

**PREVENTING CHILD MALTREATMENT IN MAUI COUNTY**  
**A REPORT ON BEST PROGRAM PRACTICES –PHYLLIS ROBINSON, ED.D**  
**SUMMARY APPLICATIONS FOR PRACTICE-JOANN FARNSWORTH, M.S.**

## A WORD FROM THE EDITOR

In her report titled Preventing Child Maltreatment in Maui County: A Report on Best Program Practices, Dr. Robinson has done an extensive study covering the causes, an analysis of best practices for prevention and an inventory of programs on in Maui County that address child maltreatment. The document presented here is a summary of her work that focuses only on applications for practice. It does not attempt to be an Executive Summary or an edited version of the whole document itself. In that regard it is meant as a supplement to the document to be used by practitioners and go hand in hand with the original report. I have taken direct excerpts from the original document and have not added anything to change the wording or professional opinion of Ms. Robinson. I have only selected sections that specifically relate to best practice implementation, leaving background, how best practices were determined and current Maui County programs in the original. The work presented here also follows the original in structure making it easy for anyone wanting more detail on a particular program or subject to reference additional information in the original document.

*JoAnn Farnsworth, M.S.*

*May 2008*

## **PART I: SUMMARY OF ROBINSON REPORT**

### **I. INTRODUCTION AND OVERVIEW**

Although there is no single identifiable cause of child maltreatment, the scientific literature has suggested that when considering prevention, a community should examine the interdependent nature of risk factors contributing to child maltreatment alongside the confluence of protective factors that might mitigate these risks. Successful prevention efforts aim to reduce risks, such as domestic violence, substance abuse, mental illness and poverty while boosting known protective factors, such as social connections, knowledge of effective parenting, and access to support in times of need. In order to meet the full range of at-risk families, communities have the greatest success when they approach the prevention of child maltreatment on four major levels:

- **Primary (or universal) prevention** is directed at the general population - all families
- **Secondary prevention** that targets families with risk factors for abuse and neglect
- **Tertiary prevention** is designed to reduce the impact of existing problems (i.e., the reoccurrence of abusive behaviors)
- **Quaternary Prevention** consists of services for parents who want to regain custody of their children

When prevention efforts engage on all of these levels, focus on family strengths and yet also provide assistance in times of greatest challenge, it is predicted that over time prevention plans can work. The evidence shows that communities that take on child maltreatment prevention as an ethical imperative must also have the coordinated help of their state system and its policymakers and funders to succeed.

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Overall, the evidence shows that communities that engage in coordinated efforts in preventing child maltreatment are most successful when they consider the ecology of the prevention picture – the hologram of life circumstances for children and families, their cultural and spiritual belief system, their informal support systems as well as possibilities available in the inter-related system of community agencies that interact to enhance family functioning. Effective program practices are not isolated interventions, but a patchwork quilt with family strength and success at its center.

Nationally, when held accountable for preventing cases of child maltreatment, state child protection agencies have fared poorly. Only six states were found in substantial conformity with the outcome of protecting children from abuse and neglect in recent congressionally mandated evaluations of the child welfare system showed that state Child Welfare Services (CWS) are challenged by:

- Limited funds, large caseloads, and the majority of funding is for children already in foster homes rather than those at risk for child maltreatment.
- Weak connections to other state systems including substance abuse and mental health services which receive funds for services to at-risk families but often lack key connections to the child welfare system to track and support families over time
- CWS has a limited capacity for early (primary and secondary) interventions
- CWS whose contact with families is largely in the context of policing reported maltreatment, may find it difficult to effectively reach out to at-risk families with supportive services.

These limitations in the prevention field have led many policy makers, professionals, parents, and child advocates to call for a more comprehensive, community-based, family-focused approach to addressing the complex problems of child maltreatment. This requires leadership and an overarching vision of how collaboration will help families. Successful collaboration efforts are able to bridge the differing philosophies and priorities that led to the creation of separate agencies and funding streams in the first place.

**A. INTRODUCTION TO BEST PRACTICE PROGRAM EVIDENCE IN CHILD MALTREATMENT PREVENTION (CMP)**

According to an extensive search of the literature carried out by the State of New Jersey Task Force on Child Abuse and Neglect and adopted by the State of Arizona Child Abuse and Neglect Prevention System, **effective CMP programs** are divided into three standards areas:

<b>Conceptual Standards</b>	<b>Practice Standards</b>	<b>Administrative</b>
1. Family Centered 2. Community-based 3. Culturally sensitive 4. Working with participants before unwanted behaviors develop 5. Developmentally appropriate 6. Participants as partners with staff 7. Empowerment and Strength-based approaches	1. Flexible and responsive 2. Partnership approaches 3. Links with informal and formal supports 4. Universally available and voluntary 5. Comprehensive and integrated 6. Easily accessible 7. Long term and frequent	1. Sound program structure, design and practices 2. Committed and caring staff 3. Data collection & documentation 4. Measures outcomes and conducts evaluation 5. Adequate funding & long-range plan 6. Participants and community as collaborators

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**B. PRACTICE STANDARDS AND THE FIELD OF PREVENTION SCIENCE**

Thanks to the Institute of Medicine (IOM) the field of CM prevention science now has a comprehensive set of standards for the development of promising interventions in parenting education and home visitation that rely on theory, basic research, and epidemiology to identify targeted risk and protective factors. A recent review of the evaluation literature on evidence based prevention programs that feature parenting and home visiting interventions with infants and toddlers by David Olds (2007) shows that “the combination of systematic intervention development with rigorous testing has led to the identification of highly effective preventive interventions in childhood and adolescence that consistently meet high evidentiary standards and that are recommended for public funding” (Olds, 2007, p 3).

Identification of programs and practices that have been evaluated in rigorous, controlled trials is only the first step, however.

*Practitioners are then faced with the challenge of implementing best practices properly. A sound program will not produce the desired results if it is implemented poorly. Programs are often thought of as a uniform set of elements that are provided to clients in a consistent manner; however, in fact, great variability exists in the manner in which programs are delivered. Programs are not implemented with the same attention to core components and dosage as found in the research models (U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention , 2004, p. 1).”*

As a growing field, child abuse prevention has benefited from the guidance and support not only at the federal and state levels as standards are explored and set based on the most recent and up to date research and evaluation, but also at the grassroots where program administrators and practitioners modify program elements to fit with the specific needs of their populations. In this regard, our report has considered both views and benefited greatly from all parties in this exploration.

**C. THE CRITERIA USED FOR CHOOSING BEST PRACTICE PROGRAM APPROACHES**

To focus this broad field we had to narrow our criteria for choosing Best Programs/Practices. We chose programs based on:

- Length of study
- Solidness of research design
- The trustworthiness of the source leading us to the research, i.e. Center of Disease Control(CDC) , Center for the Study Social Policy, Child Welfare Gateway, Harborview, CBCAP, long-time Maui program administrators
- Extent of demonstrated success
- Number of other studies using similar approach that have also proven successful
- Appeared in a peer-reviewed journal
- Innovative or promising based on prior study and relevance for Maui County
- Probability that practice would be adopted or already in Maui County

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**D. DEFINING THE CATEGORIES THAT GUIDE OUR CHOICE OF BEST PROGRAM PRACTICES**

The report noted that there were numerous ways that one could look at the field of best practices;

1. By **Level** of prevention intervention
  - Primary
  - Secondary
  - Tertiary
  - Quaternary
  
2. By **Strategy** of prevention
  - Parenting Education
  - Home Visitation
  - Child Sexual Abuse Prevention Education
  - Early Childhood Education Programs (can include many of the above)
  - Comprehensive Family Support Services (can include all or some of these)

Future study will be also be necessary that would include the following programs;

- Substance Abuse/Family Recovery Programs
  - Programs for Incarcerated Parent(s)
  - Domestic Violence Programs for Batterers and Shelters Programs
  - Mental and Behavioral Health Programs (for parents and children with disabilities)
  - Cultural and Spiritual Programs
3. By **Protective** Factors
    - Parental Resilience
    - Social Connections
    - Adequate knowledge of parenting and child development
    - Concrete support in times of need
    - Nurturing and attachment
    - Building the social and emotional development of children
  
  4. By **Risk** Factors
    - The age of the child – younger children are more likely to be abused neglected
    - Special needs (disabled or mentally retarded children are more likely to be abused)
    - Poverty, homelessness or challenging housing situations
    - Young age of mothers
    - First birth to mother
    - Single Parenthood
    - Parental depression
    - Limited education or employment
    - Social isolation (especially from extended family)
    - Lack of community services
    - History of substance abuse or domestic violence
    - Parents are victims of abuse themselves
    - Physical or mental health issues of child or parents
    - Social acceptance of violence

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**The risk factors for child sexual abuse** vary from the above to some degree, especially when the focus of abuse shifts from a parent to another adult in most cases familiar to the child. The following is based on a variety of research sources and comes to us via a web site called Advocates for Youth. See this web site for sources:

<http://www.advocatesforyouth.org/PUBLICATIONS/factsheet/fsabuse1.htm>

**E. COMBINING RISK FACTORS AND PROTECTIVE FACTORS FOR FAMILY STRENGTHENING IN PREVENTING CM**

*The reluctance of families to participate in programs that identify them as "at risk" is well-documented and amounts to a significant barrier in interventions designed to reduce abuse and neglect" (Judy Langford, Doris Duke Charitable Foundation and the Center for Study of Social Policy, 2005, p. 1)*

Since the mid-1970s, the research literature on Child Maltreatment Prevention (CMP) has been dominated by an ecological understanding of child maltreatment that posits that a complex mix of child, family, community, and social factors cause CM. Program practices have mostly focused on addressing risk factors. Addressing these "risk factors" for child maltreatment has taken the form of "deficit model" interventions that insist that families first be in trouble before they receive help. When help is available, there is no single agency that is responsible to assist families access the array of Federal, State and County programs. Also, a wide gap has existed between scientific knowledge and social policy. **The evidence-based literature is showing us that focusing on protective factors and family strengths is far more successful in preventing child maltreatment. The new approach, called *Family Strengthening* does not ignore risk factors but instead shifts the focus to strengths when actually working with families.**

## **II. Evidence-Based Best Practices by Prevention Strategy**

### **Parent Education**

#### **A. PARENTING EDUCATION BACKGROUND SUMMARY**

Theory and research in the field of CM prevention have stressed the importance of an ecological understanding of the causes of child maltreatment since the mid-1970s. This approach, which emphasizes the importance of a complex mix of individual, child, familial, community, and cultural factors in explaining the incidence of CM, rejects the highly individualized "medical" model that had previously dominated the field. This model was criticized for blaming the problem of child maltreatment entirely on the personal and/or psychological problems of maltreating parents, which were considered in isolation from contextual factors such as poverty, racism, changing family structures, child characteristics, and social isolation.

It remains true, however, that parental psychology is a critical factor to consider in both the causes and prevention of CM. Leading theorists in the field hypothesize that the most important determinants of parenting behavior are a parent's developmental history and personal psychological resources.

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For four decades, parenting education has been viewed as an important early intervention strategy for healthy child development. By the mid-1990's it is estimated that more than 50,000 parenting programs were reaching millions of parents and caregivers nationwide. These programs are designed to address a wide variety of needs and concerns, including providing general education and support, strengthening family literacy, improving school readiness, helping parents with divorce or separation, supporting parents of children with disabilities, preventing problems such as substance abuse and teen pregnancy and even supporting incarcerated parents. Parenting programs that prevent child maltreatment represent one of the largest of these program categories (Carter, 1996).

