

The second big success story is the application of well-established parent management training programs to child welfare populations. Many of these programs have been found not only to improve behavior problems caused by child abuse and neglect but also to impact child welfare outcomes such as reabuse and rereferral.

The most pressing remaining questions relate to how these interventions can be taken to scale in the mental health and service settings where abused and neglected children receive their care. These questions about implementation and sustainability are not specific to interventions in child abuse and neglect. Questions specific to child welfare relate more to service planning and to how many of what types of interventions should be readily available or ordered for families in the child welfare system. The current approach is to order a single, limited intervention for each problem, which often results in a long list of services that families must complete as part of their child welfare case plan (Society for Prevention Research, 2004). As demonstrated by Chaffin and colleagues (2004), a single evidence-based intervention may actually be more effective for both child and system outcomes than multiple services designed to address the many different problems families may have.

Finding: Significant advances have been achieved in the development of therapies that specifically target the impact of trauma or abuse on children. These advances include the extensive testing of TF-CBT models that have been shown to be effective.

Finding: The application of well-established parent management training programs with proven success to children and families involved in the child welfare system has been highly successful with regard to improved outcomes across behavioral problems caused by child abuse and neglect, as well as a reduced need for further involvement in the child welfare system across metrics such as reabuse and rereferral.

Finding: More research is needed to explore how better to deploy effective treatment intervention programs in the mental health and service settings where abused and neglected children receive care. Questions to be addressed relate to the types and breadth of services to provide for children and families, as well as how to sustain the impact of effective programs over the long term.

PREVENTION STRATEGIES

Over the past 50 years, child abuse and neglect prevention strategies evolved to draw on what was known about the scope of the problem at the

time and beliefs about how best to prevent its initial occurrence. Responding to the diverse causes of child abuse and neglect suggested by ecological theory, prevention strategists emphasized the development of a continuum of separate but integrated interventions designed to provide the array of therapeutic and support services necessary to shore up failing or vulnerable families. Within this framework, each component was equally important to achieving positive outcomes regardless of its target population; its targeted outcomes; and, in some cases, evidence of its effects.

At the time of the 1993 NRC report, the concept of prevention had begun to shift from a horizontal to a more vertical structure in which particular emphasis was placed on initiating a strong relationship between parent and child at the moment a woman became pregnant or at the time a child was born (Daro, 2009; Daro and Cohn-Donnelly, 2002). The message changed from providing a plethora of prevention services to placing highest priority on building a network of services that would strengthen the supports available to new parents and link these services in a more intentional and effective manner than had previously been the case.

Support for new parents has taken many forms over the past 20 years, with leadership in these programs generally being shared by state health and human service administrators and community-based program advocates. A comprehensive review conducted in 1993 identified 37 major parent support initiatives operating in 25 states; 9 states (Delaware, Florida, Hawaii, Kentucky, Minnesota, Missouri, Rhode Island, Vermont, and West Virginia) offered statewide parent education and support programs, generally through their department of maternal and child health (Bryant, 1993). Key components of these state efforts included parent education, child health and developmental assessments, and health and social service referrals.

These state initiatives, coupled with the continued expansion of several national home visiting models, have increased public policy interest in the pivotal role of early home visiting in this emerging system of early intervention services. The seminal work of Olds and colleagues showing initial and long-term benefits from regular nurse visiting during pregnancy and a child's first 2 years of life provided the most robust evidence for the effectiveness of this intervention (Olds et al., 2007). Equally important, however, were the growing number of national home visiting programs being developed and successfully implemented by public agencies and community-based service organizations. Although initially not rigorous in their evaluation methodologies, programs such as Parents as Teachers, Healthy Families America, and the Parent-Child Home Program demonstrated respectable gains in parent-child attachment, access to preventive medical care, parental capacity and functioning, and early identification of developmental delays (Daro, 2011).

