second, the quality of neighborhoods can either encourage or impede parenting and the social integration of the families who live in them. Third, both external and internal forces influence the quality of life in neighborhoods. And, fourth, any strategy for preventing child maltreatment should address both internal and external dimensions and focus simultaneously on strengthening at-risk families and improving at-risk neighborhoods.

Over the past ten years, a growing body of research has attempted to measure and describe the mechanisms by which neighborhoods influence child development and support parenting. In summarizing this research, the Working Group on Communities, Neighborhoods, Family Process, and Individual Development concluded that neighborhood matters both directly, in providing, for example, schools, parks, and other primary supports, and indirectly, in shaping parental attitudes and behaviors and in affecting a parent's self-esteem and motivational processes.[8]

Context also has long been viewed as important in explaining why neighborhoods that share a common socioeconomic profile can have different levels of maltreatment. In a study of contrasting neighborhoods in Omaha, Nebraska, James Garbarino and Deborah Sherman found that two communities with similar demographic characteristics but different rates of reported child maltreatment differed dramatically in terms of their human ecology.[9] Specifically, the community with higher rates of maltreatment reports was less socially integrated. It also experienced less positive neighboring and more stressful day-to-day interactions. Robert Sampson and his colleagues have found that these neighborhood assets, which they summarize as "collective efficacy," predict variation in neighborhood violence in Chicago.[10]

Building on his earlier work, Garbarino and Kathleen Kostelny found support for the hypothesis that neighborhood social capital affects maltreatment rates in a dynamic model.[11] Examining child abuse reports in four economically disadvantaged Chicago communities during 1980, 1983, and 1986, they found significant differences in the relative ratings of neighborhoods over time. To explain this pattern, the authors interviewed a sample of residents about their view of community morale and their perceptions of their neighborhood as a social environment and as a source of "neighboring." On all dimensions, residents of the community with the greatest increase in maltreatment rates expressed the most negative views of their community, knew little about existing community services or agencies, and demonstrated little evidence of a formal or informal social support network.

One particularly promising pathway for understanding the role community can play in shaping parental capacity and behaviors is the concept of social capital, defined by Robert Putnam as "features of organization such as network, norms, and social trust that facilitate coordination and cooperation for mutual benefit." [12] Jill Korbin and Claudia Coulton used census and administrative agency data for 177 urban census tracts in Cleveland to find that variation in rates of officially reported child maltreatment is related to structural determinants of community social organization: economic and family resources, residential instability, household and age structure, and geographic proximity of neighborhoods to concentrated poverty. Children who live in neighborhoods characterized by poverty, a high ratio of children to adults, high population turnover, and a high concentration of female-headed families are at highest risk for maltreatment.[13]

When the study team interviewed residents in both high- and low-risk communities, those living in areas with higher rates of reported maltreatment and other negative outcomes perceived their neighborhoods as settings in which they and their neighbors had little ability

to intervene in or control the behavior of children. In justifying their lack of action, they were likely to express concerns that the youths being corrected would verbally or physically retaliate. In contrast, residents in low-maltreatment communities were more likely to monitor the behavior of local children because they believed it was their responsibility to "protect" children from violent or dangerous neighborhood conditions, such as traffic or broken glass.[14]

Valuing collective actions to accomplish a common good also has potency in reducing violence, particularly in communities whose profiles would suggest high levels of social disorganization. Robert Sampson and his colleagues, for example, found lower crime rates in neighborhoods whose residents shared the same values and were willing to intervene on behalf of the collective good. Their sample included personal interviews with 8,782 Chicago residents living in 343 distinct "neighborhood clusters" varying in race and socioeconomic status. The researchers used interviews to construct measures of "informal social control" (the degree to which residents thought that they could count on their neighbors to help in such ways as correcting adolescent behavior, advocating for necessary services, or intervening in fights) and of "social cohesion" (the degree to which respondents felt they could count on their neighbors to help each other or be trusted). Together, three dimensions of neighborhood stratification—concentrated disadvantage, immigration concentration, and residential stability—explained 70 percent of the neighborhood variation in collective efficacy. Collective efficacy, in turn, mediated a substantial portion of the association between residential stability and disadvantage and multiple measures of violence.[15] In other words, although structural issues such as poverty are critical in establishing a community's social milieu, neighborhoods that are able to establish a sense of community and mutual reciprocity develop a unique and potentially powerful tool to reduce violence and support parents.

Another community approach, based in the mental health services sector, is system of care. Less well supported by empirical findings but theoretically and clinically strong, system of care involves developing a sound infrastructure of coordinated individualized services. The concept emerged partly in response to Jane Knitzer's dramatic 1982 call for help for children, which grew out of stark findings that too many children were living in poverty and suffering mental disorders. System of care also evolved in response to a legal mandate to provide services to high-risk violent youth within their local communities rather than detaining them in far-away training schools.[16] System of care is based on a four-part foundation that includes a continuum of services ranging from outpatient therapies to in-home family preservation; coordination of services so that a family can move from one to another without disruption; service individualization whereby services are "wrapped around" the child and family rather than having families conform to service requirements;[17] and cultural competence in services so that professionals understand the community and culture of families.[18]

How Can Community Be Used to Prevent Child Abuse?