Of all primary prevention strategies tested, parenting education for adults and adolescents before they become parents is often identified as the strategy most likely to prevent initial injuries to children. This belief is based on the theory that children learn abusive parenting practices from observing their parents and experiencing abuse during the process of growing up. Learned patterns of abusive parenting are transmitted from parent to child and are replicated by the child when he or she becomes a parent (Bavolek, 2005)

Parent education programs are based on the premise that interventions that promote nurturing, caring, consistent, and positive parenting are central to creating safe and supportive environments for children. The single factor most commonly stressed in CMP literature is the experience of a caring relationship. Both researchers and those engaged in clinical practice have repeatedly found that parents who have not effectively processed their memories of childhood trauma are likely to reenact their negative experiences with their own children. Parents who have been able to process and cope with painful emotional memories are much less likely to maltreat their own children (Egeland, Bosquet, & LevyChung, 2002) Thus, promising parent education programs are designed to address past parenting experiences: assist parents in developing nurturing, caring parenting skills; to normalize the challenges and difficulties inherent in parenting, and increase parental knowledge of child development.

Parent education programs operate on a number of levels; for example, community awareness strategies for parents operate at the **primary or universal** level designed for all parents, whereas group training sessions and one-on-one programs with parents can operate at the **secondary** or **tertiary** level with parents who are either at risk for child maltreatment or have an existing history of maltreatment designed to prevent further abuse. Parenting education programs also operate at the **quaternary** level in which parents are seeking to regain custody of their children or for foster parents wanting to understand how to improve their parenting skills. Despite these differing approaches, all parent education programs are thought to assist families primarily by increasing parental knowledge and reducing parental stress. Parent education programs achieve these results by training parents in **behavioral management techniques, problem solving, and personal coping skills.**

**Do parent education actually programs work to prevent child maltreatment?**

According the U.S. Department of Health and Human Services, two decades of research on parenting education as a way to reduce the risks for the maltreatment of children is “neither rich,

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nor particularly compelling”<sup>1</sup>, and yet the Center for Disease Control (CDC) in a 2004 research brief<sup>2</sup> stated that after consulting with a team of experts in CMP, they were advised to make *parenting interventions* the foundation piece of its portfolio of child maltreatment prevention.

Expert opinions on “Why the disparity between the clear connection between poor parenting and increased risk for maltreatment and the failure of several decades of parenting education programs to show strong results?”

1. Some experts claim that this failure can be traced to “insufficient development of the prevention models with clear attention to engaging parents in the program and specification of methods for reliably bringing about changes in targeted aspects of parenting or family context” (Olds, Sadler, & Kitzman, Programs for Parents of Infants and Toddlers: Recent Evidence from Randomized Trials, 2007, pp. 356-7).

2. Dr. Ron Prinz, the creator of the Triple P Positive Parenting Program claims that:

*Clinical models of prevention and clinical trials or evaluations are designed to answer specific questions about a particular intervention or approach (for example, how safe or effective a program is). Clinical trials are conducted under strict ‘empirical’ or scientific conditions in an attempt to test only the effect of the intervention while controlling for other circumstances. While rigorous and well regarded as a scientific method of study, such approaches to evaluating the effectiveness of child maltreatment prevention programs are considered by some to be somewhat artificial (Holtzer, Higgins, Bromfield, & Higgins, 2006, p. 20).*

3. The literature on Family Strengthening claims that the lack of evidence to prove that parenting programs are successful for preventing CM could also be attributed to the lack of a more holistic view of parents support needs that “include other interventions in order to have a significant impact particularly among highly dysfunctional families” (Judy Langford Doris Duke Charitable Foundation and the Center for Study of Social Policy, 2005, p. 17).

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<sup>1</sup> U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children’s Bureau, Office on Child Abuse and Neglect 2003 document “Emerging Practices in the Prevention of Child Abuse and Neglect” published by the title: *What Do We Know About the Effectiveness of Prevention* (Valle, 2004)<sup>2</sup> Valle, L.A, (2004) et.al. Using Evidence-Based Parenting Programs to Advance CDC Efforts in Child Maltreatment Prevention, p.1

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**B. PARENT EDUCATION KEY FINDING**

Our extensive search of the CMP literature suggests that although no single, best approach to parenting education designed to prevent CM exists, research has shown a number of CMP standard-based factors that are associated with strong parenting education programs:

**Factors that Address Conceptual Standards**

- There is a theory of program engagement that answers the fundamental question: Why would parents want to spend their time participating in this program?
- Interpersonal values that recognize the importance of developing trust between and among parents and staff, and respecting individual and cultural differences
- Focus is on parents' strengths whenever possible. The quality of interpersonal relationships within a program is crucial to any learning that may take place.
- Address issues of voluntary vs. required – parents who are required to attend parenting classes are more likely to drop out – incentives for their staying are incorporated into programs
- Models used address theories of protective factors

**Factors that Address Practice Standards**

- Parents concerns and motivations are integrated into the design and effective clinical methods for behavioral change are employed by staff
- Has researched and chosen the right target population for the design proposed
- Intervenes at points in development during which individuals have the greatest vulnerability.
- Provides services that from the participants' perspectives are likely to reduce that vulnerability.
- Curriculum is experiential making use of Adult Learning Theory
- Held at times convenient for parents to attend
- A combination of parent education strategies that included parent skills training, cognitive retraining, child development information, and concrete servicesA program structure that offers long-term service availability (two years or more).
- Minimum 15 hours of intervention and 25 hours for group format
- Combining parent education strategies with other complementary initiatives such as medical assistance, employment programs, behavioral/skills training, and therapeutic interventions  
Parents take active, participatory role in learning and practicing skills

**Factors that Address Administrative Standards**

- **Staffing patterns that feature dynamic leadership, peer facilitators** (e.g. parents who have experienced life situations similar to those of group members)
- **Ongoing staff training and supervision** - rigor of supervision processes to ensure program delivery with fidelity
- Specific **means of monitoring changes** in parenting practices (e.g., homework)

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**C. RECOMMENDED BEST PRACTICE MODELS**

- Triple P
- Nurturing Program
- Meld

<b>TRIPLE P</b> <b>LEVEL OF EVIDENCE THAT SUPPORTS THIS STRATEGY</b> <b>EFFECTIVE WELL-SUPPORTED</b>
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Developed and evaluated extensively in the 1980 and 90s in Australia and now implemented in , recommended and followed by the Center for Disease Control, National Center for Injury Prevention and Control.

Research experts recommended that the CDC fund the development and evaluation of a *“universal” parenting program* that could be introduced early in the parenting process to prevent child maltreatment. A universal program potentially benefits all parents through multiple levels of intervention tailored to parents who experience a range of problems with their children and have varying skill sets and needs. This differs from a “targeted” program for parents and children that address a single concern such as oppositional behavior. To explore the universal approach, the CDC funded the University of South Carolina to implement and evaluate a population-level, five-year effectiveness trial.

**Program Type:** Parent Education, Universal

**Official Website of Triple P:** [http://www.pfsc.uq.edu.au/02\\_ppp/ppp.html](http://www.pfsc.uq.edu.au/02_ppp/ppp.html)

**Theoretical Description of Triple P:**

[http://www.triplep.net/files/pdf/Parenting\\_Research\\_and\\_Practice\\_Monograph\\_No.1.pdf](http://www.triplep.net/files/pdf/Parenting_Research_and_Practice_Monograph_No.1.pdf)

**South Carolina Study Preliminary Findings:**

<http://www.aifs.gov.au/nch/pubs/newsletters/nl2006/winterph2.pdf>

[http://www.pfsc.uq.edu.au/downloads/Presentation\\_Ron\\_Prinz.pdf](http://www.pfsc.uq.edu.au/downloads/Presentation_Ron_Prinz.pdf)

**What is Triple P?** It is a multi-level Parenting Education strategy, which recognizes that parents have differing needs and desires regarding the type, intensity and mode of assistance they may require. This tiered system is designed to maximize efficiency, contain costs and ensure the program has wide reach in the community. The strategy 1) enhances the knowledge, skills, confidence, self-sufficiency and resourcefulness of parents; 2) promotes nurturing, safe, engaging, non-violent and low conflict environments for children; and 3) promotes children’s social, emotional, language, intellectual and behavioral competencies through positive parenting practices. The program targets five different developmental periods from infancy to adolescence.

**Theoretical Basis:** Triple P is a form of behavioral family intervention based on social learning principles. This approach to the treatment and prevention of childhood disorders has the strongest empirical support of any intervention with children; particularly those with conduct problems.

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**What are the implications of Triple P for Maui County?** Except for the DOE sponsored, Parent Community Networking Center (PCNC) which has facilitators working in the schools to help to create supportive partnerships among the home, the school and the community for supporting student success, and the Annual Hawai'i Parent Guide there are no coordinated efforts to address CMP through parenting education in Maui County. There are obviously no lack of parenting programs and some address CMP more than others. There used to be a support network for parenting educators that might be useful to rekindle so that educators could share their practices with one another. Statewide standards are set for early childhood education and CMP guidelines have been added to these via NAEYC, but this is not true for parenting education. The Triple P could be used as a way to create these guidelines for CMP in parenting education because of its proven effectiveness and similarities to existing parenting education protocols in the County.

<p><b>THE NURTURING PROGRAMS</b> <b>LEVEL OF EVIDENCE THAT SUPPORTS THIS STRATEGY</b> <b>PROMISING INNOVATIVE PRACTICE</b></p>
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The Nurturing Parenting Programs are evidenced based programs that have proven effectiveness in treating and preventing the recurrence of child abuse and neglect. Recognized by the National Registry of Effective Programs and Practice (NREPP), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Child Welfare League of America (CWLA), the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the Center for Substance Abuse Prevention (CSAP), strengths of the program is in its ability to address clinically proven theories of the causes of child maltreatment through a range of curriculum for all CMP areas from Primary to Quaternary.

**Program Type:** Parenting Education, Tertiary, Quaternary

**Web Site:** <http://www.nurturingparenting.com/home.php>

**The most recent report of the Florida study (2005) is now available at:**  
[http://www.nurturingparenting.com/research\\_validation/florida\\_project\\_six\\_year\\_report.pdf](http://www.nurturingparenting.com/research_validation/florida_project_six_year_report.pdf)

The effectiveness of some of the Nurturing Parenting Programs being offered in Florida has a greater positive impact on the families than other programs. **This may be related to the program itself, the competency of the staff implementing the programs, or the improper screening of families into parenting programs that are not appropriate for their needs.** There are still an unacceptably high percentage of the AAPI posttest scores falling into the high risk 1 to 3 sten range. Approximately 30% of the parents completing their parenting programs in Florida still express highly abusive and neglecting parenting attitude.

The relationship between parents completing their parenting program and their improvement in positive parenting attitudes is very significant. Parents who complete their program express positive posttest parenting attitudes.