The call for a major federal investment in home visiting programs was

first voiced by the U.S. Advisory Board on Child Abuse and Neglect (1990), which cited the statewide system operating in Hawaii and the early findings of Olds and colleagues. While the U.S. Advisory Board's recommendation was well received by child abuse and neglect advocates, substantial federal support for this strategy has only recently been provided. Authorized under the Patient Protection and Affordable Care Act (ACA) of 2010, the Maternal, Infant and Early Childhood Home Visiting Program will provide \$1.5 billion to states, territories, and tribal entities to expand the availability of home visiting programs and create a system of support for families with children aged 0-8. As of the end of the 2012 federal fiscal year, the federal government had awarded \$340 million in formula grants to 56 states and territories and an additional \$182 million in competitive grants to selected states and territories that demonstrated the interest and capacity to expand and/or enhance their home visiting programs. A total of \$21 million in funding also has been provided to multiple tribal entities for purposes of establishing home visiting programs targeting the unique needs of the Native American population. In terms of direct research support, the legislation provides funding for an interdisciplinary, multicenter research forum to support scientific collaboration and infrastructure building related to home visiting research.

Beyond the broad implementation of home visiting programs, those seeking to prevent child abuse and neglect continue to design, implement, and assess a range of initiatives. These initiatives include, among others, parent education services; crisis intervention programs that provide telephone numbers for families facing an immediate crisis or seeking parenting advice, as well as crisis nurseries; education for children and adolescents on assault prevention, antibullying behaviors, and nonviolence; efforts to assess new parental concerns and service needs; public education to raise awareness and alter parental behaviors; and initiatives designed to change how health care professionals and others working directly with children recognize and respond to potential child abuse and neglect. In addition to targeting change at the individual level, prevention efforts focus on altering community context and implementing a variety of strategies to create social service networks and social environments more conducive to positive parenting and healthy child development (Daro and Dodge, 2009). Compared with early home visiting, these efforts, in general, are more diffuse and less governed by national standards or expectations.

Evidence for Effectiveness

Today, prevention research is guided by a set of rigorous standards addressing research design and quality, such as the criteria for efficacy, effectiveness, and dissemination established by the Society for Prevention

Research (2004). The adoption of shared evidentiary standards in the field allows for the identification and testing of programs deemed effective and suitable for replication, adoption, or dissemination. Alternatively, these standards facilitate the identification of programs that lack a sound theoretical model or clinical base, show no effect, and should not be implemented further.

This section focuses primarily on those effective prevention interventions for which evidence shows a reduction in child abuse and neglect reports and other child safety outcomes, such as a lack of reported injuries and accidents. Also identified are programs with documented effects on risk and protective factors that are correlated with child abuse and neglect, including parent characteristics, child characteristics, and the parent-child relationship.

Home Visiting

As noted, the provision of home-based interventions at the time a woman becomes pregnant or gives birth is one of the most widely disseminated child abuse and neglect prevention strategies (Daro, 2010). Although findings remain inconsistent across program models, target populations, and outcome domains, the approach continues to demonstrate impacts on the frequency of child abuse and neglect and harsh punishment (Chaffin et al., 2012a; DuMont et al., 2010; Lowell et al., 2011; Olds et al., 2010; Silovsky et al., 2011), parental capacity and positive parenting practices (Connell et al., 2008; Dishion et al., 2008; DuMont et al., 2010; LeCroy and Krysik, 2011; Nievar et al., 2011; Roggman et al., 2009; Zigler et al., 2008), and healthy child development (DuMont et al., 2010; Lowell et al., 2011; Olds et al., 2007; Shaw et al., 2009). Likewise, home visiting programs that engage families with older children (aged 5-11) have demonstrated an ability to reduce depressive symptoms, parental stress, and life stress and enhance parental competence and social support (DePanfilis and Dubowitz, 2005).