A large body of theory and empirical research suggests that intervention at the neighborhood level is likely to prevent child maltreatment within families. The two components of intervention that appear to be most promising are social capital development and community coordination of individualized services. Social disorganization theory suggests that child abuse can be reduced by building social capital within communities—by creating an environment of mutual reciprocity in which residents are collectively engaged in supporting each other and in protecting children. Research regarding the capacity and quality of service delivery systems in communities with high rates of maltreatment underscores the importance

of strengthening a community's service infrastructure by expanding capacity, improving coordination, and streamlining service delivery.

Addressing social dilemmas through a combination of grassroots community action and coordinated professional individualized services is long-standing practice in both social work and public health.[19] At the turn of the twentieth century, settlement house workers engaged immigrant communities to address collective inequalities such as labor conditions and educational opportunities as well as personal challenges such as caring for an infant and ensuring child safety.[20] Less known but equally important were African American club women's organizations that focused on building supportive communities for migrants from the South relocating to northern urban areas.[21] More recently, urban renewal and efforts to reduce the adverse impacts of concentrated poverty have embraced community change initiatives designed both to improve context and to empower residents to use collective action to achieve common goals.[22] Although these efforts have often had disappointing results,[23] the power of community and context to change within-family behaviors and to enhance the benefits of individualized interventions continues to advance in many areas, including obesity, violence prevention, child welfare, and youth development.[24]

Community strategies to prevent child abuse and promote child protection have focused on creating supportive residential communities whose residents share a belief in collective responsibility to protect children from harm and on expanding the range of services and instrumental supports directly available to parents.[25] Both elements—individual responsibility and a strong formal service infrastructure—are important. The challenge, however, is how to develop a community strategy that strikes the appropriate balance between individual responsibility and public investment.

In framing its recommendations for fostering community efforts to prevent child abuse, the U.S. Advisory Board noted that these two capacity-building strategies—a focus on community norms and a focus on coordinated, individualized service development— are not mutually exclusive and can evolve in mutually beneficial ways. For example, expanding services may begin by establishing community-based service centers, with multiple providers sharing a common facility (for example, neighborhood service hubs located in schools and community organizations such as New Jersey's Family Success Centers).[26] Not only do such centers offer residents a communal place to get services, they also draw together a diverse set of providers. As a result, families have access to a more comprehensive array of interventions that can simultaneously address multiple risk factors.[27] Building and sustaining a network of service providers in a system of care requires participants to engage in a set of shared activities that can include establishing a common service philosophy, developing a shared assessment tool, or forming interdisciplinary teams to assess families and outline effective service plans.[28] This type of joint casework and system planning creates a more coordinated and integrated service response and effectively engages both public and private agencies. As residents or program participants become engaged in the service planning process, they can empower themselves to assume ownership of the process and make personal investments in their community. Although this chain of events begins with the goal of enhancing services, it can also, with careful implementation and planning, enhance social investments and neighborliness.

Similarly, community change efforts may begin by focusing on social networks and building social capital and, in the process, expand service availability. For example, local residents and key stakeholders might be invited to participate in a community planning initiative that asks them to identify core concerns and to make a plan for resolving key issues. Implementing such plans often requires substantial residential investment. Such investment might involve supporting the reallocation of existing public resources or the development of

new service options for all or a subset of local residents. In other cases, it might involve forming cooperatives to care for each other through existing community organizations or establishing new organizational entities. In such cases, service expansion both provides a tangible resource for the community and draws residents together in collective actions to achieve a shared common good. These dual functions are particularly evident when services include a parent-participation component, as is common in many early education programs, such as Head Start, or use a range of community-based institutions or organizations to create a context in which families can gather and build connections.[29]

Where one starts in this process is less important than recognizing that efforts to build social capital and expand service availability can be mutually reinforcing and equally important. Focusing too heavily on community capacity-building and normative change can leave families without the context and types of institutional supports essential for addressing complex social and personal needs. Focusing too heavily on system reform and service development may sustain an unproductive reliance on formal services. More important, changing only service capacity misses an opportunity to create the sense of mutual reciprocity needed for sustainable change and continuous support.

How Are Community Child Abuse Prevention Efforts Structured, and How Effective Are They?

Community-based efforts to prevent child abuse incorporate a range of strategies that place differential emphasis on the value of these two approaches. For purposes of this discussion, we examine five different community efforts that seek to reduce the frequency of child abuse and neglect—Triple P-Positive Parenting Program, Strengthening Families, the Durham Family Initiative, Strong Communities, and the Community Partnerships for Protecting Children (CPPC). As summarized in table 1, all of the interventions employ various strategies to improve service capacity. In some instances, primary emphasis is placed on building service capacity by focusing on improving quality by reshaping how direct service providers interact with their clients (as is the case of Triple P and CPPC) or how agency managers supervise their staff, define and engage participant caseloads, or interact with each other (as reflected in the Durham Family Initiative's system of care work, Strengthening Families' work with child care providers, and CPPC's efforts with child welfare agencies). In addition to improving program quality, all of the 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. Finally, three of the five initiatives use specific strategies to alter the way in which local residents view the notion of seeking help from others to resolve personal and parenting issues. 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.

Capturing the effects of these complex community change initiatives is daunting. In addition to having broadly defined outcomes, the initiatives seek to change individuals either through programs targeted directly at individual families or through institutional changes that indirectly affect families who may have only limited contact with any of the initiative's core strategies. The key operating assumption in such efforts is that change initiated in one sector will have measurable spillover effects into other sectors and that the individuals provided with information or direct assistance will change in ways that begin to alter normative behavioral assumptions across the population. This gradual and evolutionary view of change is reflected in many public health initiatives that, over time, have produced dramatic improvement in such areas as smoking cessation, reduction in drunk driving, use of seat belts, and increased conservation efforts.

