Iowa

EVIDENCE-BASED PRACTICES FOR THE PREVENTION OF CHILD ABUSE AND NEGLECT

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CONTENTS

PURPOSE

This review of literature addresses characteristics of effective, evidence-based programs designed to support families and reduce child abuse and neglect. Its purpose is to help the councils in Iowa to select the most effective programs or practices in their work with families, while learning a bit about what prevention curricula and models are available at this time.

Evidence-based practices (EBP) are generally described as methods supported by research that meet scientific standards. EBP is more important in social services and public health now than ever before; states such as Iowa are requiring the largest portion of the programs selected for delivery to be evidence-based and the others to be tested over time to see if they make a difference in the lives of families. Federal and private funding sources also want to know if programs and practices are proven to work (Benedetti, 2012; Buysse & Wesley, 2006; Chaffin & Friedrich, 2004). One purpose of the 1974 *Child Abuse and Neglect Prevention and Treatment Act* (CAPTA) and the more current amendment reauthorized as the *Keeping Children and Families Safe Act* of 2003, is to encourage providers to address maltreatment from a prevention perspective which includes research and evaluation in determining program effectiveness.

The National Alliance of Children's Trust and Prevention Funds developed criteria based on the work of Buysse and Wesley, the federal Centers for Disease Control and Prevention (CDC), and the Advisory Group to the Children's Bureau Office of Child Abuse and Neglect (OCAN) to determine levels of effectiveness[2]. These levels were used in the categorization of programs and practices considered in this paper. They are as follows, from lowest to highest evidence-base:

1. **Innovative Programs:** Professional experience and best available knowledge support the intervention that is undergoing evaluation to elicit family responses and to identify effectiveness under certain conditions with a selected group: 
2. **Promising Programs:** Professional experience and family endorsement affirm the effectiveness of evidence-informed programs that have not yet accumulated evidence of effectiveness under rigorous evaluation: 
3. **Supported Programs:** Scientific evidence of effectiveness is positive, professional experience is favorable, and family endorsement concurs but the programs have not been widely implemented. Evidence is favorable to implement a "supported program" under new conditions or a different population to generate more findings: 
4. **Exemplary Programs:** Rigorous scientific evidence, accumulated professional experience, and family endorsement concur on the effectiveness of programs through positive outcomes that are evident with diverse groups in different settings: 

2 Hornby Zeller Associates reviewed numerous categorizations of evidence-based effectiveness but determined the categories and criteria developed by the National Alliance of Children's Trust and Prevention Funds to be the most suitable for this paper's purpose.

Consistent with the prevention programs in Iowa now, Hornby Zeller Associates, Inc. (HZA) conducted a thorough search of available literature on programs in the following categories:

- Home Visiting
- Parent Education and Development
- Child Sexual Abuse Prevention
- Respite and Crisis Care Services
- Social Support Services

Note that some programs categorized under one type may also fit under another (e.g., Social Support programs could be Parent Education or Home Visiting, or both). HZA limited the search to frequently-referenced or well-regarded programs that had any level of effectiveness using the above Children's Trust proposed levels of effectiveness as well as those programs currently in place in Iowa. When using academic databases, HZA limited its search to those with full text available, and those written between 1990 and 2014, ideally published in peer-reviewed or scholarly journals. In many cases we accessed the developer's website for additional clarification and self-identified supporting research. (See Appendix A for a complete list of sources of literature and websites.)

Some programs in this paper have been in operation for many years and have been widely studied; the results are summarized, but without extensive detail.

The search resulted in a broad range of curricula and programs that have been implemented with fidelity and evidence as well as smaller-scale programs that may not have supporting research though could be characterized as promising or innovative practices. In addition, some programs are relatively new, but have gained popularity among prevention professionals, therefore a short overview is provided, where possible. The paper concludes with a brief description of common elements of highly-effective programs for Iowa to consider, even if other programs that are not included here are selected and/or used.

HOME VISITING

Home visiting programs provide individualized support for parents in the home using a variety of curricula and service delivery models. Home visiting is also effective at increasing social support and reducing isolation. Though available to any families regardless of their circumstances, home visiting programs tend to identify high-need, high-risk families with newborn or very young children, and some target prenatal populations. Home visitors meet with the family at an agreed-upon time, ideally at a frequency and intensity that matches the family need. Professionals or para-professionals are trained to provide education, support, referrals to community based services, and model appropriate caregiving strategies. Research on many of these programs is extensive, but results are varied. The following programs are summarized in this report; note that extensive information is available from the Administration for Children and Families http://homvee.acf.hhs.gov/.

Title of Program or Curriculum	In Iowa Now?	Target Population[3]	California Evidence Based Clearinghouse Scientific Rating	Effectiveness Score[4]	SAMHSA National Registry (NREPP)
Nurse Family Partnerships (NFP)	✓	First-time families with risk factors	1	Exemplary	Listed
Parents as Teachers (PAT)	✓	Families with children under 5	3	Exemplary	Listed
Healthy Families America (HFA)	✓	Families with risk factors and children under 5	1	Promising	Listed
SafeCare Augmented		High-risk families for abuse/neglect	2	Promising	Not listed
ChildFIRST		High risk families for abuse/neglect	-	Promising	Not Listed
Family Thriving Program		High risk families for abuse/neglect	-	Promising	Not Listed
Step by Step Parenting Program		Parents with intellectual/develop-mental delay	3	Promising	Not Listed
Exchange Parent Aide		High risk families for abuse/neglect	3	Supported	Not Listed

[3] Description of specific target group included.
[4] Using criteria developed by the National Alliance of Children's Trust and Prevention Funds, Evidence-Based Practice Committee 2009.