Findings of a 15-year follow-up study of families enrolled in the Nurse Family Partnership's randomized clinical trials support that program's long-term positive impacts on both parents (Eckenrode et al., 2010) and children (Kitzman et al., 2010; Olds, 2010). In contrast to control families, mothers who received the program were involved in fewer substantiated reports for maltreatment, abuse, and neglect, and children were less likely to report running away or to have had contact with the juvenile justice system. These and similar gains were most concentrated among families with the fewest material and emotional resources at the time they enrolled in the program.

As noted earlier, confidence in home visiting as an effective way to address child abuse and neglect, as well as other poor child developmental and

behavioral outcomes, contributed to the inclusion of the Maternal, Infant and Early Childhood Home Visitation Program in the ACA. As of this writing, 12 home visiting models that serve young children have met the criteria for identification as an evidence-based model appropriate for this initiative in that one or more rigorous evaluations have documented impacts in one of eight core outcome domains (child health; child development and school readiness; family economic self-sufficiency; linkages and referrals to other services; maternal health; positive parenting practices; reduction in child abuse and neglect; or reduction in juvenile delinquency, family violence, or crime) (Avellar et al., 2012). However, only 3 of the 12 approved models have had a measurable and significant impact in reducing either child abuse or neglect reports or the incidence of harsh parenting.

While home visiting programs continue to build an evidence base around a wide range of outcomes, preventing child abuse and neglect as measured by a reduction in initial or subsequent abuse and neglect reports remains an area in which consistent findings are lacking. Also, as promising models are taken to scale, sustaining their impacts is proving problematic. For example, a broad replication of the Nurse Family Partnership in Pennsylvania resulted in no significant differences in visits to hospital emergency departments for serious injuries between families enrolled in the program and a comparison group (Matone et al., 2012). Other studies also have raised concern about the extent to which home visiting services are able to prevent the recurrence of physical abuse or neglect (MacMillan et al., 2005) or alter the developmental consequences of abuse or neglect (Chaffin, 2004; Cicchetti and Toth, 2005).

For the past several years, a number of states and local communities have explored ways of extending support to a greater proportion of newborns and their parents. In contrast to targeted approaches that limit services to parents identified as high risk, these more universal initiatives are built on a public health model aimed at altering the context in which parents raise their children. Specifically, these initiatives offer comprehensive assessments and a limited number of service contacts to all parents or all first-time parents living within a specific geographic area (e.g., neighborhood, city, county) (Daro and Dodge, 2010). Assessments of the impacts of this approach have found that families are receptive to offers of such assistance and are able to access additional services in a more timely and appropriate manner (Dodge et al., 2013; Urban Institute, 2012).

At least one randomized study of this approach, conducted in Durham County, North Carolina, found that families with access to an initial nurse home visit at the time their child was born were less likely to use hospital emergency room services; less likely to present with anxiety; and more likely to exhibit positive parenting behaviors, to have strong community connections, and to participate in higher-quality out-of-home care (Dodge et al.,

2013). Additional research is required to fully understand the implementation challenges associated with such universal strategies and their ultimate impacts on parental behaviors and child outcomes.

Parenting Education

Improving parents' capacity to meet the developmental and emotional needs of their children has long been viewed as an effective strategy for preventing child abuse and neglect (Helfer, 1982; Kempe, 1976). Parenting education programs designed to increase knowledge of child development, enhance care, promote positive parent-child interaction and emotional sensitivity, and address child discipline and behavior management are considered a strong theoretical and practical approach to reducing risk and strengthening protective factors (Barth et al., 2005; Johnson et al., 2008). Since parenting education programs can occur in diverse settings, including both home-based and center-based models, and often include additional service components, such as child care services and family support groups, it is difficult to distinguish those impacts that may be attributable to specific parenting education activities (Barth, 2009; Reynolds et al., 2009). Further, the populations utilizing these programs are diverse. While unique challenges are faced by parents and families dealing with difficult circumstances, such as substance abuse, mental illness, poverty, domestic violence, or divorce, and those parenting a child with behavioral or developmental difficulties, these parents would not all be expected to engage in abusive or neglectful behavior in the absence of parenting education services.