Assessing such efforts is complicated by this evolutionary change process as well as by the tendency of these initiatives to alter their initial operating assumptions and strategies in response to the progress or lack of progress made in the early stages of implementation. Thus, traditional evaluation methods that use random assignment to treatment and control conditions and assume a "fixed" intervention that adheres to a standardized protocol over time are of limited utility in determining an initiative's efficacy or in producing useful implementation lessons. On the other hand, focusing only on level of implementation and ignoring effects will prevent these initiatives from reaching status as "evidence-based" in this era of accountability for outcomes. Furthermore, knowing the early effects of an initiative can be extremely useful in making informed mid-course corrections.

In light of these conceptual challenges, evaluations of community child abuse prevention strategies such as those we discuss in this article have used multiple methodologies to clarify the most promising pathways to achieving community change (theory-of-change analysis and implementation studies), and to more directly use these data in altering their selection of specific strategies and program emphasis (utilization-focused evaluations). As discussed below, all of the initiatives have a theoretical framework that guides their assumptions about parent-child relationships as well as about what communities can do to better support parents. They also have established methods for monitoring their implementation and using implementation data to refine their approach. Although such research does not address the very important question of impact, these evaluative functions are critical for understanding the most efficient way to approach this work.

Where appropriate, randomization procedures and various quasi-experimental strategies have been used to assess outcomes, although in most cases these procedures have been applied to specific elements or components of the initiative rather than capturing the initiative's population-level effects. In addition to the methodological limitations of this research base, few of these strategies have been operational long enough to provide an accurate profile of their potential accomplishments. Although incomplete, these data provide preliminary evidence as to the validity of a strategy's theory of change, implementation potential and challenges, and potential areas of impact.

Triple P

Theory of change and implementation

Triple P-Positive Parenting Program, originally developed in Australia to assist parents of children with developmental delays or behavioral problems, is increasingly viewed as a promising strategy to prevent child abuse. It is a behavioral family intervention designed to improve parenting skills and behaviors by changing how parents view and react to their children. Triple P consists of a series of integrated interventions designed to provide a common set of information and parenting practices to parents who face varying degrees of difficulty or challenges in caring for their children. Based on social learning theory, research on child and family behavior therapy, and developmental research on parenting in everyday contexts, each intervention seeks to reduce child behavior problems by teaching healthy parenting practices and how to recognize negative or destructive practices. Parents in every component are taught self-monitoring, self-determination of goals, self-evaluation of performance, and self-selection of change strategies.

These parenting practices are introduced to community residents through two primary avenues. Universal Triple P is a media-based and social marketing strategy designed to educate community residents about the principles of positive parents and to offer a set of simple techniques for addressing common child care issues (for example, safety, behavior management, discipline strategies, and securing basic health care). Information is

disseminated through the use of radio spots, local newspaper articles, newsletters distributed through the schools, mass mailings to local residents, presentations at community forums, and a widely publicized website. Access to this information is open to all residents willing and able to seek it out. For those parents interested in more "hands-on" assistance, Selected Triple P offers brief parenting advice and contact sessions that are available to parents through various primary care facilities such as well-child care, day care, and preschool settings and in other settings where parents may have routine contact with service providers and other professionals who regularly assist families. In addition to individual consultations, Selected Triple P also involves parenting seminars delivered within these primary care settings on such topics as the power of positive parenting; raising confident, competent children; and raising resilient children. The seminars are designed for the general parent population and provide parenting information as well as raise awareness of the overall initiative.

In addition to its social marketing and general education component, Triple P seeks to change parenting standards by ensuring that when formal services are accessed by families, all providers in the community operate within a shared understanding of key values and practice principles. Toward this end, it offers formal training in the Triple P model to direct service personnel working in a variety of clinical settings. Standard Triple P offers a series of broadly focused eight- to ten-week parenting skill training sessions delivered in the home, or through group-based sessions, or self-directed using project material. Families whose parenting difficulties are complicated by other problems, such as domestic violence or mental health concerns, or who have not been adequately served by the standard services are offered Enhanced Triple P, a more intensive behavioral family intervention.

Although service provision at each level is supported by a variety of structured unique protocols, all of the direct services are framed by a set of common practice principles. These include ensuring a safe and engaging environment for children, creating a positive learning environment, using assertive discipline, having realistic expectations, and taking care of oneself as a parent.

Effectiveness

As discussed in the article in this volume by Richard Barth, repeated randomized trials of specific Triple P interventions have consistently demonstrated positive effects on parenting skills and child behavior.[30] Although these clinical findings are impressive, few of the studies have explicitly examined the effects of Triple P's multi-layered and universal service approach on population or community-wide outcomes. Recently, with funding from the Centers for Disease Control and Prevention, Ronald Prinz and his colleagues randomly assigned eighteen counties in South Carolina to either the comprehensive Triple P program or a services-as-usual control group.[31] Within the intervention counties, project staff launched an intensive social marketing campaign to raise awareness of the initiative and its related parenting strategies and support services among the general population. Staff also identified and contacted state and county stakeholders who provided such support services for parents of young children as education, school readiness, child care, mental health, social services, and health, in a variety of settings. Direct service providers were offered the opportunity to participate in training on all of the Triple P interventions. During the project's first two years, 649 service providers received training in one or more of the interventions. The result was a mean of 38.8 trained providers per 50,000 population.