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**What are the implications of the Nurturing Parent Program for Maui County?**

The Institute for Family Enrichment (TIFFE) provides training in the Nurturing Parents curriculum to agencies across Hawaii. Nurturing Families of Hawai'i is a 12-session program based upon the "Nurturing Parenting" model to provide parent skills training and resource management. Topics include:

- Nurturing as a Lifestyle
- Understanding Discipline and Family Rules
- Money Management
- Budgeting
- Family Play and Fun
- Behavior Encouragement
- Making Good Choices
- Growth and Development of Children

<p><b>MELD</b> <b>LEVEL OF EVIDENCE THAT SUPPORTS THIS STRATEGY</b> <b>PROMISING INNOVATIVE PRACTICE</b></p>
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MELD has been making a positive difference for more than 30 years in the lives of families with children across the U.S. and internationally—nurturing crucial connections between parents and children by building skills, knowledge, support systems and confidence. Since mid-2005, MELD has been part of the Parents as Teachers National Center family of services, strengthening families through facilitated parent education and support groups. These parent programs improve the capacity of families to support, nurture, and guide their children.

**Program Type:** Parent Education-Teens

**Web Site:** <http://www.parentsasteachers.org/site/pp.asp?c=ekIRLcMZJxE&b=1703959>

A Logic Model of the Parents as Teachers Program:

<http://www.parentsasteachers.org/atf/cf/%7B00812ECA-A71B-4C2C-8FF3-8F16A5742EEA%7D/LogicModel.pdf>

MELD is listed as a MODEL program in the Strengthening America's Families website:[http://www.strengtheningfamilies.org/html/programs\\_1999/24\\_MELD.html](http://www.strengtheningfamilies.org/html/programs_1999/24_MELD.html)

Research results and references are listed on the PAT website:

<http://www.parentsasteachers.org/site/pp.asp?c=ekIRLcMZJxE&b=1703963>

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MELD was designed for new higher education or middle level parents and then modified for young moms and dads. MELD for growing families from pre-school children and parents tend to have a couple of kids, Latino families, African American families, Hmong families. It was kind of a laboratory for experimenting with the curriculum based on the needs of a particular population. Now PAT has merged with MELD.

**Why is MELD a worthwhile program for Maui County to consider?**

Two of Maui's High Schools have comprehensive teen parenting programs, one at Baldwin High and the other at Maui High School, but it seems that neither program uses an Evidence-Based Best Practice to guide its curriculum except for the MFSS and Head Start resource folks who come in to the classrooms.

In the Maui Family Support Services Teen Services Program the Nurturing Parents AAPI constructs are used as the basis of monitoring progress for participating teens. In a conversation with the new Teen Services Program Coordinator, she said that one of the aims of the current program is to attract peer educators (one of the key facets of the **MELD** program structure).

**D. RECOMMENDATIONS FOR PARENTING EDUCATION FOR MAUI COUNTY**

The research on best practice parenting programs hopefully will have something to offer our Maui County programs especially in the areas of evaluation and monitoring tools and as a guide for program elements that have proven effective. Of course to avoid the cookie cutter approach it is very important to adapt program elements to the population being served.

**Question:** Would the use of the Nurturing Program and its principles when compared to the Triple P and then compared to our current CMP parenting programs help us examine the principles that underlie programs, and come up with some agreed upon standards that might guide parenting education practices to more effectively address CMP in Maui County?

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## **HOME VISITATION**

### **A. HOME VISITATION BACKGROUND SUMMARY**

As a strategy for preventing child maltreatment, home visitation came to the forefront of the national agenda in 1991 when the U.S. Advisory Board on Child Abuse and Neglect recommended universal implementation of home visitation programs. It promoted a program of paraprofessional home visiting for vulnerable families known as Hawaii Healthy Start Program (HSP) which had been developed and implemented statewide in Hawaii. Eventually, HSP became a national initiative to prevent child maltreatment known Healthy Families America (HFA).

HSP/HFA and other home visiting program models have been evaluated and researched many times over. While not universally positive across all evaluations, **when the right elements are working together, home visiting has proven to be an effective approach for CMP.**

#### **Recent Mixed Reviews Produce Scrutiny**

Interestingly, as research has become more rigorous and studies become subject to meta-analyses, evidence has begun to unfold that has raised important questions about the effectiveness of home visitation programs in preventing child maltreatment. A very recent meta-analysis which Olds co-authored in 2007, seems to shed a more scrutinizing light on just how effective. He says: *Most reviews of the literature on home visiting programs have produced sobering pictures of the prospects of home visiting programs in general* (Olds, Sadler, & Kitzman, Programs for Parents of Infants and Toddlers: Recent Evidence from Randomized Trials, 2007, p. 363).

His statements of concern highlight the fact that although many home visitation programs focus on common goals, they also differ in important ways such as:

- the backgrounds of the visitors,
- the segment of the population targeted,
- the content and clinical methods of the programs and
- the structure provided to visitors in the delivery of services (2007, p. 364).

The 1999 issue of the *Future of Children*, (a journal published by the David and Lucile Packard Foundation on home visiting programs) also noted that despite some positive findings, many of the programs still struggled in numerous areas. **Challenges** were raised concerning:

- enrolling, engaging, and retaining families, most HV programs have a 50% retention rate
- the lower rates of effectiveness when using paraprofessionals versus nurses,
- staff retention, and
- the training needed by home visitors
- pay range for home visitors
- requirements for overwhelming paperwork (Daro, The Future of Children, 1994)

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A 2002 article in the *Journal of the American Academy of Pediatrics* compared the effectiveness of home visiting by paraprofessionals and by nurses as separate means of improving maternal and child health. Both types of visitors were trained in a program model called the **Nurse-Family Partnership** that has demonstrated effectiveness when delivered by nurses. This study showed that nurses produced significant and important effects on areas that provide a reduced risk of child maltreatment such as:

- timing and likelihood of subsequent pregnancies,
- subsequent births,
- participation in the workforce;
- mother-child responsive interaction; and
- the emotional, language and mental development of children born to mothers with low psychological resources.

For most outcomes on which the nurses produced beneficial effects, **the paraprofessionals' effects in these areas were approximately half the size.** The research team concluded that:

*It is likely that professionals other than nurses can serve as effective home visitors for low-income parents of infants if they are given the right program resources, and effective paraprofessional models eventually may be developed. But until there is consistent evidence from well-conducted randomized trials to support paraprofessional home visiting with any program model, the small effects observed here and elsewhere sound a cautionary note for the many maternal and child health and early intervention programs that purport to promote the health and development of pregnant women and infants with visitors who have limited professional training* (Olds D. , Robinson,, O'Brien, & Luckey, 2002, p. 488).

More recently, in Olds, et.al. concluded:

***Simply having nurses deliver the service, however, is insufficient. They need guidance as to:***

- *what to focus on,*
- *how to bring about adaptive behavior change that is based upon solid epidemiology and theory, and*
- *sufficient contact with families for change to occur* (Olds, Sadler, & Kitzman, Programs for Parents of Infants and Toddlers: Recent Evidence from Randomized Trials, 2007, p. 383).

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**B. KEY FINDINGS IN HOME VISITATION**

**Summary** In light of extensive efficacy evidence on home visiting, there is growing consensus that the field must now move from asking whether early childhood intervention works to asking **how it works**. In all of the research studies on home visitation examined in this report<sup>3</sup>, including the issues raised by Olds, et.al above, the following were found to be essential standard-based factors in home visitation programs:

**Factors that Address Conceptual Standards**

- identified preventing child abuse as an explicit program goal
- early intervention, programs should begin prenatally and continue for at least six months
- programs that are flexible and individualized to meet specific family needs

**Factors that Address Practice Standards**

- worked with high-risk parents, but focused on their strengths
- developed a therapeutic relationship between the home visitor and parent
- careful observation of the home situation, focus on parenting skills, child-centered services and provision of "concrete" services (e.g., shelter, health care)
- an ongoing review of family needs to determine frequency and intensity of services
- the inclusion of fathers in services
- intensive services over a sustained period - most believe home visits should occur at least once a month; however, a tiered level of service delivery is recommended by many
- programs that provide a core educational curriculum (with modeling and observation as key components) but must initially focus on family needs and family stressors

**Factors that Address Administrative Standards**

- home visitors who are well-trained, well-supervised, sensitive, culturally competent, consistent and have plenty of opportunities for peer support
- program goals that are well developed by all key stakeholders and once established are clearly communicated
- partnerships formed across programs and communities
- research designs to improve the implementation and quality of services

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<sup>3</sup> Sources include: Alabama Children's Trust Fund *Home Visiting with Families At Risk for Child Abuse and Neglect: Review of Programs, Findings, Best Practices, and Lessons Learned from the Field* . By Sweet and Appelbaum (Sweet M. &, 2004) in their meta-analysis of over 60 home visiting research studies, and in study into the effectiveness of parent education and home visiting child maltreatment prevention programs by carried out by the Australian Institute of Family Studies (Prue J Holzer, 2006).

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**C. RECOMMENDED BEST PRACTICE MODELS**

- **Nurse Family Partnership**
- **Hawaii Healthy Start and Healthy Families America**
- **Enhanced Healthy Families**
- **Project Self-Care**

<p><b>NURSE FAMILY PARTNERSHIP</b> <b>LEVEL OF EVIDENCE THAT SUPPORTS THIS STRATEGY</b> <b>EFFECTIVE WELL SUPPORTED PRACTICE</b></p>
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A prenatal and early childhood home visitation program designed to improve maternal and child health and well-being. NFP was developed in over 270 counties in the United States outside of research contexts since 1996 – chosen by the Department of Justice as a model violence-prevention program in their Blueprints *Initiative*<sup>4</sup>. Home visits are conducted by experienced, well-trained and supervised nurses who work intensively with first-time, low-income mothers and their families over a period of two to three years. Public officials have invested in the nurse visitor program in light of replicated evidence of its effectiveness from randomized trials.

The crafters of NFP saw **the importance of nurses to the success of the program due to their professional status enabling them to command the respect of the families to a greater degree than could paraprofessional visitors**. Second, they reasoned that **women pregnant with their first child would be more receptive to preventive services than women who had already established parenting practices**.

Although the Nurse Family Partnership is probably the best supported model of peri-natal home visiting, recent evaluations have pointed out that **outcomes are not as strong when substance abuse and domestic violence are present**, and efforts are now underway to address these issues by intensifying the nurses' efforts **to help women find resources for protection from domestic violence, to help abusive people stop abusing and to promote effective partner communication**.

**Program Type:** Home Visitation

**Website :** [www.nursefamilypartnership.org](http://www.nursefamilypartnership.org)

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<sup>4</sup> The Blueprints Initiative was a joint program between the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the State of Colorado Division of Criminal Justice which led to the funding of program replications in sites across the U.S. of model programs identified as effective and research based. The OJJDP provided funds for training and technical assistance and monitoring assistance along with dissemination information about factors that enhance the quality and fidelity of implementation.

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See also, <http://www.rwjf.org/reports/npreports/nursefamily.htm> and Olds, D.L., Programs for Parents of Infants and Toddlers: Recent Evidence from Randomized Trials, *Journal of Child Psychology and Psychiatry* 48:3/4 (2007), pp 355–391 for a complete report of the initial trial evidence.