Nurse Family Partnerships

Purpose: *Nurse Family Partnerships* (NFP) is an early childhood home visiting program that employs nurses as home visitors and targets high-risk, first-time mothers. The program has many inter-related objectives toward improving health outcomes for parents and children:

- Increasing positive connections between parents and children:
- Assuring women have access to good prenatal and postnatal care;
- Reducing the use of tobacco, alcohol and illegal substances;
- Encouraging positive, appropriate parenting practices;
- Reducing unintended pregnancy;
- Promoting family economic self-sufficiency;
- Promoting school readiness, improving child health and development; and
- Reducing child maltreatment.

How delivered: Weekly or biweekly home visits are delivered typically for 90 - minute sessions, beginning prenatally and continuing through the child's second birthday (frequency and intensity depends on the child's age).

Availability/cost: NFP is currently located in 34 states including Iowa and actively recruits new locations and promotes the home visiting field as a component of the nursing profession. The training and ongoing support to staff are extensive. According to the program developers, the benefits of NFP far outweigh the costs. The cost per family is estimated at $4,500 per year, with a range between $2,914 and $6,463, with the majority of the cost covering the nursing staff salaries (Retrieved December 2012 from http://www.nursefamilypartnership.org/assets/PDF/Fact-sheets/NFP_Benefits-Cost)

Evidence base: NFP has been rigorously studied and widely implemented since 1977 (Gomby, 2005; Gonzalez & MacMillan, 2008; Karoly et al.,. 2005; Sweet & Applebaum, 2004; The Future of Children, 1999). Several rigorous studies suggest that NFP effectively improved women's health and pregnancy outcomes, decreased negative behaviors in children, and prevented associated problems such as child abuse, maternal substance abuse and maternal crime involvement as well as juvenile crimes later in life (Gonzalez & MacMillan, 2008; Howard & Brooks-Gunn, 2009; Olds, Hill, Rumsey, 1998; Paulsell et al., 2010)[5].

NFP is commonly touted as the most widely-accepted and well-developed home visiting model, particularly for high-risk families (Chaffin & Friedrich, 2004; Howard & Brooks-Gunn, 2009). The elements that make NFP a high-quality program include: trained, experienced home visitors; home visits that begin in early pregnancy and continue over a long-term; regular visits scheduled every one to two weeks; a reasonable caseload for direct service staff; and the inclusion of family members in program development, to name a few.

[5] To access the complete list of published research, see the Nurse Family Partnership website: http://www.nursefamilypartnership.org/Proven-Results/Published-research

This particular form of nurse-based home visiting has also proven to be cost-effective. When the program is focused on low-income women, the government's cost to fund the program is recovered by the time the child reaches four years old. Youth whose mothers received home visiting services were 60 percent less likely to have run away, 55 percent less likely to have been arrested, and 80 percent less likely to be convicted of a crime. They also smoked fewer cigarettes per a day, drank less alcohol in the prior six months, and exhibited less behavioral problems due to drugs and alcohol than those whose mothers had not received home visiting services (Olds, et al., 1997; Olds, Hill, Rumsey, 1998).

Parents as Teachers 

Purpose: *Parents as Teachers* (PAT) is a voluntary program designed to partner with new parents to address the health and developmental priorities of families with young children. While PAT does not dictate specific criteria for eligibility, PAT providers typically focus their efforts on families who are pregnant and/or parenting a newborn through children under five years old. According to the PAT Annual Report for 2011-12, "Recognizing that children learn, grow and develop within the context of 'family,' *Parents as Teachers* embraced a deeper approach this year…one that focuses on parent/family well-being; on strengths, capabilities and skills; and on building protective factors within the family." The program goals include focusing on effective parenting strategies, knowledge of child development, and parent-child relationships through one-on-one home visits, child screenings, group activities, community events, and by providing resources and referrals to other agencies.

The goals of the PAT program as articulated by the Parents as Teachers National Center, 2013 are summarized as follows:

1. Increase parent knowledge of early childhood development and improve parenting practices;
2. Provide early detection of developmental delays and health issues;
3. Prevent child abuse and neglect; and
4. Increase children's school readiness and school success.

How delivered: Home visitors who are trained and accredited by PAT provide parents support and information in a range of child development and health topics to improve outcomes for the family through regularly-scheduled home visits (frequency depends upon the family's needs). Visits include parent-friendly developmental screening for the enrolled children such as the Ages and Stages Questionnaire (ASQ), along with family-centered assessments of basic needs, parenting practices, and various health and safety topics. These tools help the parent educator and caregivers uncover the strengths, resources and needs for each family. PAT also offers opportunities for families to connect with each other through socialization events or groups.