Effects were assessed by comparing trends between the intervention and comparison counties on three independently derived population indicators. These comparisons yielded statistically significant, large positive effects. Between the period just before implementation and twenty-four months later, intervention counties increased in substantiated child

maltreatment rates by just 8 percent, compared with 35 percent for the control counties. Out-of-home placements decreased in intervention counties by 12 percent but increased by 44 percent in control counties. Hospital admissions for child injuries decreased by 18 percent in intervention counties but increased by 20 percent in control counties. This study is the first to randomize geographical areas to intervention and control conditions and show preventive effects on child maltreatment at a population level. Although these findings are impressive, it remains unclear how the social marketing, universal service offers, and training in the Triple P model to direct service providers might have produced these results. Additional analyses regarding potential variation across the intervention and comparison counties with respect to both implementation efforts and outcomes is needed to understand more fully the mechanisms through which Triple P might affect maltreatment rates.

Strengthening Families Initiative

Theory of change and implementation

The Strengthening Families Initiative (SFI)—not to be confused with a selective individual-family program to prevent child abuse and child problem behavior started by Karol Kumpfer, also called Strengthening Families[32] —is designed to reduce child abuse by enhancing the capacity of child care centers and early intervention programs to offer families the support they need to avoid contact with the child welfare system. Similar to the Triple P model, Strengthening Families also seeks to affect parent behavior by using an existing service delivery system. Specifically, SFI 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. By building relationships with families, early care and education programs can recognize signs of stress and strengthen families' protective factors with timely, effective help. Unlike previous training and educational efforts to engage child care workers in child abuse prevention, SFI is presented as "problem solving" rather than "problem identification." Families are encouraged to understand that if they have concerns, they can go to any staff member at these centers and receive help or direction. And if they are reported for suspected maltreatment, the family can count on the child care center to serve as their advocate with child welfare officials.

In 2001, with funding from the Doris Duke Charitable Foundation, the Center for the Study of Social Policy (CSSP) began studying the role that early care and education programs nationwide can play in strengthening families and preventing abuse and neglect. After developing the overall framework and related training materials, CSSP implemented the model in seven states on a pilot basis. In each state, officials enhanced their policies and practices through collaboration among their early childhood, child abuse prevention, and child protective services sectors. Several of the states integrated SFI's five protective factors and the strategies for achieving them into the state's child care quality rating and improvement systems.

Moving out of the pilot phase, SFI has broadened its focus beyond states' early care and education programs to include building links between these programs and child welfare departments and building the protective factors into the training and monitoring systems governing home-based child care providers. At present, twenty-three states are participating in the Strengthening Families National Network.

Effectiveness

SFI's primary pathway for change, enhancing protective factors within families with young children, has strong empirical support in both basic and applied research. No one can

disagree that the initiative's key protective factors, if in place and robust, are likely to reduce the odds of parents' abusing or neglecting their children. Parents who have strong social connections, knowledge of child development, and a sense of personal efficacy are indeed among those who have the most rewarding relationships with their children, and these children are more likely to have strong self-perceptions and robust cognitive and social development. Equally compelling is evidence that enrollment in high-quality early education programs, particularly those that augment children's services with direct support to parents, have measurable immediate and long-term effects on child and family outcomes, including the prevention of child abuse.[33]

Despite the theoretical promise of this approach, it is unclear whether these types of child and family outcomes can be achieved through SFI's implementation plan. Six elements of the theory must still be investigated. The first is assumptions regarding the number of child care centers with the capacity and motivation to engage in the type of self-reflection and practice change required to adopt fully a focus on enhancing protective factors. The second is the belief that child care centers have contact with large numbers of families who need this type of assistance to avoid abuse. The third is the belief that the relationship of child care centers with families is sufficiently robust to meet the needs of the high-risk families they do encounter. The fourth is the view that social networks built around child care centers can shape normative standards regarding how to care for a child, as opposed, for example, to merely reflecting existing standards that may or may not be appropriate. The fifth is the assumption that child care centers have access to the array and quantity of material support and mental health services that families may need or request. And the sixth is the assumption that families have chosen a given child care center from an array of available options and therefore have a more personal relationship with their care provider than they do with other service providers. Although the program has anecdotal evidence to support all of these assumptions, the ability of the SFI to achieve normative change within local child care and early care networks and to provide families with sufficient support to reduce maltreatment rates remains untested. There are no published reports of program efficacy using a rigorous design and no known trials under way.

Durham Family Initiative

Theory of change and implementation

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.[34] It has two goals. One is to enhance community social and professional capital and improve community capacity to provide evidence-based resources to families. The other is to increase families' ability to access community resources. To reach these goals it focuses on universal assessment and referral. Established with funding from the Duke Endowment in 2002, the initiative posits that child abuse is best prevented by addressing the risk factors and barriers that affect the healthy development of parent-child relationships. Adopting an ecological perspective, DFI works to strengthen and expand the pool of available evidence-based direct services, to identify and secure meaningful public policy reforms, and to build local community capacity. Its activities fall into four main areas. First, it fosters local interagency cooperation regarding adoption of a coordinated and consistent preventive system of care. Second, it increases social capital within a number of Durham city neighborhoods through the targeted use of outreach workers and community engagement activities. Third, it develops and tests innovative direct service models to improve outcomes with high-risk families or those already involved in abuse or neglect, while also increasing supports for high-risk new parents through early identification and service referrals. Finally,

it reforms county and state policies affecting the availability and quality of child welfare and child protection services.