An assessment of parenting education models by the California Evidence-Based Clearinghouse for Child Welfare identified several social learning-based educational efforts with robust results supported by repeated randomized controlled trials, including two that are often cited as demonstrating strong potential to reduce the risk for child abuse and neglect. Participants in Webster-Stratton's *The Incredible Years*, a multifaceted and developmentally based curriculum for parents, teachers, and children delivered in both primary school and early education settings, demonstrated more positive affective responses and a corresponding decrease in the use of harsh discipline, reduced parental depression, and improved self-confidence and better communication and problem solving within the family (Daro and McCurdy, 2007; Gardner et al., 2010; Reid et al., 2001, 2004; Webster-Stratton et al., 2011b). Significant aspects of the model include group-based training in parenting skills; classroom management training for teachers; and peer support groups for parents, children, and teachers.

Triple P, mentioned earlier, is another well-established and well-researched parent management training program. It consists of a series of integrated or scaled 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 is designed to reduce child behavior problems by teaching healthy parenting practices and how to recognize negative or destructive practices. Parents are taught self-monitoring, self-determination of goals, self-evaluation of performance, and self-selection of change strategies (Daro and Dodge, 2009, p. 75). A geographically randomized study illustrated the effectiveness of Triple P at a population level (Prinz et al., 2009). Triple P was implemented in 18 randomized medium-sized southeastern U.S. counties over a 2-year period, demonstrating a decrease in child abuse and neglect. Additionally, multiple randomized controlled trials of the model in various cultural contexts have found it to have positive impacts on parent-reported child behavior problems, reducing dysfunctional parenting and improving parental competence (Bor et al., 2002; Leung et al., 2003; Martin and Sanders, 2003).

Most recently, those examining parenting education programs have focused on identifying those elements of the programs that appear to have the most consistent impact on participant outcomes (Barth et al., 2012). A meta-analysis conducted by the Centers for Disease Control and Prevention on training programs for parents of children aged 0-7 identified components of programs that have a positive impact on acquiring parenting skills as demonstrated by increased use of effective discipline and nurturing behaviors (CWIG, 2011). The 77 studies selected for the review all assessed parenting programs that incorporate active learning strategies such as completing homework assignments, modeling, or practicing skills. Among the 14 content and program delivery characteristics examined, the factors most frequently associated with positive outcomes were 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; Kaminski et al., 2008). The study also found small program effects on parent behaviors and skills outcomes with those programs having ancillary services. The researchers hypothesized that these ancillary services were a burden for the parents and program staff, and could impede skills development focused on parent-child interactions.

Universal Antiviolence Education Programs

In contrast to efforts designed to alter the behavior of adults who might commit child abuse or neglect, a category of prevention programs that emerged in the 1980s was designed to alter the behavior of potential victims (CWIG, 2011). Initially, such efforts focused exclusively on provid-

ing children information on physical and sexual assault; how to avoid risky situations; and if abused, how to respond. Meta-analyses and evaluations of these programs found they were effective in conveying safety information to children and imparting skills to avoid or lower the risk of assault (Berrick and Barth, 1992; Daro, 1994; MacMillan et al., 1994; Rispens et al., 1997). It remains unclear, however, to what extent these programs can alter adult behavior and responsiveness or change institutional culture in ways that reduce the likelihood of children being victimized and if they are, having their case addressed in an appropriate and transparent manner (Daro, 2010).

More recently, the focus of these universal education programs has expanded to encompass issues of bullying and aggressive behavior, particularly among elementary and middle school students. While the immediate goal of these interventions is to reduce levels of bullying and aggressive behavior among children and youth, accomplishing this goal might potentially contribute to a reduction in these behaviors in adulthood, thereby reducing levels of child abuse. A 2006 Cochrane review of school-based violence prevention programs targeting children identified as being or at risk of being aggressive found that aggressive behavior was significantly reduced in the intervention groups compared with the control groups in 34 trials with data on this outcome, and that positive impacts were maintained in the seven studies reporting 12-month follow-up data (Mytton et al., 2006).