Availability/cost: The Administration for Children and Families HoMVEE online reference for evidence-based home visiting programs provides an estimated per family cost of $2,652 per year (based on visits twice a month and monthly socializations) for PAT. Annual professional development fees per parent educator and supervisor are approximately $350. Benefits to affiliate users include printed guides for personal use and access to additional online resources. The difference in cost is dependent on different pathways to professional development, one being the basis for all implementation, the other more detailed information provided as a continuation of the foundational knowledge; the PAT *Foundational* training is $800, the *Foundational* combined with *Model Implementation* is slightly higher at

$915 per person, though prices can vary based on location. For more information: http://homvee.acf.hhs.gov/Implementation/3/Parents-as-Teachers-PAT--Program-Model-Overview/16

Evidence base: Looking at the relationship of the goals outlined above and the PAT curriculum design the most positive results *overall* occurred with very low income families. These results were found in both parenting and child development measures. Regardless of family socio-economic status, but in consideration of efforts to reduce maltreatment of any kind, numerous studies cited home visiting models such as PAT as effective in engaging parents in learning about their child's development and influencing child-rearing practices, which ultimately reduces the risk of abuse and neglect (Gomby, 2005; Stagner & Lansing, 2009; Sweet & Appelbaum, 2004; Wagner, Spiker & Linn, 2002). While PAT does not explicitly target certain populations, by setting a goal to prevent child abuse and neglect, the PAT home visitors must consider populations who are at greatest risk for maltreatment. Numerous studies demonstrate the correlation of maltreatment with specific risk factors like, substance abuse, domestic violence, single parenting, and teen pregnancy (Stagner & Lansing, 2009). PAT operates with a primary prevention approach: "attempting to influence the attitudes and behaviors of the population," (p.26), meaning the program contributes to increasing families protective factors and reducing the potential or existing risk factors with the flexibility of targeting the specific risks that a family may present.

Healthy Families America

Purpose: *Healthy Families America* (HFA) is a home visiting program that targets high-risk families who are expecting a baby or who have children under five. HFA is affiliated with Prevent Child Abuse America (PCA) and as such is the primary home visitation model used by PCA in working to reduce child abuse and neglect and other adverse childhood experiences. As indicated on the website for HFA, "the HFA model is based upon *Twelve Critical Elements* derived from more than 30 years of research to ensure programs are effective in working with families. These *Critical Elements* are operationalized through a series of best practice standards that provide a solid structure for quality yet offer programs the flexibility to design services specifically to meet the unique needs of families and communities." The program asserts that different communities have different needs that can be addressed through their structured prevention service, when provided as part of a system of care.

How delivered: Identified families are served by paraprofessionals through regular home visits, and as necessary referrals to ancillary services related to basic needs, mental health or substance abuse, school readiness, employment, and childcare. This program is flexible in that it does not have a prescribed or rigid method of service delivery, though all programs must adhere to the program's goals toward preventing child maltreatment which include:

1. To systematically reach out to parents to offer resources and support;
2. To cultivate the growth of nurturing, responsive, parent-child relationships;
3. To promote healthy childhood growth and development; and
4. To build the foundations for strong family functioning.

Availability/cost: The Administration for Children and Families HoMVEE online reference for evidence-based home visiting programs provides an estimated per family cost between $3,214 and $3,892 per year, depending on the number of families served. The cost to programs is $500 per year for annual affiliation and credentialing fees; training is $3,800 for a certified HFA trainer, and a materials fee of $40 per participant. Two trainers are provided for each primary training (the maximum number of participants allowed in a training group is between 12 and 15 participants, depending on the level.)

Evidence base: HFA has been extensively studied; there are approximately 30 evaluations completed or are in- process across the country, including three randomized control trials and numerous quasi-experimental studies (Duggan et al., 2000, 2004, 2007; Howard & Brooks-Gunn, 2009; Gonzalez & MacMillan, 2008). According to the HFA website, in 2006, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) rated HFA as an "effective" program. While HFA and Prevent Child Abuse America studies continue, the randomized trials completed did not determine that home visiting services were effective in preventing child maltreatment exclusively, though other high and moderate-quality impact studies showed favorable results for secondary outcome measures. Some outcomes related to

prevention are difficult to capture in randomized control trials, given the nature of trying to show what did not happen (e.g., abuse or neglect) as a result of certain program efforts. These studies concluded with remarks to continue evaluation and research in effective, evidence-based programs for high-risk populations (Duggan et al., 2004, 2007; Gonzalez & MacMillan, 2008; Paulsell et al., 2010).

Reviews of more than 15 evaluation studies of HFA programs in 12 states produced the following outcomes[6]:

- Reduced child maltreatment;
- Increased prenatal care and decreased pre-term, low weight births;
- Improved parent-child interaction and school readiness;
- Decreased dependency on Temporary Assistance to Needy Families (TANF) and other social services;
- Increased access to primary care services; and
- Increased immunization rates.

[6] Retrieved November 2014 from http://www.healthyfamiliesamerica.org/research/index.shtml

SafeCare Augmented

Purpose: *SafeCare Augmented* is based on *Project 12-Ways* and *SafeCare* developed by Georgia State University. The program uses trained professionals to work with families who are at-risk of abuse or neglect in their homes to improve parents' skills in several domains. The areas of focus include teaching how to respond appropriately to child behaviors, how to improve home safety, and child health and safety issues. *SafeCare* is generally provided in weekly home visits lasting between one and two hours. The program typically lasts 18-20 weeks for each family.

How delivered: Following the guidelines of the curriculum using four preset modules: Health, Home Safety, Parent-Child/Parent-Infant Interactions, Problem Solving and Counseling, parents are taught so that skills gained are generalizable for various environments and experiences with their child. Each module is implemented through approximately one assessment session and five training sessions and is followed by a "social validation questionnaire" to assess parent satisfaction with training. Home visitors work with parents until they meet a set of skill-based criteria that are established for each module. All modules involve baseline assessment, intervention (training) and follow-up assessments to monitor change. *SafeCare Augmented* also includes motivational interviewing and additional training of home visitors in identification and response to family risk factors and child maltreatment, such as substance use and mental illness. *SafeCare Augmented* was adapted for high-risk, rural communities.