One of DFI's most notable features has been its efforts to nurture local interagency cooperation by developing the comprehensive Durham System of Care (www.durhamsystemofcare.org), an integrated network of community services and resources to help families meet the needs of children with serious, complex behavioral, academic, social, and safety needs. It is based on the view that key public and private health and human service agencies must share a consensus on how best to identify, engage, and meet the needs of troubled children and their families. This consensus has developed gradually, beginning in 2002 with initial meetings among key agency directors and their middle management. Building on relationships established during these meetings, the effort has expanded to provide theory-to-practice training across a diverse set of local agencies and community professionals. Most recently, project staff members assisted the local system of care leadership team in writing a cross-agency manual, developing a quality improvement and evaluation plan, and expanding the system of care to include an adult focus. Project staff members also have used the lessons learned from their collaboration within Durham County to advocate and support statewide reforms.

The focus on collaboration and capacity building has been reflected in the project's work within its targeted service communities in the city of Durham. In the early stage of implementation, DFI supported a number of community partners or outreach workers in three of the project's six target neighborhoods. These outreach workers gathered information about neighborhood residents and resources, built relationships among residents, and developed neighborhood "teams" to address specific issues of high interest or concern to local residents. The process generated such neighborhood projects as community day activities, resource centers, language classes, neighborhood watch programs, and emergency food and clothing distribution centers. More recently, efforts to strengthen the informal systems of support among local residents in these communities have been fostered through a leadership training program developed in partnership with the Durham Housing Authority and DFI efforts to recruit, train, and link grandmothers in the community to women struggling with the care of young children.

DFI's most ambitious effort is Durham Connects, a recent attempt to assess the needs of all newborns and their families in Durham County and then to link them with supports to address their needs. Piloting began in July 2007, when DFI began planning an aggressive campaign to provide an initial assessment and facilitate appropriate service linkages for the estimated 4,000 babies born each year in the county. Durham Connects will be grafted onto existing early-intervention services that now give approximately 85 percent of all infants access to a pediatric practice visit within forty-eight hours of their births. Its goal is to augment these services with a more comprehensive psychosocial assessment and to expand coverage to the families of newborns that are not now offered or do not accept these visits. The assessment will be conducted by a nurse, most likely during a home visit. In addition to completing the standard risk assessment protocol, the home visitor will ensure that the family is linked to a medical provider and that any immediate needs identified through the risk assessment are addressed through an appropriate service referral. By building on the existing network of well-baby care within Durham County, DFI staff members believe they can provide universal coverage to all newborns and effectively link families to needed services.

Effectiveness

Among children from birth to age seventeen, the rate of substantiated child maltreatment in Durham County fell 49 percent between 2001–02, the year before the DFI began, and 2007.

In contrast, the rate for the mean of five demographically matched comparison counties in North Carolina over the same period fell just 21 percent. Of particular interest is the recidivism rate, that is, the rate at which children who have been assessed for possible maltreatment by the Division of Social Services must be reassessed within six months. A high rate would indicate a failure of the professional system to respond adequately. Among children from birth to age seventeen, the reassessment rate in Durham dropped 27 percent between 2001–02 and 2007. In contrast, the rate for the mean of five demographically matched comparison counties over the same period dropped 15 percent.

Independent sources provide additional information. Anonymous sentinel surveys were completed with 1,741 family-serving professionals in Durham and one comparison county (Guilford) in 2004 and 2006. Professionals' estimates of the proportion of children who had been abused decreased 11 percent in Durham but increased 2 percent in Guilford over this period. Estimates of the proportion of children who had been neglected decreased 18 percent in Durham but only 3 percent in Guilford. Estimates of the proportion of children who had been spanked fell 11 percent in Durham but rose 4 percent in Guilford. For positive parenting behaviors, professional estimates of the proportion of children shown love, affection, or hugs by parents increased 5 percent in Durham but decreased 2 percent in Guilford.

Because it is plausible that the DFI has changed professionals' perceptions without changing children's outcomes, emergency department and in-patient hospital records from local hospitals were scrutinized for evidence regarding child maltreatment and well-being. The rate of possible maltreatment-related injury among all children from birth to age nine in Durham fell 17 percent between 2001–02 and 2005–06, whereas in Guilford it fell 10 percent.[35] Pediatric hospitalizations for any reason represent a reverse measure of child well-being. Between 2001–02 and 2005–06, the overall hospital visit rate for children from birth to age seventeen in Durham decreased 12 percent, whereas in Guilford County it increased 5 percent.

Repeated population-based surveys also found significant reductions in parental stress and improvements in parental efficacy over time among randomly selected parents of young children in the Durham city neighborhoods as compared with residents in the project's matched comparison areas. These data, however, did not reveal any significant changes in parental self-reports of positive or potentially abusive interactions with their children, changes in observed acts of potential abuse in other families in the community, or any changes in resident interactions, collective efficacy, or neighborhood satisfaction.[36] Trends were particularly unfavorable on these measures in the high-risk communities in which DFI provided outreach workers. It is not clear why anecdotal reports of favorable impact by outreach workers were not reflected in population surveys. It is possible that the workers' impact was limited to a small number of families and did not reach enough families to yield population change on the more direct measures of parent-child interactions.

Because the evaluation design is not a randomized trial, alternate explanations for the positive and less favorable findings are possible. Unknown corresponding changes in community economics, demographics, or politics, rather than DFI, could be responsible for changes in child maltreatment over time. To provide a more rigorous evaluation and to systematize the assessment and community resource connections, the next phase of the DFI will involve a randomized trial within Durham. Half of the newborns will be assigned randomly, by neighborhood, to receive the home-visiting program and network of community resources, while the other half will be provided with the intervention in subsequent years. This trial began in 2008 and will last several years.