**What are the implications of the Nurse-Family Partnership for Maui County?**

The use of nurses in this program as an important factor in its effectiveness in the prevention of child maltreatment supports the use of nurses in the Hawaii’s Enhanced Healthy Start model (as followed by Maui Family Support Services and other agencies receiving Enhanced Healthy Start funds in the State). Healthy Start does not use nurses, but does have a good clinical support system for its paraprofessional visitors. In addition, there may be effective model elements of the NFP which could be compared to Healthy Start and Enhanced Healthy Start programs and other Maui home visitation programs such as PARENTS, Inc. and Child and Family Support Services approaches to see how they measure up, such as:

- Consider the psychological immaturity of the mother and mental health problems that affect parental competency.
- Concern with environmental conditions that create stressful household conditions
- Visitors handling of intimate partner violence
- Improving visitors management of parents’ mental illness
- Increasing involvement of fathers in their children’s lives
- Helping mothers and fathers recognize their strengths and how to use them to meet goals using small steps and when accomplished moving on to bigger steps
- Goals met must be mother’s not visitor’s
- The role of staff in family retention
- Community involvement and its role in retention
- Looking at factors from NFP that improve retention
- The importance of the staff team approach
- Secondary traumatization
- Importance of developing a supportive organizational culture
- Emphasis on multi-disciplinary team approach
- Strong and effective clinical supervisors
- Flexibility of staff in meeting family’s needs

**Further Questions:** Are there retention issues in any of our Maui programs? How are they addressed? Do PARENTS, Inc and Child and Family Services use nurses? What other challenges do staff face and what are the trainings they receive to address these challenges?

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**HAWAII HEALTHY START AND HEALTHY FAMILIES AMERICA**  
**LEVEL OF EVIDENCE THAT SUPPORTS THIS STRATEGY**  
**PROMISING INNOVATIVE PRACTICE**

*Healthy Families America (HFA)*, a national initiative launched in 1992 by Prevent Child Abuse America and modeled after Hawaii's Healthy Start Program (HSP), links expectant and new mothers on a voluntary basis to trained staff who provide home visits and referrals to community services. HFA currently has home visitation programs in over 420 communities in the United States and Canada. Hawaii's current Healthy Start Programs are carried out by 6 contracted agencies, at 16 community sites in Hawaii statewide.

**Program Type:** Home Visitation, Secondary

**Website :** <http://www.healthyfamiliesamerica.org/home/index.shtml>

Although there is a large body of quasi-experimental and single group studies that has shown promise in producing positive child health outcomes and reducing child maltreatment, all evaluations of Healthy Families America and Hawaii Healthy Start programs have produced mixed results. Findings from these and other randomized, controlled trials of Healthy Families programs have not produced significant effects with regard to maltreatment reduction. Part of the problem may be due to the fact that **HFA which modeled its programs after HSP has chosen not to offer a clearly defined program model**. Olds, et.al conclude the following:

*In order for HFA and HSP to benefit from the studies already done, **promising elements need to be combined to delineate a clearly defined program**, testing that program in rigorous RCTs, and then assuming that the results show significant impact, using the clearly defined evidence-based model as the foundation for a national dissemination effort. Overall, additional experimental evaluation is needed to discern which program elements need to be re-tooled to produce more significant effects and programs need to more effectively address risk-clusters such as domestic violence, substance abuse, maternal depression and delay of second pregnancy* (Olds, 2007, p. 383).

**What are the implications of Healthy Start and Healthy Families America for Maui County?**

Hawaii's Healthy Start Program (HSP) is currently looking at 3 pilot studies. They are:

1. Johns Hopkins University: Fidelity to the Family Thriving Protocol
2. Johns Hopkins University: Healthy Start Early Identification (EID)/Child Welfare Services (CWS) Study: to analyze and compare families who received services from Healthy Start with data from Child Welfare Services to determine whether HS families were confirmed by CWS.
3. A pilot study to determine feasibility of a statewide home visiting curriculum.

The further question here is whether MFSS/HSP and other home visiting programs on Maui, Molokai and Lanai have effectively addressed the risk clusters of, *domestic violence, substance abuse, maternal depression and delay of second pregnancy*. Other questions arise about program elements in Healthy Start on Maui, such as: have the strength-based and the team approach shown promise in reducing these risk factors? Perhaps the Nurturing Families curriculum and Family Thriving Protocols in the studies underway will address this.

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**ENHANCED HEALTHY FAMILIES  
LEVEL OF EVIDENCE THAT SUPPORTS THIS STRATEGY  
PROMISING INNOVATIVE PRACTICE**

This augmented version of the HFA program was based upon findings that parents who abuse or neglect their children often attribute negative intent to their babies' crying (e.g., 'She's only trying to get back at me.' 'He's mean just like his father'). In this program, the visitors were trained to focus explicitly on helping parents accurately interpret their infant's communicative signals and devise strategies for managing care-giving problems (Bugental, 2002).

**Program Type:** Home Visitation Quaternary

The home visiting program was **modeled after the Hawaii Healthy Start program, but used the Parents as Teachers parenting curriculum** to guide their work with parents, with enhancements that included:

- specific strategies for helping parents accurately diagnose problems in parent–infant interaction,
- develop a specific plan to address the problem, and
- to pay particular attention to helping parents re-frame their negative attributions of their children's behavior and intent.

**Major findings:** Compared to mothers in the control condition and the un-enhanced home visiting program, mothers in the enhanced home visiting program reported less harsh parenting, superior child health, and lower rates of physical abuse in the first year of the child's life (4% in the enhanced home visiting program, 26% in the control condition, and 23% in the un-enhanced home visiting program). The benefits of the program were greatest among families in which the children had low APGAR scores or pre-term delivery, a finding which suggests that families with a greater sense of vulnerability are more likely to engage and make use of these kinds of programs. While this trial is small, it illustrates the kind of formative work that the field (and Healthy Families in particular) needs to move forward. By focusing on a single risk factor (negative attributions) with a clearly delineated set of interventions, the enhanced home visiting program has produced promising effects that should be replicated.

**What are the implications of this practice for Maui County?**

Home visitation administrators on Maui question the wisdom of focusing on a single risk factor during an intervention because there are often many happening at the same time. Instead this enhancement such as working with a family member in better interpreting what their child is communicating could be highlighted in the overall approach of increasing the protective factor of understanding the social and emotional development of their child.

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**PROJECT SELF CARE**  
**LEVEL OF EVIDENCE THAT SUPPORTS THIS STRATEGY**  
**SUPPORTIVE EFFECTIVE PRACTICE**

SafeCare/Project Twelve Ways works with families with multiple child maltreatment risk factors and offers services aimed at ameliorating social/ecological factors that appear to contribute to child maltreatment. Project 12-Ways has operated continuously since 1979. Its primary focus is to teach children and their parents the skills necessary to get along without abuse and neglect. The guiding philosophy of Project 12-Ways is that family problems can be eased by eliminating stress-producing factors such as unemployment and by teaching parents effective child-rearing skills. Project SafeCare uses a succinct teaching format to focus on parent-child interaction training, home safety, and child health-care. Chosen by the Center for Disease Control as an effective practice based on previous RCT trials in the prevention of child maltreatment, Project SafeCare is being implemented statewide in Oklahoma and tested in a randomized trial to determine whether a statewide replication can reproduce the positive effects seen in earlier trials. Preliminary results of the Oklahoma trial are included here.

**Program Type:** Home Visitation, Tertiary

**Web Site:** <http://www.p12ways.siu.edu/>

Dr. John Lutzker, the developer of the SafeCare model is at the Marcus Institute in Atlanta, GA home of the National SafeCare training and Research Center. There is availability of a SafeCare manual and training for staff. For more information contact: Anna Edwards  
[GWIA.Anna.Edwards@marcus.org](mailto:GWIA.Anna.Edwards@marcus.org)

For updated information on the Oklahoma Study contact: [Jane-Silovsky@ouhsc.edu](mailto:Jane-Silovsky@ouhsc.edu)

The standard SafeCare components (health, safety and cleanliness, and planned activities parent training) are enhanced by adding counseling and problem-solving components. SafeCare service providers also receive training in **motivational interviewing techniques** and **intimate partner violence screening and referral**. By addressing these factors as crucial to maltreatment prevention, the SelfCare approach could be used to augment both Nurse-Family Partnership and Healthy Families models in which poor prevention results were attributed to multiple risk factors and the inability of staff to address them. There is a manual that describes how to implement this program. It was also designed especially for **children with developmental delays**.

### **Conclusions**

Preliminary results of the pilot project suggest that the project is feasible and shows the potential to impact high risk families with significantly greater reductions in depression and child abuse potential and improvements in social support for the caregivers.

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**Other recommendations:** Training of service providers involves direct observation, coaching, and feedback. The early results and abundant past literature support a conclusion that implementation of new practices and corresponding improved client outcomes are not well secured by simply providing information, workshops, or guidelines. Training also benefits from selecting agencies and individual providers who are committed to the uptake of innovative practices and implementing them precisely as they are designed.

**D. HOME VISITING RECOMMENDATIONS FOR MAUI COUNTY**

Healthy Start Hawaii begins their new contract period in July, 2008. The State HSP office is currently engaged in three small studies:

1. Johns Hopkins University: Fidelity to the Family Thriving Protocol
2. Johns Hopkins University: Healthy Start Early Identification (EID)/Child Welfare Services (CWS) Study
3. Pilot study to determine feasibility of a statewide home visiting curriculum (Nurturing Families curriculum)

**Are any of these current studies named above addressing the following?**

- The adequate training of paraprofessionals?
- What standards are used?
- When there are multiple risk factors, how successful have we been?
- What helps to insure success with each risk factor?
- How are they off-set with protective factors?
- How do we measure success with protective factors?
- What program elements in home visitation have we found to be most effective for CMP?
- How are we addressing retention rates in Maui's home visitation programs?

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**CHILD SEXUAL ABUSE**

**A. CHILD SEXUAL ABUSE PREVENTION BACKGROUND SUMMARY**

In child maltreatment where physical abuse is concerned, treatment and prevention advocates have often worked jointly in conceptualizing theoretical models of maltreatment and intervention systems. This type of marriage between treatment and prevention has not occurred for child *sexual abuse*. On the whole, scholars concerned with the underlying causes and consequences of sexual maltreatment have paid less attention to prevention efforts. Treatment programs rarely include individuals who haven't offended, or are identified as at-risk for offending, partly because many programs are located within prison facilities or are accessible only after an individual has been convicted of an offense.

While many who advocate the prevention of physical or emotional maltreatment are therapists or counselors who treat families involved in maltreatment, the majority of sexual abuse prevention efforts have been designed by individuals in the rape crisis movement, elementary and secondary education, or law enforcement. These new prevention planners saw child sexual abuse as a pervasive problem requiring a pervasive intervention. Efforts to prevent child sexual abuse therefore focused primarily on curricula to educate all children about the need for self-protection (Daro, Preventing Child Sexual Abuse: Promising Strategies and Next Steps, 2003)

In 2000, M.K. Davis and C.A. Gidycz of the Department of Psychology at Ohio University, Athens conducted a meta-analysis of 27 control group studies (8115 participants)<sup>5</sup> school-based sexual abuse prevention programs and reported that children who participated in prevention programs performed significantly higher than control group children on outcome measures used in the studies, indicating improvements in knowledge and skills concerning sexual abuse. However, in the process of developing the sample of studies to include in the analysis, the researchers indicated that they identified **no studies that had analyzed the effect of prevention programs on actual rates of abuse.**

A conclusion of this meta-analysis is that research on school-based programs for the prevention of child sexual abuse **offers little evidence to conclude that these programs actually prevent child sexual abuse.**

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<sup>5</sup> Studies were identified by searching PsycINF, Medicine ERIC, HealthSTAR, and Dissertation Abstracts, scanning bibliographies of relevant articles; and handsearching recent volumes of relevant journals (e.g. Child Abuse and Neglect). Studies were selected if they evaluated a school-based sexual abuse prevention program in children 3-13.