Availability/cost: The cost of *SafeCare* model varies according to the number of individuals trained, and the level of training needed. For more information http://safecare.publichealth.gsu.edu/. For price estimates, customers are advised to email requests to: safecareinfo@gsu.edu.

Evidence base: This model in included in the list of 17 home visiting models that meet the DHHS criteria for evidence-based early childhood home visiting service delivery. *SafeCare Augmented* meets the DHHS criteria because there is at least one high or moderate quality impact study with favorable, statistically significant impacts in at least two of the eight outcome domains. At least one of these impacts is from a randomized controlled trial that has been published in a peer-reviewed journal. At least one of the favorable impacts from the randomized controlled trial was sustained for at least one year after program enrollment (See http://homvee.acf.hhs.gov/document.aspx?sid=18&rid=1&mid=1 for full list of relevant studies). According to the National SafeCare Training and Research Center, "Adding *SafeCare* to an in-home service program reduced child welfare reports for neglect and abuse by about 26 percent compared to the same in-home services without *SafeCare* for parents of children ages 0-5…. The study is the largest and longest randomized trial within a child welfare system to date that shows such a positive impact on child maltreatment recidivism." Retrieved November 2014 from http://publichealth.gsu.edu/968.html.

ChildFIRST

Purpose: *ChildFIRST* coordinates services and therapeutic support to decrease problematic outcomes for youth, including behavioral and emotional problems, developmental and learning difficulties, and abuse and neglect among high-risk families. The home visiting service is shaped by recent developments in neuroscience, which suggest that toxic environments (including poverty-ridden environments) can lead to negative outcomes. By combining mental health, early care and education, health care and social support programming, *ChildFIRST* seeks to "improve parent-child relationships while creating an environment for healthy emotional and cognitive development" (Benedetti, 2012).

How delivered: *ChildFIRST* begins with a detailed family assessment including a family observation conducted by a clinician and care coordinator. With this information, the team (which is comprised of the family members, clinician, and care coordinator) develop a Child and Family Plan of Care. This plan includes determining goals, parent priorities, strengths, culture, and needs of the family. Weekly home visits teach parents about child development, behavior and age-appropriate expectations; help parents understand the long-term effects of trauma; review and practice problem solving strategies; and provide time for parent reflection on difficulties. An important component of this program is that it provides social support and connections to appropriate services. For more information, please see http://homvee.acf.hhs.gov/Model/1/Child-FIRST/42/1.

Availability/Cost: Currently *ChildFIRST* only operates in the state of Connecticut. However, in 2015, the program intends to expand and replicate the model into other sites. For more information, please see http://www.*ChildFIRST*.com/.

Evidence base: One randomized control study has been published to date for *ChildFIRST*. This study found improvement to maternal health, reduction in child maltreatment, and increase in child development and school readiness (Lowell et al., 2011).

Family Thriving Program

Purpose: Used in conjunction with home visiting programs, this program seeks to use "cognitive reframing" as a way to challenge and correct negative biases expressed by new parents towards their children. Not unlike other similar supports, the main object is to prevent child abuse and neglect. The *Family Thriving Program* is designed to be an ancillary support or an enhancement to existing home visiting programs. For more information, please see http://www.promisingpractices.net/program.asp?programid=271.

How delivered: *Family Thriving Program* is used as an enhancement curriculum to working with families already receiving home visiting services. The home visitor uses cognitive and motivational reframing to engage parents and identify the root cause of caregiver challenges and perceptions of their child's behavior and development. Together, the parent and home visitor consider the issue from different perspectives, and decide on a strategy to best address the challenges at hand. At subsequent home visits, the home visitor follows up to find out whether the strategies were followed, and if so, if they were effective for the family.

Availability/Cost: There is little information available on the specific agencies or organizations that currently use the *Family Thriving Program* outside of California. There is additional training required for home visiting staff, available through the developers: https://labs.psych.ucsb.edu/bugental/daphne/ftp-tapes/index.html.

Evidence base: The program has been evaluated by combining *Family Thriving Program* with the *Healthy Start* home visiting program. Through a number of peer-reviewed articles that have substantiated the efficacy of the program, researchers compared families receiving *Health Start* home visiting program with the *Family Thriving Program* enhancement, families receiving the "unenhanced" *Health Start* home visiting program, and families receiving no home visiting services. In these groups, four percent of families receiving the enhancement reported physical child abuse, compared to 23 percent receiving *Healthy Start* services, and 26 percent who received no intervention (Burgental et al., 2002). Several studies show youth who received the enhanced home visiting treatment had superior health outcomes compared to both those who received unenhanced home visiting services, and those who had no home visiting services (Burgental et al., 2010).

Step by Step Parenting Program

Purpose: The *Step by Step Parenting Program* is designed to help parents with learning and intellectual disabilities learn to parent properly in order to reduce and prevent child abuse and neglect. However, the developers purport that the program is useful to other populations of parents. The program divides guidance to parenting newborns through three year olds into small, manageable steps; topics include: feeding and nutrition, diapering, bathing, sleeping safety, first aid, toilet training, parent-child interactions and positive behavior support. Goals include "1. Objectively identify impediments and supports to successful parenting, and specific parenting skill deficits; 2. Help organize supports and services to meet the family's needs and keep the child safe; 3. Increase parenting skills to reduce the risk of, or actual, child neglect through in-home step-by-step parent training; 4. Improve child health, development and behavior problems related to parenting skill deficits; 5. Help parents maintain learned skills over time and generalize skills to all needed situations; 6. Reduce need for out-of-home placements and removal of the child; 7. Help parents decrease reliance on paid supports; and 8. Help parents develop a natural support network for the family." For more information, please see http://www.cebc4cw.org/program/step-by-step-parenting-program/detailed.