These programs also may impact the response of bystanders to bullying behavior. A randomized controlled trial of a whole-school intervention provided universally to students by teachers found that the program moderated the developmental trend of increasing peer-reported victimization, self-reported aggression, and aggressive bystanding compared with schools randomly assigned to the control group. The program also moderated a decline in empathy and an increase in the percentage of children victimized compared with the other intervention conditions (Fonagy et al., 2009). Likewise, an observational study of playground interactions in schools randomly assigned to a bullying prevention program found declines in bullying and argumentative behavior, increases in agreeable interactions, and a trend toward reduced destructive bystander behaviors (Frey et al., 2005). Children in the intervention group reported enhanced bystander responsibility, greater perceived adult responsiveness, and less acceptance of bullying/aggression (Frey et al., 2005). While not well researched, the observed impacts on children's response to acts of peer aggression and their increased willingness to speak up and support the victim may have implications for subsequent reductions in various forms of child abuse and neglect. Adolescents and young adults who become increasingly comfortable with the concept of actively resisting aggression toward their peers may be more likely to support normative standards by which such behavior

toward children is less tolerated and individuals feel more empowered to seek ways to stop it.

Public Education and Awareness

A consistent feature of child abuse and neglect prevention programming has been the development of public awareness campaigns. Initially, these efforts focused on raising awareness of the problem and enhancing the public's understanding of behaviors that constitute abuse and neglect and their impact on child well-being (Daro and Cohn-Donnelly, 2002). In recent years, broadly targeted prevention campaigns have been used to alter specific parental behaviors. For example, the U.S. Public Health Service, in partnership with the American Academy of Pediatrics (AAP) and the Association of SIDS and Infant Mortality Programs, launched its "Back to Sleep" campaign in 1994 to educate parents and caretakers about the importance of placing infants on their back to sleep so as to reduce the rate of sudden infant death syndrome (SIDS). Campaign strategies included media coverage; the availability of a nationwide toll-free information and referral hotline; the production of television, radio, and print ads; and the distribution of informational brochures to new parents. As of 2002, the National Center for Health Statistics reported a 50 percent drop in SIDS deaths and a decrease in stomach sleeping from 70 percent to 15 percent. Although the evidence linking the campaign to changes in these population-level indicators is exploratory, the data are suggestive of how public education might be used to change normative practices (Mitchell et al., 2007).

One of the most thoroughly examined public education and awareness campaigns addressing child abuse has been the effort to prevent shaken baby syndrome, now termed abusive head trauma. In an evaluation of a 1992 federal campaign to educate the public about the dangers of this practice ("Never Shake a Baby"), one-third of those providing feedback on the campaign indicated that they had no prior knowledge of the potential danger of shaking an infant (Showers, 2001).

Moving beyond basic awareness, Dias and colleagues (2005) developed a universal education program on shaken baby syndrome, which they implemented in an eight-county region in western New York. The program provided information on shaking to parents of all newborns prior to the infants' discharge from the hospital. During the 6 years before the program, 40 cases of substantiated abusive head injuries were identified in the targeted New York counties—an average of 8.2 cases per year, or 41.5 cases per 100,000 live births. During the 5.5-year period of the intervention, 21 cases of substantiated abusive head injury were identified—3.8 cases per year (a 53 percent reduction), or 22.2 cases per 100,000 live births (a 47 percent reduction). In the Pennsylvania comparison communities, there

was no change in the number of such cases observed during the same two time periods (Dias et al., 2005).