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**B. KEY FINDINGS FOR CHILD SEXUAL ABUSE**

**Few studies have been able to establish a relationship between acquisition of knowledge about child sexual abuse and subsequent behavior change in children.** One of the most consistent recommendations in response to this deficit is the need to provide children with opportunities **for role play to practice new skills** such as assertiveness, clear communication, and maintaining a safe distance (that is, arms length from strangers) (Wurtele, 1987). Wurtele and her colleagues found role playing and participant modeling (that is, actively practicing a skill as opposed to watching others do it) a more effective method than experimenter modeling of prevention skills.

It does not seem prudent to advocate doing away with child empowerment programs altogether, but instead to draw closer attention to what has and hasn't worked and to encourage following some of the best practices guidelines from the research literature.

**For example, Davis in a meta-analysis of programs, makes the following observations:**

- programs that include the active involvement of children (role playing, skills rehearsal) were more successful than those that did not;
- programs that consisted of incremental learning over more than three sessions were more effective than those of 1-3 sessions;
- the youngest children (preschool and early elementary) showed more learning immediately post-training than older children (Davis & Gidycz, 2000).

**Tutty makes the following additional points:**

- prevention programs often teach children to engage in behavior that is at odds with familial and cultural norms, such as saying "no" to a grown-up and not keeping any secrets;
- the cognitive development of young children does not allow them to understand some concepts involved in prevention programs, the idea of "stranger" (Tutty, 2000)

**Tutty also makes the recommendations that program developers:**

- present material repetitively and in multiple modalities;
- direct prevention lessons toward younger children, beginning in pre-school violence and peer abuse for older children;
- involve parents, school and community staff in the teaching of prevention concepts;
- incorporate sexual abuse prevention into programs that address wider issues such as assertiveness, self-esteem, bullying prevention and conflict resolution.

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**Daro adds the successful programs are one's that have:**

- a behavioral rehearsal of prevention strategies;
- curricula tailored to each age group's cognitive characteristics and learning ability;
- for young children, material presented in a stimulating and varied manner;
- generic concepts, such as assertive behavior, decision-making skills, and communication skills, which children can use in everyday situations, not just to fend off abuse;
- emphasis on the need for children to tell every time someone touches them in a way that makes them uneasy; and longer programs that are better integrated into school curricula (Daro, *The Future of Children*, 1994)

**David J. Kolko offers the following recommendations for child empowerment programs that adds more depth to the methodological considerations in response to research results:**

- Programming must be strongly based on interactive theories that integrate such factors as family and sexual dynamics and the psychology of victims and perpetrators.
- Curricula should emphasize clarification of terminology and concepts as well as integrate simulated practice of preventative responses.
- Program content should extend beyond discussion of touches and include topics such as assertiveness and problem-solving.
- Initial child abuse prevention should be reinforced periodically.
- Support services should be available after training sessions to handle disclosures.
- The integrity of program content should be monitored periodically by comparing program manuals with ratings of actual program material to determine which components are beneficial.
- Participants should be informed of confidentiality and mandated reporting issues.
- More attention should be paid to the school/program's response to the child's participation in the program.
- Program evaluation should pay more attention to methodological requirements for such an evaluation (e.g. Control groups, experimental design permitting an analysis of change, etc) (Kolko, 1988).

**The U.S. Department of Health and Human Services** (2003a) published a synthesis of lessons learned from school-based maltreatment programs, including those with primary prevention strategies addressed to children. They concluded that “children who attended prevention presentations showed an increased awareness of safety issues and demonstrated greater knowledge of child abuse and neglect. In some cases, this led to disclosures about their own experiences of maltreatment.” <http://nccanch.acf.hhs.gov/pubs/focus/schoolbased.cfm>

**The National Center for Missing and Exploited Children** (n.d.) has published guidelines for programs aimed at prevention which includes a curriculum scorecard and a program evaluation checklist to aid schools and communities in the evaluation of prevention programs. Available: <http://www.missingkids.com>

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**Prevent Child Abuse Iowa**, in a document from their web site called **Child-focused Sexual Abuse Prevention Programming Best Practices** has developed a **list of key elements to include in sexual abuse prevention programs**. Extrapolated from a review of best practices in the research literature, these elements are a good guide for our purposes here.

Website: [http://www.pcaiowa.org/documents/research/best%20practices%20approved%206\\_Oct06.pdf](http://www.pcaiowa.org/documents/research/best%20practices%20approved%206_Oct06.pdf)

Daro emphasizes the following actions that are needed for a comprehensive strategy to prevent child sexual abuse:

- Expand public education efforts to improve the public’s understanding of CSA
- Focus education efforts on perpetrators of CSA to encourage them to seek services to alter behavior
- Offer educational programs to parents that strengthen a parent’s protective instincts and provide parents with the tools and information on how to talk to their children, monitor their children, and what to do if their children are abused.
- Provide life skill training for younger adolescents that include, for example, the following skills: assertiveness, self awareness, critical thinking, making low-risk choices, etc.
- Offer support groups for vulnerable children who are limited in their abilities to resist abuse
- Offer support groups for vulnerable adults who are limited in their abilities to protect their children from abuse (Daro, Preventing Child Sexual Abuse: Promising Strategies and Next Steps, 2003).

**C. RECOMMENDED BEST PRACTICE MODELS**

- **FROM DARKNESS INTO LIGHT**
- **STOP IT NOW!**
- **PROJECT TRUST**
- **SAFECHILD PROGRAM**
- **GOOD TOUCH, BAD TOUCH**

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<p><b>FROM DARKNESS INTO LIGHT LEVEL OF EVIDENCE THAT SUPPORTS THIS STRATEGY EMERGING PRACTICE EFFECTIVENESS UNKNOWN</b></p>
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In 2000, Anne Lee, now Darkness to Light's President and CEO, developed and implemented a strategy for a non-profit primary prevention program with the mission of reducing the incidence of child sexual abuse through public awareness and education. It is a Public Awareness Campaign that includes 7 Steps to preventing, recognizing and reacting responsibly to child sexual abuse, and a sexual abuse prevention training. The State of Georgia has launched a \$4 million dollar campaign using Darkness to Light's Stewards of Children training. They are committed to training 1 million adults over the next 10 years.

**Program Type:** Child Sexual Abuse Prevention, Public Awareness Campaign

**Website:** [www.darkness2light.org](http://www.darkness2light.org), to see the State of Georgia's efforts

**Why is this a worthwhile program for Maui County to consider and why?**

These steps are simple and an adult media campaign and a collaborative effort of community centers and youth programs could attract members of the community to participate in forums where the 7 Steps are taught. Our Maui agencies might consider building grassroots leadership - people who are willing to surface child sexual abuse and work with other community members in finding preventative and restorative solutions that make sense in a local context.

Communities need support in designing their own plans for prevention, intervention, and accountability in order to make best use of the capacity to stop child sexual abuse – this strategy and the one below are good first steps as are the community efforts being supported by the CDC.

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**STOP IT NOW!**  
**LEVEL OF EVIDENCE THAT SUPPORTS THIS STRATEGY**  
**EMERGING PRACTICE, EFFECTIVENESS UNKNOWN**

Founded in 1992 by Fran Henry, a survivor of childhood sexual abuse, who recognized that standard ideas about preventing sexual abuse of children weren't working, STOP IT NOW! is a national organization based in Massachusetts. It has been tested in pilots in Vermont, Philadelphia, Minnesota and the United Kingdom. Stop It Now! **seeks to change behavior by teaching adults about their role in preventing child sexual abuse, and challenging abusers and those at risk for abusing to stop abusive behavior and reach out for professional help.** Stop It Now! also challenges families and friends to question inappropriate behaviors and not isolate themselves with difficult situations. This model shifts the focus of prevention from children to adults and from victims to perpetrators. Using a public health social marketing campaign and public education, STOP IT NOW! encourages individuals and communities to stimulate adult to adult discussion of the topic. It supports the possibility that perpetrators and even family members will turn themselves in voluntarily given the right understanding of the issue and the right community climate.

**Program Type:** Child Sexual Abuse Prevention, Public Awareness Campaign Targeting Offenders

**Web site:** <http://www.stopitnow.com>

The CDC wrote the following editorial regarding this study in the Journal of the American Medical Association (Center for Disease Control, 2001) saying that:

*the greatest potential for prevention may be with persons who abuse or other adults who can intervene with the abuser. With treatment, those who abuse can modify their behaviors.*

*This report underscores the potential efficacy of targeting persons who abuse and the adults who know them.*

*Community factors may be critical to the success of these programs. Vermont has treatment programs throughout the state and within the prison system. In this setting, STOP IT NOW! can guarantee treatment to anyone who enters the legal system. Vermont also offers accessible media markets for its small population. Finally, Vermont has a coalition of victim and abuser treatment organizations that supported the introduction of this approach to prevention.*

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*Evaluation of programs such as STOP IT NOW! will help determine the potential efficacy and need for media and outreach campaigns that focus on persons who abuse and the adults who know them. A collaborative effort between public health officials, sex offender treatment providers, and the criminal justice system in the model of STOP IT NOW! may benefit the well being of children (CDC, p.3)*

**Why is this a worthwhile program for Maui County to consider and why?**

This particular study, although not actually an evaluation of the STOP IT NOW! Program, does emphasize the importance of doing so, and the importance of knowing that given the appropriate community climate toward offenders, good treatment programs and using the data available on pedophilia and its diagnosis to educate the public about ways they can participate in early detection that each of these could contribute to CSAP for Maui County. What is needed is a more thorough understanding of our current approaches and proceeding from there. We might want to consider finding funding for doing a statewide survey and use that to guide our efforts.

There is currently is no primary prevention/social marketing efforts in Maui County for preventing child sexual abuse. The Darkness Into Light steps are somewhat easier and more concise than STOP IT NOW!, but there might be merit in combining the two and in looking at the CDC funded programs cited above.

**SAFE CHILD PROGRAM**  
**LEVEL OF EVIDENCE THAT SUPPORTS THIS STRATEGY**  
**INNOVATIVE AND/OR PROMISING**

Developed in 1981 and updated in 1994, the Safe Child Program provides children ages three to ten with a set of skills to help them prevent sexual, emotional, and physical abuse. **The main idea guiding the program is that there are times when children can and must be responsible for their own well being.** At the same time, however, the program emphasizes that a child’s security can be enhanced without creating misunderstanding, fear, or anxiety or reducing a child’s sense of trust. The program does not provide explicit information about child abuse, does not define touching – good or bad and does not suggest that the adults children know may abuse them. The program can effectively be used with young (preschool-aged) children.

- A key component of the program is the use of role-playing, which allows children to practice the skills the program is trying to teach.
- The program’s goal is to provide only the information that is absolutely necessary to teach the prevention skills. Thus, the program does not provide explicit information about child abuse, does not define touching--as good or bad, and does not suggest that the adults that children know may abuse them.