How delivered: *Step by Step Parenting* is delivered through weekly home visits lasting 1.5 to two hours, though more frequent visits may be arranged, especially for families with newborns. The program includes pre-defined essential components intended to be used with families for up to two years. First, there is an assessment to determine risks, impediments and issues that exist for the family. The results of the assessment also provide information required to create a treatment plan, which may be in collaboration with child welfare agencies, other service providers, and family supports as needed. Next, the home visitor encourages using the *Step by Step* checklists for parenting help. The home visitor also directly helps with parenting and teaching parenting skills. As the parent becomes more comfortable with their skills, and as they use them repeatedly with their child, services are phased out.

Availability/Cost: There is no information available regarding extensiveness of use or cost of program.

Evidence base: Extensive research for Step by Step Parenting Program shows that the program demonstrated positive outcomes including rapid and sustained parenting skills for low-functioning mothers (Feldman et al., 1986; 1989; 1992a; 1992b; 1993; 1997a; 1997b; 1999a; 1999b; McDaniel & Dillenberger, 2007).

Exchange Parent Aide

Purpose: *Exchange Parent Aide* is a home visiting program that is designed to help prevent child abuse and neglect through assuring child safety, improving parenting and problem solving skills and improving social supports. Families that are at risk of child abuse or neglect, who voluntarily agree to engage in services, are matched with trained and qualified Parent Aides, who provide education and support to at risk families. The program focuses on strength based, family centered services.

How delivered: At-risk families who agree to participate in the program are assigned a Parent Aide, who is either a volunteer or paid staff member of the *Exchange Parent Aide* program. Families are given an Initial Needs Assessment (INA), which identifies abuse histories, needs of the family, internal relationships, coping skills, and other basic information about the family. From this information, a treatment plan is created. The treatment plan focuses on "child safety, problem solving skills, parenting skills, and social support." The Parent Aide then begins visiting the home once or twice weekly for several months, providing the family with support and education, and helping them achieve goals on the treatment plan. There are weekly phone calls as well, and parents have access to their Parent Aide 24 hours a day, seven days a week. These in-home services are long term, and designed to last between nine and twelve months. For further information, please see http://www.cebc4cw.org/program/exchange-parent-aide/detailed.

Availability/Cost: The *Exchange Parent Aide* model has been practiced in 70 locations across the United States since 1981. The program has reportedly helped 700,000 families and 1.7 million children since inception; however, it is unclear if these numbers reflect the *Exchange Parent Aide* program exclusively, or all participants in its affiliate programs. Although the program extensively outlines how agency staff can become accredited, there is no information on cost that is publicly available. For more information, please see https://www.preventchildabuse.com/.

Evidence base: Two peer-reviewed studies have been conducted on *Exchange Parent Aide*; however, one has considerable design concerns in the selection of the control groups (Harder, 2005). The second is a randomized control study (Guterman et al., 2013). These studies showed that families involved with *Exchange Parent Aide* had fewer subsequent substantiated child abuse allegations (Harder, 2005), and had fewer child abuse risk factors after treatment than families not involved in treatment (Guterman et al.,2013).

PARENT EDUCATION AND DEVELOPMENT

Prevention programs designed to provide caregivers with education and support in methods of parenting can be effective in reducing the incidence of child abuse and neglect. Because there is such diversity in the types of programs offered and service delivery options suggested, it is difficult to know exactly which components or strategies are most effective in parent support programs. What is known, however, based on research to date, is that programs that target the highest risk populations see the greatest positive effect (Daro, 2006; Daro & McCurdy, 1994; Gonzalez & MacMillan, 2008; Huebner, 2002). According to a meta-analysis of prevention programs targeted to work with parents with young children, "the greatest benefits are seen in programs that begin prenatally or at birth, and provide services for more than six months," or for home visiting: a minimum of twelve visits (MacLeod & Nelson, 2000 as cited in Huebner, 2002).

This section describes a selection of evidence-based or evidence-informed programs that can be incorporated into the system of prevention efforts. There are many more programs available that offer a wide variety of service delivery options and some that are designed to work with very specific programs while others are universally available. Note that this list is not exhaustive, though it provides a cross-section of the types of parent development and social support programs commonly used by prevention teams. The programs included in this review are listed in the table on the following page.

Title of Program or Curriculum	In Iowa Now?	Target Population[7]	California Evidence Based Clearinghouse Scientific Rating	Effective-ness Score[8]	SAMHSA National Registry? NREPP[9]
Incredible Years	✓	Families with children 2-10 yrs having difficulty	1	Exemplary	Model Program
Parent Child Interactive Therapy (PCIT)	✓	Families with children 2-6 yrs having difficulty	1	Exemplary	Model Program
Triple P (Positive Parenting Program)		Families with children 0-16 yrs	1	Exemplary	Model Program
Parents Anonymous, Inc.	✓	Families at risk for abuse or neglect	3	Supported	Not Listed
Strengthening Families Program	✓	Families at risk for abuse or neglect	-	Supported	Model Program
Families and Schools Together (FAST)		All families, partnering with schools	-	Supported	Listed
Systematic Training for Effective Parenting (STEP)	✓	Families with children 0-3 yrs at risk for abuse or neglect	3	Supported	Listed
Nurturing Parenting Programs (NPP)	✓	Families with children of all ages	No Rating	Promising	Listed
24/7 Dad	✓	Fathers	-	Promising	Not Listed
Active Parenting Now	✓	Families with children 2-12 yrs	No Rating	Promising	Listed

[7] Description of specific target group included.