Strong Communities

Theory of change and implementation

Among the community-based prevention initiatives we have discussed, Strong Communities is unique in placing primary emphasis on changing residential attitudes and expectations regarding collective responsibility for child safety and mutual reciprocity. Begun by the Duke Endowment in 2002, the initiative is targeted at six communities in Greenville County, South Carolina. Its aim is to help the general public and local service providers within those communities 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.[37] The project unfolds in four distinct phases. The first phase is to raise awareness about the nature of the problem and identify opportunities for enhanced family support. The second is to mobilize the community to develop and implement plans to prevent child maltreatment. The third is to increase resources to enable families to get non-stigmatizing help whenever and wherever they need it. The final phase is to institutionalize the provision of those resources so that support is sustained over the long term.

Strong Communities places heavy emphasis on educating all elements of the community based on the program's core message—a sense of collective responsibility among all community members to keep children safe. Initially, the project assigned community outreach workers to address particular issues, such as workforce development, of concern to residents. After the first year, however, the focus of outreach workers changed from specific issues to specific neighborhoods, ranging in population from 5,000 to 50,000.

Strong Communities' outreach workers follow a flexible implementation plan in which specific activities expand or contract based on staff assessment of their utility in advancing community engagement. Over the initiative's first five years, a broad array of strategies were initiated, terminated, and reinstated. These efforts included recruiting volunteers through pledge card drives, hosting various community wellness fairs and events centered on "back-to-school" planning, and educating families about the issue of Shaken Baby Syndrome, as well as "Blue Ribbon" Sabbath campaigns within local churches during Child Abuse Prevention Month (April) each year, media outreach, and public awareness campaigns. Because the initiative's primary goal is contextual (rather than output driven), its leadership team stresses the need for flexible implementation that allows staff to respond to emerging opportunities as they materialize. In many cases, such opportunities are not easily anticipated and may be recognized only after spending considerable time within a given community or working within a given sector. A flexible work plan allows staff to capitalize on a new program that might be adopted by a community agency or find a useful role for an individual or organization with a promising new idea that complements the project's vision.

Efforts to increase direct services to young children and their families also have varied over time. Although the initial plan was to expand home-based interventions for new parents, the current approach is more diverse and draws together a variety of community resources under a general strategy called "Strong Families." After identifying families with young children through a variety of intake points and enrolling them, the program provides the Connections for Strong Families Newsletter and a "family friend" to help parents with children under six find appropriate family and child activities or to help those with children four or five years of age get ready for school. The program also provides Extra Care for Caring Families, which offers enhanced developmental screening and tips on child and baby care (providing the family's primary care physician is linked up with Strong Families). Finally it provides

access to a local Family Activity Center, which offers a range of activities including playgroups, parents' night out, parent-child activities, financial education and counseling, and assistance from local professionals who volunteer to work with a family as their "family advocate."

Effectiveness

Project implementation data suggest Strong Communities has had notable success in attracting a wide range of stakeholders and volunteers.[38] For example, outreach efforts have engaged many community organizations, faith-based institutions, and local public agencies such as police and fire departments. By 2007, the project estimated that almost 200 churches, 77 community organizations, and 186 businesses had provided resources, leadership, and infrastructure support to one or more of Strong Communities' activities. Equally impressive, the project attracted almost 5,000 volunteers—3.5 percent of the service area's population. Collectively, the volunteers contributed an estimated 43,667 hours of service.

The success of these community engagement efforts is reflected in improved parent-child interactions as measured by repeated surveys of randomly selected parents of young children in both the intervention and matched comparison areas. The surveys found significant improvement over time in parent self-reports of positive interactions with their children and a corresponding reduction in parent reports of acts suggestive of neglect.[39] These surveys, however, revealed no significant change on indicators of collective efficacy, mutual reciprocity, or neighborhood satisfaction, areas of change one might have expected given the project's primary focus. Indeed, on several of these measures, performance in the intervention community was less positive than that in the comparison community. In addition, local administrative records revealed no significant declines in child abuse reports, substantiation rates, or hospitalizations related to injuries suggestive of maltreatment when compared with similar records in the comparison community.

The absence of measurable effects on indicators of resident perceptions of their community and interactions with their neighbors is unexpected given the project's implementation profile. Similarly, the improvements observed in self-reported parent-child interactions were not supported by comparable improvements in parental personal functioning or reflected in any changes in administrative data regarding child abuse reports or substantiations. It is plausible that continued implementation would lead to reduced official child maltreatment reports and child injuries over a longer period of time. Alternatively, it is possible that the intervention is too far removed from within-family maltreatment behavior to have its desired impact, particularly on families facing the greatest challenges.

Community Partnerships for Protecting Children

Theory of change and implementation

One of the most consistent and seemingly intractable problems in formulating a coherent child maltreatment policy has been the lack of coordination between the formal child welfare response and community-based prevention efforts.[40] Community Partnerships for Protecting Children (CPPC) is a twelve-year child welfare initiative that addresses this problem by incorporating family support principles into the public child welfare system and elevating child safety concerns among those working in family support settings. Originally implemented and evaluated in four communities, the model now operates in fifty partnership sites across the country. As outlined in several publications on the CPPC method, four core elements constitute the initiative's theory of change.[41] The first is developing an Individualized Course of Action (ICA) for all families in which children are identified as being at substantial risk of child abuse and neglect. The second is creating a neighborhood

network that includes both formal services and informal supports. The third is changing policies, practices, and culture within the public child protective services (CPS) agency to better connect child welfare workers with the neighborhoods and residents they serve, increase service effectiveness, and improve accountability. And the fourth is establishing a local decision-making body of agency representatives and community members to develop program priorities, review the effectiveness of their strategies, and mobilize citizens and other resources to enhance child safety. The aim is to make it less likely both that children will experience child abuse and neglect and that children who have been abused will experience subsequent maltreatment and serious injury.