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**Program Type:** Child Sexual Abuse Prevention, School based Education Model

**Website:**<http://www.safechild.org/> Source of information: Promising Practices Network  
<http://www.promisingpractices.net/program.asp?programid=129>

Funded by a grant from the National Center on Child Abuse and Neglect, the program was evaluated twice with promising results. **Both evaluations emphasized that the positive results are due to the role-playing aspect of the program.** The evaluations found that correct answers on the paper tests were not predictive of success in the simulations, nor was previous exposure to educational materials. **The researchers concluded that knowledge of facts and even conceptual understanding are not enough to translate into behavioral changes. Rather, children need to practice the skills.**

**Why is this a worthwhile program for Maui County to consider and why?**

As noted above, the results of this study clearly demonstrate that knowledge of facts and even conceptual understanding is not enough to translate into behavioral changes. Rather, children need to practice the skills. Child and Family Services, “Let’s Talk About Touching” does use some skill practice, participant modeling and role play as part of their current child empowerment program.

Little is known about the effectiveness of Maui’s child empowerment prevention efforts even though 4-5000 students have seen “No More Secrets” and countless more have participated in the Child and Family Service “Let’s Talk About Touching” interventions. This study offers a very interesting way of testing whether children are actually learning the behaviors being asked of them. In addition the study offers the *Children Need to Know Knowledge Attitude Standardized Test* as a way to measure a child’s awareness and understanding of risk issues and an evaluation could contribute to the funding possibilities for the expansion of both of these excellent Maui County programs.

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**PROJECT TRUST  
LEVEL OF EVIDENCE THAT SUPPORTS THIS STRATEGY  
INNOVATIVE AND/OR PROMISING**

Funded by the National Endowment for the Arts, Project TRUST, which stands for Teaching Reaching Using Students and Theater, uses a series of plays to raise the issues of sexual abuse and violence prevention with students from elementary school through high school. The play “Touch” is specifically designed to introduce the concepts of sexual abuse and its prevention to elementary-school-age children. It has been performed since 1978 by a company called Illusion Theater in collaboration with the Bloomfield County Attorney’s office in Michigan for over a million children and adults in all 50 states and the Virgin Islands. “Touch” is in the process of being made into a film.

**Program Type:** Child Sexual Abuse Prevention Education for children using live theater

**Website:** <http://www.illusiontheater.org/education/>

This program received a “promising” rating. There is only one evaluation, and it only assessed the elementary-school version of the program, the play Touch. While the independent evaluation of the play Touch found some positive results, the impact only indirectly affects the benchmark. The evaluation demonstrated that the program increased children’s knowledge about abuse, and clearly the intent is that informed children will be able to prevent instances of abuse. **The evaluation did not show, however, that the gain in knowledge led to changes in behavior.**

The evaluation study recommended:

- exploring ways to improve children’s understanding of these concepts, such as modifying the play, increasing audience participation, and
- perhaps adding a home component to reinforce the concepts.

Although the evaluation did not directly demonstrate a reduction in abuse, the program does show evidence of being an effective way to communicate prevention concepts to elementary school children. The treatment group reported more incidents of first-time maltreatment after receiving the program, all of which were verified by Child Protective Services. Thus, there was no evidence that the intervention encourages misreporting of abuse. Finally, the program did not cause anxiety in the children, which may be a concern with raising children’s knowledge about this topic.

**Why is this a worthwhile program for Maui County to consider and why**

The Maui Friends of Children’s Justice Center’s collaboration on the sexual abuse prevention play “No More Secrets” that was performed to all 3<sup>rd</sup>, 4<sup>th</sup>, and 5<sup>th</sup> grade classes in Maui County and also has high school student performers, but was never evaluated for its effectiveness. The evaluation design and instruments used by Olds, et al. might be helpful should the play be performed again. Consideration, however, should be given to the fact that this evaluation was not able to measure a change in student behaviors. Theater tends to be a passive form of

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prevention, just as films and videos are. Research indicates that children are more likely to change their behaviors if they are given a chance to be active participants in the behaviors they are being asked to exhibit. Perhaps the actor/facilitators from “No More Secrets” can train the teachers in how to take the key concepts taught in the play and have children role play them after the performance. Depending on the age group, modifications could also be made in the messages being conveyed that are more in keeping with the guidelines outlined above.

**GOOD TOUCH, BAD TOUCH**  
**LEVEL OF EVIDENCE THAT SUPPORTS THIS STRATEGY**  
**INNOVATIVE AND/OR PROMISING**

Using a stringent educational design to provide research-based effective body safety and violence prevention education for children in Pre-K through 6th grades, GTBT goal is to eliminate child abuse. In existence since 1983, and revised 11 times in an effort to stay up to date, programs are trademarked by Childhelp. The curriculum has been field-tested with hundreds of children and 6000 educators but no research has been done in clinical trials since 1988 . Although only one trial has been done, the program has had significant field-testing, well-developed materials, a web-site, and uses role playing. Very little information is available on this study and the web site does not lead the reader to see the evidence for themselves. All efforts to find the original study were in vain. When compared to the control group at posttest, experimental group children scored significantly higher on knowledge of preventing abuse and responding to sexual abuse scenarios, retaining this advantage at 7-week follow-up.

**Program Type:** Prevention education and intervention for children

**Website:** <http://www.childhelp.org/gtbt>

**Why is this a worthwhile program for Maui County to consider and why?**

The curriculum of Child and Family Services “Let’s Talk About Touching” is based loosely on the Good Touch, Bad Touch approach. Again seeing how this program was evaluated might offer some guidance for demonstrating the effectiveness of the current efforts and help increase funding opportunities, as well as giving important feedback to the programmers about the effectiveness of their efforts.

**D. RECOMMENDATIONS FOR MAUI COUNTY**

It seems clear that aside for what we are already doing to educate the public about CSAP in our County with news and other media presentations once a year, the Children’s Justice Centers, *General Dynamics of Child Sexual Abuse* training of agency representatives five times a year, and the CFS child empowerment program,” Let’s Talk About Touching” and the theater piece, “No More Secrets” and offender diagnosis and treatment taking place through contracts with the State Judiciary, there still seems to be a gap about working with our adult population- the caretakers of so many of our children in the kinds of processes that *Darkness into Light* and *STOP IT NOW!* offer. It might be fruitful for the Board of the Friends of Children’s Justice to explore ways of making that happen.

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## **EARLY CHILDHOOD EDUCATION**

### **A. EARLY CHILDHOOD EDUCATION BACKGROUND SUMMARY**

In 2001, the Center for the Study of Social Policy (CSSP) in Washington, D.C. with funding from the Doris Duke Foundation gathered experts in the field of early childhood education and child maltreatment prevention and undertook an extensive search of the literature to determine if early childhood education (ECE) might prove to be an effective avenue for preventing child maltreatment. CSSP chose to focus on early care and education programs because:

- these programs represent a systematic way to reach the largest number of very young children (children younger than kindergarten age).
- There is a uniquely close relationship between the caregiver or teacher and parents of very young children which offer daily opportunities for observation and learning with parents.
- There is a relationship between early childhood programs and other resources for young parents.
- Parents come to ECE centers as “empowered consumers” rather than as clients or recipients of service.
- It is cost-effective - most early childhood programs can rather easily add or enhance program components that build protective factors for CM into their current curricula. And it is affordable because most public and private child care programs could add relevant components rather inexpensively (Judy Langford Doris Duke Charitable Foundation and the Center for Study of Social Policy, 2005)

**Website:** [CSSP.org](http://CSSP.org)



### **B. EARLY CHILDHOOD EDUCATION KEY FINDING**

Notwithstanding the limited data linking ECE with a reduction in CM, the findings of the CSSP have led to the development of a new framework for preventing abuse and neglect that recognizes the central role of early childhood professionals. It is the intention of this strategy to help practitioners understand the greater impact of what they are already doing and to encourage them to supplement their programs in affordable ways so that they will be more powerful forces against CM.

*Our work found that small significant changes in programming and staffing of early childhood programs offer an effective new strategy for supporting parents under stress and preventing harm to children. These changes enable programs to respond quickly and effectively to help families that are struggling or children who are at risk of harm or who exhibit challenging behaviors.*

Judy Langford, CSSP Family Strengthening Project Director

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**Family Strengthening and Protective Factors**

The CSSP framework called “Family Strengthening”, shifts the focus away from concentrating solely on the risk factors for CM. Instead CSSP search efforts have revealed a number of “conditions” related to a lower incidence of child abuse and neglect called “protective factors”. A Protective Factors Framework examines how many different strategies interact to produce a protective impact. The CSSP comprehensive literature review was commissioned to discover pertinent research evidence in the final formulation of protective factors for this framework by studying what actually happens in programs in the field. Not unique to Early Childhood Education programs, the research has shown that when these conditions are present children are more apt to be protected against maltreatment. The protective factors are:

- parental resilience
- an array of social connections
- adequate knowledge of parenting and child development, and
- support in times of need, including access to necessary services such as mental health,
- children’s healthy social and emotional development.<sup>6</sup>

**C. RECOMMENDED BEST PRACTICE MODELS**

In 2001, CCSP asked individuals across the country to nominate exemplary early care and education programs that support families as well as children. 100 programs were nominated, 21 were chosen. Two Hawaii programs were chosen, Parents and Children Together (PACT) Head Start on Oahu, and MEO Head Start on Maui. These programs are part of a national learning network of exemplary programs that bring their knowledge and expertise into Hawaii’s main collaborative working on CMP, the Child Safety Collaborative. Although these exemplary programs are based on the CSSP’s in depth review of the literature, neither program have the kind of clinical trials associated with them that have characterized the parenting education and home visiting best practices, however, they do have a set of comprehensive program elements that address both the risk and protective factors known from the research literature to prevent child maltreatment. We should consider them as models on Maui and hope that their evaluation processes are strong enough to merit future funding support.

The CSSP literature review only produced one study of merit that links Child Maltreatment directly to a large Early Childhood Education program. That program is the:

**CHILD PARENT CENTERS –CHICAGO**

**EARLY HEAD START - SHOWED SOME PROMISE IN REDUCING CM IN A 2002 EVALUATION**

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<sup>6</sup> There are other factors linked to a reduction in child abuse and neglect, such as mitigation of poverty and a lower incidence of mental illness, domestic violence and substance abuse by parents. These issues are beyond the reach of early care and education programs and are not included in this framework. The extent to which these factors interact with those in the framework or have an overwhelming impact on the capacity of an early care and education program to prevent child abuse and neglect are addressed in the literature review.

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<p><b>CHILD PARENT CENTERS –CHICAGO LEVEL OF EVIDENCE THAT SUPPORTS THIS STRATEGY PROVEN EFFECTIVE</b></p>
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The Chicago Child-Parent Centers (CPCs) provide comprehensive educational support and family support to economically disadvantaged children and their parents. The guiding principle of the program is that by providing a school-based, stable learning environment during preschool and during kindergarten through third grade, in which parents are active and consistent participants in their child's education, scholastic success will follow. The CPC program was founded in 1967 to serve families in high-poverty neighborhoods that were not being served by Head Start or similar programs. After 15 years, children who attended a CPC preschool program as compared with children who did not were 52 percent less likely to be victims of child maltreatment.

**Program Type:** Early Childhood Education and Family Support

**Website:** (doesn't seem to be one)

Recent research conducted by Reynolds and Robertson is encouraging. The authors believe that CPC family support services, which included parental involvement in the classroom, vocational and educational training, and receiving home visits from a school-community representative, were one of the two factors that best explain why this reduction in child maltreatment occurred (Reynolds & Robertson, 2003). Reynolds and Robertson (2003) found that by the 15-year follow-up:

- **Children who attended a CPC preschool program as compared with children who did not attend preschool were 52 percent less likely to be victims of child maltreatment**

**Why is this a worthwhile program for Maui County to consider?**

This program has wider appeal for areas of the county with higher poverty rates who are not likely to enroll in Head Start. The parameters of the curriculum are not unlike other strong ECE programs we have highlighted above. Encouraging strong parent involvement combined with home visiting and support services shows a striking resemblance to our Early Head Start program at Maui Family Support Services, to MEO Head Start, and in the FLIP programming which is part of the Keiki Steps and INPEACE programs on Oahu and the Big Island. It would appear we are not only on the right track, but exceeding this CPC program.