[8] Using criteria developed by the National Alliance of Children's Trust and Prevention Funds, Evidence-Based Practice Committee 2009.

9 The Substance Abuse and Mental Health Service Administration developed a National Registry of Evidence-based Programs and Practices (NREPP) with somewhat different categorizations as than those used by the NACTF; included here as a second reference.

Incredible Years

Purpose: The *Incredible Years* (IY) program for parents seeks to reduce challenging behaviors, increase social skills, and encourage self-control abilities in children. Concurrent to these goals for children, goals for parents are intended to promote social support, positive discipline and encourage parent involvement in the child's education experiences. This program is geared toward families with children who have been identified as having challenging behavior, either due to the child's development or experiences or the parenting strategies or skills.

How delivered: The IY programs are delivered to groups of parents, organized by the child's age offered at various frequencies and intensities depending on the program series selected[10]. Parents use the group times to collectively and individually develop new guidance strategies for their children.

Availability/cost: The *Incredible Years* curriculum cost is between $1,395 and $1,995 for materials and about $400 for the optional certification fee; consultation services can be costly at $600 per participant. Costs vary depending on location and components, as the IY is implemented internationally it is difficult to define the true range; estimated costs include $476 for each parent in parent groups, $775 for each child in child treatment groups, and $30 for each teacher receiving the teacher training. For more information: *http://incredibleyears.com/ or http://nrepp.samhsa.gov/ViewIntervention.aspx?id=311*

Evidence-base: According to the website, IY has been evaluated by the developers and independent researchers in at least 18 states and 15 countries beyond the United States. The more rigorous studies have included randomized control trials with diverse groups of adults, uncommon in prevention programs research. "The programs have been found to be effective in strengthening teacher and parent management skills, improving children's social competence and reducing behavior problems" (McGilloway et al., 2010, reported from the Incredible Years Ireland Study as one prominent and recent example).

Through this research review, numerous studies were found to label the *Incredible Years* as one of the most effective programs for reducing undesirable behaviors in children thereby reducing the risk of maltreatment (Barth et al., 2005; Eames et al., 2009; Jamila Reid, Webster-Stratton, & Baydar, 2004). Likewise many studies found the program effective in increasing positive parenting behaviors and decreasing negative behaviors, particularly with those that were long-term and more intense (Barth, 2009; Beckmann, Knitzer, Cooper & Dicker, 2010; Eames et al., 2009).

[10] Incredible Years also has a component designed for teachers, and a component designed for children in a group setting. See website www.incredibleyears.com for details on these development-based programs.

Parent-Child Interaction Therapy (PCIT) 

Purpose: *Parent- Child Interaction Therapy* is categorized as a relationship-based therapy based primarily on attachment theory (Beckmann et al., 2010). PCIT is a great example of the merging of social work, adult education, early childhood intervention, and child abuse prevention. The program was originally designed for children with very difficult behaviors and families who have young children with diagnosed conduct disorders. PCIT has since been adapted to suit families with young children under twelve with history of physical abuse, child behavior issues, or for parents who wish to improve their parenting skills, targeting specific skills for improvement.

How delivered: PCIT follows a very specific protocol and requires specialized training and supervision. Treatment is generally provided by a mental health professional, through one or two one-hour weekly sessions lasting twelve to twenty weeks. This program is described by the developers as "mastery-based," meaning the dosage depends on the acquired skill and success over time. The interesting training methods used include an audio feedback system, where the parent is observed interacting with the child and given cues through a headset discreetly placed in the ear. The child is not aware that the parent has an audio feed, nor do they know that they are being observed.

Availability/cost: PCIT is available throughout the United States to qualified and trained clinicians. In 2009 NREPP provided a general cost estimate of $1,000 for the necessary training materials and between $3,000-4,000 per person to be completely trained and scheduled for the required follow-up consultation. A study of high-risk families involved in the child welfare system estimated the cost for each parent-child pair completing the program to be $2,208-$3,638 (Chaffin et al., 2004). Retrieved July 2011 from *http://nrepp.samhsa.gov/ViewIntervention.aspx?id=23*

Evidence base: The current research has demonstrated the effectiveness of the PCIT program in increasing parent skills and confidence as well as nurturing affect (Barth, 2009; Beckmann et al., 2010; Chaffin & Friedrich, 2004). This program is regarded as a model parent development program in "improving parent competence and reducing child maltreatment" (Barth, 2009; Beckmann et al., 2010; Benedetti, 2012; Chaffin & Friedrich, 2004). There is rigorous research continuing directly through PCIT laboratories and in eight universities throughout the United States; the program places a priority on connecting direct service providers with the academic research to assure continuous connection and refining of practice (http://www.pcit.org/).

Triple P (Positive Parenting Program) 

Purpose: *Triple P* is currently one of the leading parent training programs in the United States (and Australia, which is where it began), designed to reduce challenging behaviors; improve parenting knowledge, confidence and skills; and encourage healthy home environments.

How delivered: This program uses a developmental approach that incorporates various theories of intervention including applied behavior analysis (ABA), social learning, family systems, and psychopathology within a public health and systems of care framework (Nowak & Heinrichs, 2008). This parent education and outreach program is family-focused and has multiple layers of intensity, each building on the previous step. Target populations for each step are defined, though with the multiple levels, and all families with children can participate.