CPPC embraces several reforms that are increasingly common within the child welfare system. As Jane Waldfogel discusses in her article in this volume, structural reforms include differential response systems, co-locating child welfare workers with other key health and income maintenance staff in community settings, geographic assignment of cases, and increased interagency collaboration and service partnerships.[42] Practice-level reforms also have been promoted within some agencies to make child welfare workers more responsive to the needs of families and children in these systems.[43]

In addition to these structural and practice reforms, CPPC embraces a specific commitment to building a sense of social responsibility for child well-being. The community partnership approach harnesses the creative talents of neighborhood leaders, human services providers, the faith community, and local organizations to work with the public child protection agency to enhance safety and well-being for all families. CPPC proponents argue that such a fundamental, conceptual shift across multiple domains, if sustained, can improve child safety and measurably reduce child maltreatment rates.

Effectiveness

Chapin Hall at the University of Chicago conducted a comprehensive evaluation of CPPC, beginning with a 1996 assessment of early implementation efforts and concluding with a 2000–04 assessment of program effects in the four communities in which CPPC was originally implemented.[44] The evaluation observed few positive effects on the initiative's four core outcomes—child safety, parental capacity and access to support, child welfare agency and network efficiency, and community responsibility for child protection—at either the individual or population level. Among the child welfare cases that received the most direct CPPC intervention (an Individualized Course of Action, or ICA), modest but significant improvements were observed among participants in their self-perception of progress and in standardized measures of depression and parental stress. In addition, more than 90 percent of the families' lead workers considered the ICA process helpful in improving child safety. However, the individual improvements observed among ICA cases were not positively correlated with a reduction in the likelihood of subsequent maltreatment reports or placement. Further, the frequency of subsequent maltreatment reports and placement rates among ICA recipients was generally consistent with the outcomes of a comparable group of child welfare cases not exposed to an ICA. Similarly, trends in the number of child abuse reports, subsequent reports, and placement rates within the four target communities did not suggest consistent, community-wide reductions in child abuse.

Although ICA practice did demonstrate the ability to marshal additional service resources for families, survey data from both local agency managers and child welfare workers showed minimal evidence of increased collaboration and no evidence of improved community-wide service availability or service quality. The evaluation was not able to directly measure changes in resident behavior in responding to families at risk for maltreatment or acting to improve child protection. However, repeated interviews over time with a sample of CPS workers did not identify steady increases in the application of CPPC

strategies to better integrate child welfare workers and community resources (for example, geographic assignment of cases, locating child welfare workers in community settings, and co-locating child welfare workers with other human service providers), nor did the partnership sites develop and sustain far-reaching recruitment efforts to educate and engage residents in providing informal support to families within the child welfare system.

The initiative did provide some evidence that widely adopted practice changes were able to alter organizational culture and improve worker satisfaction within child welfare agencies and to create greater opportunities for collaboration between child welfare and family support agencies. CPPC leadership and local agency representatives reported that placing child welfare workers in community settings helped reduce the negative perceptions residents had of the local child welfare agencies and enabled the workers to draw on neighborhood resources more effectively. In addition, ICA practice created a more collaborative decision-making process among families, child welfare workers, and other community service providers with respect to case planning. Although not universal, the evaluation also found some evidence that the CPPC partnerships contributed to a similar sense of shared decision making at the community level.

Are Community Child Abuse Prevention Strategies Worth the Investment?

Although nascent, the current evidence base for community child abuse prevention offers both encouragement and reason for caution. Implemented on the scale represented by these five models, prevention requires significant resources and long-term investment. For example, the DFI and Strong Communities initiatives cost approximately $1 million a year each to serve, in the case of DFI, a single county and, in the case of Strong Communities, six neighborhoods within a county.[45] The initial development and evaluation of the CPPC concept in four pilot communities cost $41 million over a seven-year period, or $1.5 million a year for each service site.[46] Investments in Triple P and Strengthening Families have been more modest but not in significant.[47] Generating the resolve among private philanthropy and public institutions to sustain these investments in community prevention will require stronger empirical evidence that the concept of universality and community change embedded in these models can achieve these objectives.

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

But community prevention of maltreatment also raises some concern about its effectiveness. Not all families can, or wish to, invest in their community or interact with their neighbors. In some instances, this reluctance may reflect a lack of skills in understanding how to ask for or accept assistance. In other cases, it may reflect an informed choice to avoid situations perceived as negative. It is unclear how community initiatives can or should address the mixed effects of social supports—the positive outcomes of positive networks and negative effects of negative networks.