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**EARLY HEAD START**  
**LEVEL OF EVIDENCE THAT SUPPORTS THIS STRATEGY**  
**INNOVATIVE AND/OR PROMISING**

Early Head Start is designed to provide high-quality child and family development services to low-income pregnant women and families with infants and toddlers. Administered by the Administration on Children, Youth, and Families (ACYF), Early Head Start operates in 664 communities and serves about 55,000 children. Roughly 3 percent of all eligible infants and toddlers are enrolled in Early Head Start programs. Early Head Start, like Head Start, is a comprehensive program of cognitive, health, nutrition and parent involvement for very low income pregnant women, infants and toddlers. In June 2002, the U.S. Department of Health and Human Services, Administration for Children and Families released its funded report evaluating the Early Head Start programs.

**Findings:**

- Three-year-old Early Head Start children performed significantly better on a range of measures of cognitive, language, and social-emotional development.
- Early Head Start parents were observed as being less detached in their interactions with their children and less likely to have spanked their children in the past week, and as having a greater repertoire of discipline strategies.
- Early Head Start parents were more likely to read to their children.
- Early Head Start programs also had impacts on parents' progress toward self-sufficiency
- Early Head Start fathers were less likely to report spanking their children, and were observed to be less intrusive and more attentive during play.

**What are the Implications of this Practice for Maui County?**

Maui Family Support Services has an Early Head Start Program. It might be interesting to see whether some of the measures used in this study might be helpful as MFSS looks at its evaluation and monitoring system in early 2008. They could contact Mathematica Policy Research, Inc., and Columbia University's Center for Children and Families at Teacher College or the Early Head Start Research Consortium for examples of their assessment tools.

**D. RECOMMENDATIONS FOR EARLY CHILDHOOD EDUCATION FOR MAUI COUNTY**

The Hawaii Early Learning Task Force's report to the Hawaii Legislature needs to have language regarding Child Maltreatment Prevention in it. With the help of the Child Safety Collaborative, this language could reflect the risk and protective factors for CMP, as well as Family Strengthening. For many of the reasons outlined by the CSSP above, this will go a long way in creating more seamless family support in the prevention of CMP within ECE in Hawaii and will ultimately find its way into Maui County as well. This same language and guidelines should be incorporated into training curriculums where standards are set for quality early childhood education and even in licensing of home-based pre-schools and in the Kith and Kin programming as well.

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## **COMPREHENSIVE FAMILY SUPPORT SERVICES**

*For child maltreatment prevention programs to work, intensive efforts for those families facing the greatest challenges need to be nested within a more broadly defined network of support services. Successfully engaging and retaining those parents facing the greatest challenges will not result from more stringent efforts to identify and serve only these parents. Until systems are established which normalize the parent support process by assessing and meeting the needs of all new parents, prevention efforts will continue to struggle with issues of stigmatization and deficit-directed imagery (Daro, Home Visitation: Assessing Progress: Managing Expectations, 2006)*

Although it is true that child maltreatment occurs among all socioeconomic groups (a view prevalent in the early 1970s), however, every national survey of CAN has indicated that the vast majority of reports involve families from the lowest socioeconomic levels. The claim that these statistics are artifacts of class-based discrimination is simply not correct. The data shows that most child maltreatment occurs among lower-income families have been consistent, and no contradictory evidence has been produced. Further, they indicate that the highest incidences of CM, as well as the severest child injuries are found among the “poorest of the poor.” (Pelton, 1978) argues that the “myth of classlessness” persists because many professionals prefer to view child maltreatment as an individual, psychological problem, rather than as connected to the larger social environment. In addition, some well-meaning professionals fear that recognizing the relationship between poverty and CM will become another means of unjustly stigmatizing the poor. Pelton contends, however, that ignoring this connection does a disservice to poor families by directing attention and resources away from the societal problem of widespread poverty.

The results of a qualitative study funded by the Annie E. Casey Foundation indicates that a promising path to improving the lives of disadvantaged families is through more holistic, comprehensive approaches to family support. These approaches combine traditional family support activities with the development of human and economic capital. The effectiveness of comprehensive programs is based on the premise that adult and child well-being is interconnected with the physical, economic, and social aspects of their lives. Recommendations are provided for improving existing family support programs through the implementation of holistic strategies (Sherif-Trask, 2006)

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**III. PUBLIC AWARENESS**

Although public service campaigns have effectively raised concern and awareness of the existence and nuances of the problem, they have been *unable neither to convince the public that prevention is possible nor to motivate positive behavior change, either individual or societal, in support of prevention* (Wrigley, 2006, p.367). In recent years, public awareness campaigns have grown more sophisticated and strategic, however, the vast majority of public awareness campaigns are still designed around the notion that if you give people enough information about a topic, they will voluntarily change their behavior. Behavioral research has shown us the flaw of this thought pattern.

What changes behavior is usually when an issue hits close to home. If we can understand more fully how people’s past and present experience frame their reality around child maltreatment prevention, then messages about prevention can be embedded in that existing perceptive reality. This is known as “framing theory”. It says that people use “mental short cuts” to make sense of the world around them. And when presented with new information, we look for “cues” to help us connect the new information and sorting is based on our past experiences of the world. Public campaign messages can be encoded with meaning associated with existing beliefs or ideas to allow for easier public comprehension of new information and ideas. This approach is called “**strategic reframing**” (Kirkpatrick, 2006).

*One thing is clear above all else: doing “more of the same” will not help. Indeed, continued reliance on the strategies and messaging of the past (and in too many cases, the present) will only serve to further undermine efforts to advance a social movement to prevent child maltreatment, undoubtedly minimizing the issue as an important social problem, and perhaps relegating issue advocates even further to the periphery of public policy.*

Axel Aubrun and Joseph Grady of Cultural Logic (Kirkpatrick, 2006, p.3)

**FOR A COMPLETE DISCUSSION OF REFRAMING RECOMMENDATIONS PLEASE SEE THE FULL STUDY PAGES 137-140.**

**Recommendations**

**At the state level**, it is obvious that this is an ongoing discussion and it might be helpful within the context of the current search for a consultant to carry out the statewide Child Abuse and Neglect, Community Strengths and Needs Assessment that there be a way to write in to his or her scope of work to include a survey of the current public perception of CAN and CAN prevention.

**On Maui**, most agencies working with children and families have a key role to play in shaping the public’s perception of child maltreatment prevention. There is a need to examine the effectiveness of current and past public awareness campaigns and create a unified approach. It is hoped that this document and its well-researched recommendations will help guide this effort. Due to the diversity of Hawaii’s population, there is a need to examine the cultural bias in the research above and see if there are contradictions here such as references to the “family bubble”.

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#### **IV. EVALUATION**

It is important for a program to know internally whether their programs are effective for their given population. Designing and using appropriate evaluation tools that actually give the kind of information at the right time necessary to modify program elements to make them more effective should go hand in hand with the need to satisfy outside funding sources. Getting clients and participants involved with evaluating and monitoring their own progress and outcomes can also be an empowering activity for not only measuring program success, but for providing a sense of ownership of a process that has built-in incentives for positive behavior change.

#### **The Community Based Child Abuse Prevention (CBCAP)**

**Website** <http://www.friendsnrc.org/outcome/toolkit/outin.htm> is a key resource in providing helpful tools for service delivery organizations involved in child maltreatment prevention to develop effective methods for charting progress. One of these tools is called **A Logic Model**, which focuses on identifying the logical links between:

- the outcomes you desire,
- your program assumptions or theories, and
- your program strategies or services.

Developing a Logic Model will help clarify a program's thinking about the programs and services in terms of how they are intended to work and what may need fine-tuning to make them more effective in producing positive results for families.

#### **References:**

<http://www.friendsnrc.org/outcome/toolkit/evalplan/logic/index.htm>.  
<http://www.friendsnrc.org/resources/onlinelearn.htm>

#### **Conclusion and Recommendations**

The challenge of CMP program evaluation is that each funding source has its own best practices and their own evaluation requirements. In the words of one Maui agency director who services families at risk of Child Maltreatment:

*We choose best practices for each service we provide, but each of our funding sources look at it differently. If the state hasn't bought into a particular practice, they aren't going to require it and none of the state departments are on the same page. I may make a commitment to a best practice, but the funders aren't there yet. Definitions of child maltreatment prevention and what constitutes prevention are also an issue.*

The current collaboration between the DOH, CBCAP and HCTF may be a good start for creating a cohesive guide for CMP program evaluation. Those interested should look at the HCTF matrix <http://www.friendsnrc.org/download/fy06reports/fy06hawaii.pdf>. It can help representative

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agencies understand better how this logic model guides current RFPs and how funding sources might envision measuring success in CMP programs state wide.

Perhaps someone at the State Level could host a Best Practices in Child Maltreatment sharing day among stakeholder agencies to talk about ways that have been successful in strengthening families and share and compare evaluation approaches. It might be useful for this group to be proactive in their efforts to agree on standards for measuring child maltreatment prevention that take into account the discoveries within this document especially in measuring what program best practices enhance protective factors and reduce risk factors.

## PART II IMPLEMENTING EVIDENCE-BASED PRACTICE

*“Implementing a program is like constructing a building. An architect draws upon general engineering principles (theory) to design a building that will serve the purposes for which it is designed. However, the specific building that results is strongly influenced by parameters of the building site, such as the lot size, the nature of the site’s geological features, the composition of the soil, the incline of the surface, the stability and extremes of climate, zoning regulations, and cost of labor and materials. The architect must combine architectural principles with site parameters to design a specific building for a specific purpose on a specific site. ...This dynamic is mirrored in the rough-and-tumble world of the human services. Despite excellent plans and experience, ongoing redesign and adjustment may be necessary.”*

(Bauman, Stein & Ireys, 1991, p. 34)

Bauman, Stein, & Ireys (1991) refer to the “principle of program uniqueness”—that in its actual implementation, any program will have some unique elements because of the unique characteristics of the environment. They point out that many programs are created under unusual conditions (special funding, charismatic leaders, etc.) that are not widely available in the field. This principle of program uniqueness removes the debate from the level of the ideal—“Should we permit reinvention?”—to the actual issue: “How and what is going to change while still preserving core components faithfully?”

Reinvention of some operational components of programs is inevitable. In that context, fidelity by the innovative program to the prototype’s theory base is what is most critical. It is appropriate to modify, or even replace, procedural aspects of programs, but the theory-based intermediate outcomes must be maintained.

*“The ultimate goal is to maintain the basic integrity of a program model while matching the innovation to the unique features of the setting and the preferences/reactions of the relevant population.”*

(Jason, Durkal & Holton-Walker, 1984)

## Guidelines for Balancing Program Fidelity/Adaptation

*1 - Identify and understand the theory base behind the program.* Published literature on the program should provide a description of its theoretical underpinnings; if not, an inquiry to the program developer may yield this information.