Availability/cost: *Triple P* founders are located in Queensland, Australia, though providers can be trained in the United States at select times and locations (see website http://www.triplep-america.com/index.html for details). Provider training courses are offered only to professionals with post-secondary qualifications in Health, Education, or Social Services. Practitioners should have some knowledge of child and adolescent development and have some experience working with families as prerequisites. Programs may adopt all levels of the *Triple P* system or choose to select desired levels of *Triple P*. The greatest cost for the program is in the training required for new staff who wish to implement *Triple P*. This can cost between $21,495 and $26,195 for up to twenty staff; there is clinical and pre or post-accreditation support available for about $3,000 per day, optional but necessary for programs participating in evaluation and quality control. The materials needed for each parent participant range in cost between $20 and $39 per person.

Evidence-base: *Triple P* has been widely implemented and evaluated with rigorous studies extensively covered in a meta-analysis completed in 2008. SAMHSA's National Registry of Evidence-Based Programs and Practices provided key findings for *Triple P*, "with research findings first published in the early 1980s, *Triple P* has been examined in a series of controlled outcome studies with results published in more than 90 articles. More than 40,000 service providers around the world have received professional training in *Triple P*. The program has been implemented in Australia, Belgium, Canada, England, Germany, Hong Kong, Iran, Japan, the Netherlands, New Zealand, Romania, Singapore, Switzerland, and the United States."

In one of the more prominent studies summarized, Sanders, Prinz, et al. (2009) examined the difference in the pre-post change across communities and found statistically significant effects of *Triple P* on all three measured outcomes from pre- to posttest. Specifically:

1. Substantiated rates of child maltreatment grew in the control counties during the implementation period, from 11.12 cases per 1,000 children to 15.06 cases per 1,000. In the treatment communities, substantiated cases of child abuse and neglect did not change significantly over the course of the intervention;
2. Out-of-home placements in the treatment counties fell from 4.27 to 3.75 per 1,000 children, compared with an increase in the control counties from 3.10 to 4.46 per thousand;
3. Rates of child hospitalizations and emergency room visits resulting from child maltreatment fell from 1.73 to 1.41 cases per 1,000 in the treatment communities, compared with an increase in the control communities from 1.41 to 1.69 per 1,000.

Triple P is a highly-effective program that is far -reaching in attempt to customize the curriculum according to family and community need, incorporating a professional development component for service providers, and awareness of the importance of child abuse prevention through effective mass-media efforts (Barth, 2009; Nowak & Heinrichs, 2008; Sanders, Prinz, et al., 2008).

Parents Anonymous, Inc. 

Purpose: *Parents Anonymous, Inc.* is the nation's oldest and largest child abuse prevention, education and treatment program (Rafael & Pion-Berlin, 2000) delivered as a peer support group model. The program was originally designed for working with high risk populations, though according to their website, "*Parents Anonymous* welcomes any parent or adult in a parenting role who feels stress and concern about their parenting ability and seeks support, information and training."

How delivered: The structured training follows the curriculum through weekly meetings with a certified instructor. (Parent meetings are held separately but concurrently with optional children's groups). Parents learn to use appropriate methods of communication and work on building a network of positive peer relationships for themselves and their families.

The unique and effective aspects of the program include groups being co-facilitated by a parent leader and the professionally-trained facilitator; parents determine the agenda at the beginning of each meeting; basic parenting skills such as communication and discipline are always reviewed at every meeting; and there is 24 hour support to parents when they experience stress or crises. The children's program activities help them develop skills in conflict resolution, appropriate peer interactions, identifying and communicating thoughts and emotions, and increasing self-esteem (Rafael & Pion-Berlin, 2000).

Availability/cost: There is no cost for partnering with *Parents Anonymous, Inc.*; however agencies planning to develop Parents Anonymous programs must contact and work directly with Parents Anonymous, Inc. to become accredited and trained in the model.

Parents Anonymous actively seeks donations and financial support for a variety of sources. This funding allows them to provide this free service to families through a variety of groups and workshops, and welcome the opportunity to partner with organizations interested in becoming accredited in effort to expand *Parents Anonymous* programs.

Evidence base: *Parents Anonymous* has been independently evaluated and when compared to eleven other programs, has been found to be most successful in parent satisfaction, child welfare outcomes, and cost effectiveness (ibid.). One study found an almost immediate decrease in reported frequency of physical abuse. Parents developed feelings of competence in their parenting role and ability to deal with stress. Length of time in the program was significantly correlated to increased self-esteem and increased knowledge about child behavior and development (Barth, 2009; National Council on Crime and Delinquency 2008; Polinsky et al., 2010).

Strengthening Families Program

Purpose: The purpose of the *Strengthening Families Program* is to "increase resilience and reduce risk factors for substance abuse, depression, violence and aggression, delinquency and school failure in high-risk, six to twelve year old children and their parents" (Kumpfer, 1999).

How delivered: The *Strengthening Families* curriculum is delivered through 14 sessions, organized in three courses: Parent Skills Training, Children Skills Training, and Family Life Skills Training. Two group leaders typically work with parents and children separately at first, then each group has had the opportunity to practice their new skills. Participants are provided meals, incentives, child care, and ideas for follow through (including homework assignments) after the sessions. Positive participation is rewarded, and "booster" sessions are arranged after the initial series is complete.

Availability/cost: The *Strengthening Families Program* is available in every state as well as a number of other countries. The six-book master set of materials on CD, including evaluation instruments, implementation forms and a license to copy all needed materials for the agency's own use costs each program around $450. The cost to hire two trainers to travel to a site and deliver the program is $3,650 for a group of 35 or less. The developers encourage smaller programs to partner together and share the cost of training (though purchase their own materials). This program has a wide range in the cost for evaluation, between $1,950 and $12,000 depending on the number of participants, staff to be involved, and evaluation reports needed.