Another promising public education and awareness program, The Period of PURPLE Crying, focuses on helping parents understand and cope with the stresses of normal infant crying. The program was tested through four different types of delivery systems: maternity services, pediatric offices, prenatal classes, and nurse home visitor programs. More than 4,200 parents participated in the program. A randomized controlled trial of the program found that it succeeded in enhancing mothers' knowledge about infant crying. Women who participated in the program were more likely to differentiate "inconsolable crying" from other types of crying that signaled hunger, discomfort, or pain in an infant (Barr et al., 2009).

While these findings are encouraging, others implementing these types of broadly targeted efforts have not achieved comparable results. The extent to which these programs can result in sustained population-level change in parenting behaviors remains unclear.

Professional Practice Reforms

In addition to the provision of direct services to new parents, increased consideration is being given to how best to use existing service delivery systems that regularly interact with families to address the potential for abuse and neglect. For example, the medical field has long sought ways to better address healthy child development and child abuse and neglect within clinical settings. Historically, health professionals have faced barriers to using the traditional checkup appointment to carry out this responsibility. Doctors are often uncomfortable discussing sensitive issues, and they frequently lack the training to instigate such conversations and the ability to recognize key warning signs (Benedetti, 2012). Additionally, adequate and comprehensive screening tools have not been made available to all primary care providers (Benedetti, 2012; Dubowitz et al., 2009). The Healthy Steps program, an evidence-based model that places child development specialists within selected pediatric practices, was initially created in 1994 to address this issue. Today, Healthy Steps is available in 17 states and has demonstrated consistent impacts on child health, child development and school readiness, and positive parenting practices (Benedetti, 2012; Caughy et al., 2003; Minkovitz et al., 2003, 2007).

More recently, the Safe Environment for Every Kid (SEEK) program was created to help health professionals address risk factors for child abuse and neglect through a training course, the introduction of a Parent Screening Questionnaire, and the addition of an in-house social worker team to work with families. Two studies were recently conducted to test existing SEEK programs: one to determine outcomes for children and families and

one to measure effects on the health professionals participating in the intervention (Benedetti, 2012; Dubowitz et al., 2009). The first was a randomized trial conducted between 2002 and 2005 in resident clinics in Baltimore, Maryland. Families enrolled in the SEEK treatment group showed significantly lower rates of abuse and neglect across all measures compared with controls (Dubowitz et al., 2009). The second study, conducted 2 years later, investigated whether the program changed doctors' attitudes, behaviors, and competence in addressing child abuse and neglect among their patients (Dubowitz et al., 2011). Eighteen private practice primary care clinics participated in a cluster randomized controlled trial. The pediatricians in the SEEK group showed significant improvement in their abilities to address substance use, intimate partner violence, depression, and stress, and they reported higher levels of comfort and perceived competence in doing so (Dubowitz et al., 2011).

Community Prevention

A focus on the community as an appropriate prevention target is supported by findings of public health surveillance efforts and research on the effects of neighborhood contexts (Coulton et al., 1997; Pinderhughes et al., 2001; Zimmerman and Mercy, 2010). Research using population- and community-level data underscores the pressing need to design, target, and promote preventive service programs in jurisdictions exhibiting the greatest need (Putnam-Hornstein et al., 2011; Wulczyn, 2009). Accordingly, a number of strategies have emerged that focus on ways to better coordinate and integrate services provided through multiple domains and to alter the context in which parents rear their children (Daro and Dodge, 2009). The goal of such efforts is to move from simply assessing the prevention impacts on program participants to achieving population-level change by creating safe and nurturing environments for all children, as well as communities in which parents are supported through both formal services and normative values that foster mutual reciprocity. Although such initiatives are not fully operational in any community, the goal of altering both individuals and the context in which they live potentially provides a potent programmatic and policy response (Daro et al., 2009).