This may or may not include a logic model that describes in linear fashion how the program works. The theory and logic model are not in themselves core components of a program, but they can help identify what the core components are, and how to measure them. This step also identifies core values or assumptions about the program that can be used to help persuade community stakeholders of the program's fit and importance for their environment.

*2 – Locate or conduct a core components analysis of the program.* This will provide implementers with a roster of the main “program ingredients,” and at least some sense of which components are essential to likely success and which are more amenable to modification, given local conditions. In essence, core components analysis represents a bridge between developer and implementer, and between fidelity and adaptation. Ideally, the program developer or a third party will already have conducted the core components analysis. If not, with good information about the program, an implementer can at least approximate this informally.

CSAP, through its National Center for the Advancement of Prevention, is undertaking a large-scale core components analysis of effective and model programs. Checking to see if a selected program is in the database of CSAP's National Registry of Effective Prevention Programs (NREPP) is a first step in determining the status of a core components analysis. For online access to this database, go to [www.samhsa.gov/csap/modelprograms/](http://www.samhsa.gov/csap/modelprograms/).

*3 – Assess fidelity/adaptation concerns for the particular implementation site.* This step means determining what adaptations may be necessary, given the target population, community environment, political and funding circumstances, etc.

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*4 – Consult as needed with the program developer to review the above steps and how they have shaped a plan for implementing the program in a particular setting. This may also include actual technical assistance from the developer or referral to peers who have implemented the program in somewhat similar settings.*

*5 – Consult with the organization and/or community in which the implementation will take place. This is a process to allow fears and resistance to surface, build support for the program, and obtain input on how to do the implementation successfully.*

*6 – Develop an overall implementation plan based on these inputs. Include a strategy for achieving and measuring fidelity/adaptation balance for the program to be implemented, both at the initial implementation and over time. By addressing all of the complex stages of implementation, such a plan can increase the opportunities for making choices that shape a program, while maintaining good fidelity.*

Taken from; “Finding the Balance: Program Fidelity and Adaptation in Substance Abuse Prevention”, SAMSA, 2002

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The following document was printed from the website of the California Evidence-Based Clearinghouse for Child Welfare (CEBC). The CEBC is focused on the identification of evidence-based practices (EBPs) and on the dissemination of that information. It is important to understand, however, that identifying EBPs is just one vital step in the process of implementing these practices in the real world of child welfare. In fact, the process of implementing new practices with fidelity in an established system is extraordinarily challenging. While each practice and each community present unique concerns, there are some common issues to consider when selecting a practice to adopt.

**Website:**<http://www.cachildwelfareclearinghousetest.org/>

**Organizational Readiness:** While there are numerous factors that influence an organization or a community's readiness to adopt a new practice, you will find a list below of common factors that should be taken into consideration. If any of these factors have not been addressed, the leadership of the change effort would be well advised to exert effort to bring the element of organizational readiness into alignment.

- **Leadership** - Does the senior leadership of the agency or agencies involved endorse and believe in the proposed change? That question must be asked of the program or clinical leadership of the agency and the front line supervisors. Unless and until all three levels are supportive, real change is very difficult and unlikely.
- **Support of opinion leaders** - In a similar vein how do the informal opinion leaders feel about the change? The support from such champions of the effort to adopt a new EBP is invaluable and their resistance can be fatal to the effort.
- **Staff** - The agency staff needs to understand the benefits that adoption of the EBP will bring to their clients, the organization, and their professional identity.
- **Time** - Adopting new practices takes time. Time is needed for training, to learn new processes, for added supervision and consultation and somehow the organization needs to find the time if they wish to succeed.
- **Connections with other supportive organizations/individuals** - Successful adoption will be enhanced if you can build a sense of community and mutual support among the staff working to adopt the new practice. That community can exist within an agency, across several agencies in the local area, or across the state or nation as the staff involved in the change effort are linked with others who have gone down the same path or are currently doing so.
- **Capacity to evaluate change** - Know if it is working - The presence of data feedback loops that give practitioners and supervisors real feedback as to the value and impact of their efforts to change helps reinforce the efforts to implement Evidence-Based practices.
- **Meaning to staff** - Understand the meaning the agency staff is placing on the change. It is important they attach a positive meaning to the effort, such as a means to improve their services or outcomes or their image in the community. If they see the change as a negative comment on their past efforts, they will be less supportive of the new effort.
- **Staff concerns** - Understand what concerns the staff has about the proposed change. Does successful adoption threaten their job security or status in any way?
- **Values** - How well does the proposed new practice fit with the values of the community, in general, and the clients to be served, in particular?
- **Financial support** - Are there ways to actually pay for ongoing service delivery once the practice is adopted?
- **Political support** - Is there political support from the County Board of Supervisors, or other key political leaders, that will help support the process through the developmental stages into routine practice?
- **Community support** - Are there advocates or families in the community will help support the process through the developmental stages into routine practice? **Summary prepared by Charles Wilson, MSSW, Executive Director, Chadwick Center**

## What About the Realities of Using Evidence-Based Programs?

There are increasing demands on project staff to choose incorporate evidence-based programs. Although many of these programs were developed with substantial funding and implemented under special conditions (e.g. university settings), the move toward accountability has increased the importance of local communities using proven programs.

Many situations exist where staff are unable to implement an evidence-based program for several reasons. First, an evidence-based program may not exist for their identified needs, selected target population, and/or environmental/cultural context. For example, does a family strengthening program developed in the Midwest generalize to families in the southeast? The answer is not always clear. Do the materials come in different languages? These are practical issues that need to be addressed when trying to replicate already "proven" programs.

Second, the monetary cost of many evidence-based prevention programs may be too high for community-based initiatives. This is a real challenge. Balancing the monetary costs of implementing an evidence-based program with an agency's own resources and capacities is something that each agency will have to address. The cost of NOT implementing an evidence-based program should also be considered. In other words, implementing a less-expensive program that does not lead to the desired changes in your target population is not an attractive alternative.

If funding is not sufficient to purchase a prepackaged, "evidence-based" program, a common question is, "Should I adapt or modify an evidence-based program?" If so, how can I adapt a program if I am supposed to be implementing the program close to how the developers intended (i.e., the issue of fidelity)? These are difficult questions and ones that many prevention researchers are trying to answer. So far, there are no easy answers, but the

**Fidelity is ...**  
the degree to which a program is implemented like the program developer intended.

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**Definition of Local Innovations**



Consumers, clients, and citizens as well as practitioners can and do develop new ideas about effective programming and put them into practice. For example, someone who was neither a scientist nor a practitioner developed one of the most effective treatments for alcoholism. The developer of Alcoholics Anonymous was simply someone who was seeking help for his own problem with alcohol. We are strong advocates that those working in the area of prevention frequently generate best practice information that should be accessible to all. However, these local innovations must at least meet the CSAP criteria for promising programs (show some positive outcomes, but not enough for effective program status) in order to be considered for continued implementation or dissemination. There are also community-developed programs that may be effective even though they have never been formally evaluated. Although the program may be accomplishing positive results in a particular community, it is hard to recommend the program to others without some positive evaluation results.

**Local innovations are ...**

knowledge that is developed from the field that has shown some positive outcomes.

**National Registry of Effective Prevention Programs (NREPP): Promoting Local Innovations**

To promote local innovations, CSAP has developed a registry of high-quality programs that come from local prevention practitioners. The following are 15 criteria these programs must meet to be included in NREPP.



Getting to Outcomes 2004, Matthew Chinman, Pamela Imm, Abraham Wandersman, Rand Corporation

## Definition of Program Fit



Program fit can be thought of in a variety of ways. In this question, the idea is that there should be an assessment of how the proposed intervention (chosen in the previous chapter) will fit with:

- values and practices of the community
- the characteristics (e.g., age, gender, ethnicity, language, rural/urban, level of need, etc.) of the target populations
- the philosophical mission of the host agency or organization
- the culture of the target population, which affects how they can be reached and best served (e.g., poor mothers with several young children at home may not be able to travel to distant programs)
- the community's level of readiness for the prevention intervention
- the priorities of key stakeholders, including funders, policymakers, service providers, community leaders, and program participants
- other programs and services that already exist to serve the targeted population.

### **Program fit is...**

the degree to which a selected best practice program fits within the program and community context.



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**PROGRAM ASSET ANALYSIS**

**Important!**  
Please remember that there is no magic bullet in prevention, and no one program will be sufficient. You must be comprehensive in your approach and work towards targeting multiple domains.

STEP 1	<p>Data Analysis</p> <ul style="list-style-type: none"> <li>• Identify by census tract communities of highest CWS confirmations</li> <li>• Identify by ethnicity highest CWS confirmations</li> <li>• Identify by age of child the highest CWS confirmations</li> </ul>
STEP 2:	<p>Plot current services by accessibility for targeted groups</p> <ul style="list-style-type: none"> <li>• Affordable</li> <li>• Culturally relevant</li> <li>• Language</li> <li>• Convenience               <ul style="list-style-type: none"> <li>• Scheduling</li> <li>• Childcare</li> <li>• Location/transportation</li> </ul> </li> </ul>
STEP 3:	Are current services modeled on an identified best or promising practice as identified in the CMP study (reference Key Findings Section B in “Adaptations for Practice”)
STEP 4:	Have those best/promising practices been adopted according to program fidelity standards?
STEP 5:	Identify service gaps
STEP 6:	Identify implementation challenges
STEP 7:	Identify organizational improvement needs
STEP 8:	You’ve got your plan

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Insert Prevention Service Continuum

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**ORGANIZATIONAL CAPACITY TOOL**

Agency: _____ Program Name _____ Person Completing Form _____ Date _____			
Capacity Assessment item	Considerations regarding the capacity	Is the capacity sufficient?	Plan to enhance the capacity
<b>Leadership</b>	Leadership understands the importance of the best and /or promising practice and supports the implementation by providing the necessary resources. ( money, access to training and technical assistance)		
<b>Logic Model</b>	A logic model has been developed by the agency to determine program assumptions, fit and proposed outcomes		
<b>Fidelity to Best Practice</b>	The program model can or has been implemented according to the guidelines for “ model fidelity”		
<b>Staffing</b> <ul style="list-style-type: none"> <li>• <b>Staff qualifications</b></li> <li>• <b>Staffing levels</b></li> <li>• <b>Staff training</b></li> </ul>	<ul style="list-style-type: none"> <li>• Staff have qualifications that meet minimum requirements</li> <li>• There are adequate numbers of staff to implement the program model according to its design</li> <li>• Staff has received training from a “certified trainer” of the chosen model.</li> </ul>		
	<ul style="list-style-type: none"> <li>• The program is</li> </ul>		

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<b>Engagement and Retention</b>	<p>perceived as <u>relevant</u> and of value to the target population.</p> <ul style="list-style-type: none"> <li>• The program supports and enhances the culture of its participants.</li> <li>• The rate of engagement and retention is greater than 50%</li> </ul>		
<b>Staff Turnover</b>	<p>The agency conducts an annual staff turnover study.  Note: every time a staff case management position turnover they lose upwards to 50% of their caseload.</p>		
<b>Accessibility</b>	<p>The program is designed to be accessible to working families; i.e. evening hours, childcare, transportation if necessary and food</p>		
<b>Clinical Supervision</b>	<p>The staff has access to professional clinical supervision in addition to administrative supervision.</p>		
<b>Long Term Relationship</b>	<p>Program participants have an opportunity to have an ongoing relationship with the agency providing the program service.</p>		