Which neighborhoods are best suited for community prevention efforts is not clear, nor is the basis for matching a program's focus with a community's needs. Living in a community

where the norm is already for residents to be highly engaged may make a program to increase collective efficacy superfluous. The critical challenge, of course, is creating engaged communities where they do not yet exist. In such cases, simply talking about the benefits of place-based social exchange may not be enough to alter behaviors. Indeed, the dissemination literature suggests that adopting new actions requires far more than knowledge transfer or even modest exposure and experimentation with an innovation.[48] The target audience has to "own the idea" and believe the reform can indeed produce tangible differences for them personally. To meet this challenge, community-based initiatives will need to move beyond simply creating opportunities for change and embrace strategies that begin to alter deeply held values and perceptions. It is unclear whether these models have clearly defined strategies for engaging residents in this type of self-reflection and substantial change. Better understanding the appropriate pathways of change may require incubating these efforts in hospitable environments rather than testing them in the most distressed communities.

Building social capital is more than providing resources to families; it requires building within individuals a willingness to make an investment of their own. Those who enjoy rich social networks are in part reaping the investments they have made through their own contribution to the social exchange. Social capital as a community change agent works only if a significant proportion of residents or members of the target group contribute their own energy into making the community the type of environment they desire. At present, it is not clear how to catalyze this type of social capital investment or how to define it. For example, the degree of social interaction with one's neighbors and membership in various community organizations appear to have minimal correlations with how one interacts with one's own children.[49] To some degree, this independence may suggest that an individual's investment in his or her community, as measured by these types of associations and memberships, does not provide as rich a pool of support for or influence on one's parenting as might have been first thought. Using community to support parents and prevent child abuse is more than creating "a group hug." Such efforts need to create multiple pathways to provide parents with timely and tangible support.

Another caution is that the public health model of reducing adverse outcomes through normative change may not be directly applicable to the problem of child maltreatment. In contrast to "stop smoking," "don't drink and drive," and "use seat belts" campaigns, child abuse prevention lacks specific behavioral directions that the general public can embrace and feel empowered to impose on others in their community. Exceptions may exist for specific forms of maltreatment, such as Shaken Baby Syndrome, but most maltreatment is neglect that takes diverse forms.[50]

In the end, community effects explain only a small proportion of the variance in child maltreatment rates, raising the question about the value of investing in changing community context over offering direct assistance to parents. Designing and implementing a high-quality, multifaceted community prevention initiative is not inexpensive. As costs increase, policy makers need to consider the trade-offs in investing in diffuse strategies to alter community context versus expanding the availability of services for known high-risk individuals.

What Will It Take to Advance the Concept of Community Prevention?

Protecting children from abuse and neglect is a complex task and one that most certainly involves changing parental behaviors, creating safer and more supportive communities, and improving the quality and reliability of public institutions. Although several prevention programs targeted toward individual families have had positive effects on the families they

serve, these effects often fade over time in part because local communities and public institutions fail to reinforce the parenting practices and choices these programs promote. If the concept of community child abuse prevention is to move beyond the isolated examples that we have noted in this article, additional conceptual and empirical work is needed for the idea to garner sufficient investments from public institutions, community-based stakeholders, and local residents.

Specifically, researchers and those engaged in community child abuse prevention efforts need to be more effective in how they describe their intent and how they measure both the scope of the problem and their ability to address it. Community prevention initiatives, as with any intervention, need to be guided by strong theoretical models that link program strategies to specific outcomes and to be subjected to evaluation methods appropriate for their complexity and reach. When initiatives are multifaceted, it may be important to introduce elements in a sequential manner, allowing one to assess the added value generated by successive iterations of the plan or by each additional element.

When interventions are targeting broad-scale community change, some type of population-based assessment of baseline values and parent-child interactions is essential. Such surveys allow for a careful monitoring of normative changes in behaviors toward children and attitudes toward local service systems and community resources. In addition, they can contribute to a basic understanding of how community values and normative standards shape parental choices and the willingness on the part of residents to engage in acts of mutual reciprocity regarding child rearing responsibilities. Such methods provide a much-needed alternative to the use of child abuse reporting data as the sole method for determining change in a community's risk for maltreatment.

Finally, achieving appropriate investments in community child abuse prevention programs will require a research and policy agenda that recognizes the importance of linking learning and practice. It is not enough for scholars and program evaluators, on the one hand, to learn how maltreatment develops and what interventions are effective and for practitioners, on the other, to implement innovative interventions in their work with families. Instead, initiatives must be implemented and assessed in such a way as to maximize both the ability of researchers to determine the effort's efficacy and the ability of program managers and policy makers to draw on these data to shape their practice and policy decisions.

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Table 1

Community Child Abuse Prevention: Common Strategies and Evidence Base for Five Major Initiatives

	Five major Community child abuse prevention initiatives				
	Triple P-Positive Parenting Program	**Strengthening Families**	**Durham Family Initiative**	**Strong Communities**	**Community Partnerships for Protecting Children**
Intervention strategies					
Practice reform For example, training providers to deliver services in a different manner or alter the provider-participant relationship	**X**				**X**
Agency reform For example, altering institutional culture or altering how agencies and entities within a community relate to each other through partnership development		**X**	**X**		**X**
Expand service capacity or access, or both For example, introducing a new service or improving service access or reach in a comprehensive manner	Access	Access	Capacity/ Access	Capacity/ Access	Access
Alter normative standards For example, developing personal responsibility for child protection		X		**X**	X
Evaluation strategies					
Randomization of communities	X				
Randomizations of participants within program components	X		X		
Quasi-experimental designs (trend analysis, surveys) with comparison communities or participants			X	X	X
Theory-of-change analysis	X	X	X	X	X
Implementation research	X	X	X	X	X
Utilization-focused evaluation			X	X	

Note: Areas of primary emphasis for each initiative are indicated in bold.