In a recent review of five multicomponent community initiatives, Daro and Dodge (2009) conclude that the implementation of multifaceted interventions that combine direct service reforms with attempts to alter residents' access to and use of both formal and informal supports are promising but largely unproven. Based on comparisons of administrative data, at least some of the models they reviewed had 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), and repeated population-based sur-

veys revealed that the models had altered adverse parent-child interactions, reduced parental stress, and improved parental efficacy (Daro et al., 2008). When focusing on community building, several models demonstrated a capacity to 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 (Daro et al., 2008; Melton et al., 2008). At present, however, little information is available on how these attitudes and willingness to support one's neighbors will translate into a measurable or sustained reduction in child abuse and neglect and enhanced parental support (CDC Essentials for Children, available at <http://www.cdc.gov/ViolencePrevention/childmaltreatment/essentials/index.html> [accessed March 7, 2014]).

Designing and implementing a high-quality multifaceted community prevention initiative is costly. The models examined by Daro and Dodge (2009), each of which focused on only a single county or community within a county, cost approximately \$1-\$1.5 million annually to implement and evaluate. Moving forward, policy makers need to consider the trade-offs of investing in diffuse strategies designed to alter community context versus expanding the availability of services for known high-risk individuals. For the research community, a potential area of inquiry may lie in examining key mediators of either individual- or population-level outcomes and identifying less costly ways to create these mediators within prevention efforts.

The Bottom Line

Investments in preventing child abuse and neglect increasingly are being directed to evidence-based interventions that target pregnant women, new parents, and young children. Since the 1993 NRC report was issued, the prevention field has become stronger and more rigorous both in how it defines its services and in its commitment to evaluative research. And although greater attention is being paid to the development of home visiting interventions, the field embraces a plethora of prevention strategies. Communities and public agencies continue to demand and support broadly targeted primary prevention strategies such as school-based violence-prevention education, public awareness campaigns, and professional practice reforms, as well as a variety of parenting education strategies and support services for families facing particular challenges.

None of these program approaches are perfect, and they often fail to reach, engage, and retain their full target population successfully. Notable gaps exist in service capacity, particularly in communities at high risk and among populations facing the greatest challenges. And a substantial proportion of those families that do engage in intensive, long-term early intervention programs will exit the services before achieving their targeted

program goals. That said, the committee finds the progress in prevention programming to be impressive, but the strategies employed to be underdeveloped and inadequately researched.

Finding: A broad range of evidence-based child abuse and neglect prevention programs increasingly are being supported at the community level to address the needs of different populations. Strategies such as early home visiting, targeting pregnant women and parents with newborns, are well researched and have demonstrated meaningful improvements in mitigating the factors commonly associated with an elevated risk for poor parenting, including abuse and neglect. Promising prevention models also have been identified in other areas, including school-based violence prevention education, public awareness campaigns, parenting education, and professional practice reforms.

Finding: Despite substantial progress in the development of effective prevention models, many of these models require more rigorous evaluation. Research is needed to devise strategies for better reaching, engaging, and retaining target populations, as well as to develop the capacity to deliver services to communities at high risk and among populations facing the greatest challenges.

COMMON ISSUES IN IMPROVING PROGRAM IMPACTS

Developing a pool of high-quality interventions is essential to address the problem of child abuse and neglect. Equally important is understanding how best to replicate, sustain, and integrate these programs into an effective system of care. Unfortunately, in child abuse and neglect as in other areas of health, mental health, and social services, a wide gap exists between available evidence-based interventions and practices and effective methods for their dissemination, implementation, and sustainment. This is a critical concern because the potential public health benefit of these interventions will be severely limited or unrealized if they are not implemented and sustained effectively in usual-care practice, be it in child welfare, mental health, substance abuse, or primary health care settings (Balas and Boren, 2000). Indeed, the success of efforts to improve services designed to support the well-being of children and families is influenced as much by the process used to implement innovative practices as by the practices selected for implementation (Aarons and Palinkas, 2007; Fixsen et al., 2009; Greenhalgh et al., 2004; Palinkas and Aarons, 2009; Palinkas et al., 2008). It is increasingly recognized that investment in the development of interventions without attention to how they align with service systems, organizations, providers, and consumers results in poor application of evidence-based practices.