Evidence base: According to the developers and the *Strengthening Families* website, positive results from over 15 independent research replications demonstrate that the program is robust and effective in increasing protective factors through: strengthening family relationships, parenting skills, and improving children's social skills. *Strengthening Families* has been modified for African American, Asian/Pacific Islander, Hispanic and American Indian families, rural families, and families with early teens. Although originally developed for children of families with substance abuse issues, *Strengthening Families* is effective and widely used with non-substance abusing parents in many settings: schools, churches, mental health centers, housing projects, homeless shelters, recreation centers, family centers, and drug courts (Kumpfer, 2002).

Further, independent evaluation using standardized clinical and prevention measurement instruments have "reported similar positive results in preventing substance abuse, conduct disorders, and depression in children and parents, and improving parenting skills and family relationships. These positive results were first demonstrated in the original NIDA research study (1983 to 1987) employing a true experimental design with random assignment to four groups. Most recently, a two-year longitudinal, true experimental randomized design found a rural school model of *Strengthening Families* highly effective (.85 to 1.11 effect sizes) in decreasing anti-social behaviors, conduct disorders, and aggression" (Kumpfer, 2002).

Families and Schools Together (FAST) 

Purpose: The purpose of *FAST* is to build relationships between and within families, schools and communities through group-based or social support activities. By utilizing social ecology, family systems and family stress theories, *FAST* works to: "1. Enhance parent–child bonding and family functioning while reducing conflict, isolation and child neglect; 2. Enhance school success through more parent involvement and family engagement at school and improved school climate; 3. Prevent substance use by both adults and children by building protective factors and referring appropriately for treatment; and 4. Reduce the stress that children and parents experience in daily life situations in their communities by empowering parents, building social capital, and increasing social inclusion."

How delivered: *FAST* is delivered through several phases. First, the program actively recruits families to participate in eight weeks of multifamily meetings that include: family communication and bonding games, social support groups for parents, followed by activities and between-family engagement. These meetings are approximately 2.5 hours long and are generally led by the certified FAST trainer. Long-term involvement includes parent group meetings for the following two years, which are parent-led sessions with support from the program.

Availability/costs: *FAST* currently operates in 48 states in the United States and reportedly 20 countries including Australia, Austria, Brazil, Canada, German, Iran, Russia, and the United Kingdom, among others. To date, it has been implemented in 2,500 schools and has hosted approximately 450,000 students. There is a licensing fee ($550 per site), a training package ($4,295 per site, plus travel expenses), ongoing technical assistance ($200), and an evaluation package ($1,100).

Evidence base: The peer-reviewed studies have typically focused on school-based outcomes related to children and youth. For example, recent results have shown that youth involved in FAST are less likely to transfer schools (Fiel et al., 2013); showed improvement in problematic behaviors such as aggression, anxiety and depression (Kratchowill et al., 2004; 2008; McDonald et al., 2008); had greater academic competencies (Kratchowill et al., 2004; 2008; McDonald et al., 2008); and increased social skills (Kratchowill et. al., 2004; 2008; McDonald et al., 2008). While these studies did not focus on parent perspective, family engagement or improved social support from the families' perspective, the *FAST* program is well established and serves as an example of an evidence-based program for those seeking to collaborate with schools on improving social outcomes.

Systematic Training for Effective Parenting (STEP)

Purpose: *Systematic Training for Effective Parenting* (STEP) is a parent development program as well as an outreach service. The goals of this program are to identify circumstances that put children at risk for child abuse and neglect, reduce parenting stress, and improve the child's learning environment, including the emotional environment or connections with their caregivers (Huebner, 2002). STEP is targeted to work with families who have children under three who are at risk of maltreatment.

How delivered: This program is part of a system of care framework and consists of eight two- hour class sessions once a week for a total of sixteen hours of intensive interaction with an interdisciplinary team. The interdisciplinary team can be made up of professionals such as public health nurses, early childhood educators, social workers, and nutritionists, to name a few examples.

Availability/cost: The STEP curriculum is available for purchase online or by phone at a cost of $345 for the core curriculum, plus an additional $17 for each parent handbook. A one-day training workshop with the curriculum included is about $300 per participant, or $115 per person without the curriculum. Retrieved November 2014 from http://www.steppublishers.com/.

Evidence-base: A study examined parents of infants and toddlers (up to 36 months) who were at risk for child maltreatment due to a lack of personal and financial resources and other life circumstances. Using a quasi-experimental, non-randomized design, data were collected from twelve series of classes over the course of four years (1995-1999), through a survey completed at intake and after the final class (Huebner, 2002). The 199 participants as a whole as well as two subgroups (two community samples and a group of mothers and children who resided in a drug treatment program) revealed positive effects (ibid). "Parents' improvement over time was statistically significant and clinically noteworthy, especially considering the high-risk nature of all participating families and the brevity and low cost of the intervention" (p. 386).

Additional analysis illustrated a dose-response relationship between program attendance and the magnitude of gain in observed parenting skills. After the program, participants had more positive perceptions of their children and were significantly less likely to be abusive (Fennell & Fishel, 1998). That said, STEP may not be strong enough to realistically resolve family issues for those with complex mental health and substance abuse issues. In these cases programs with longer durations and greater intensity may be better options.

Nurturing Parenting Programs

Purpose: The *Nurturing Parenting Programs* (NPP) developed by Stephen Bavolek have been widely used and incorporated into other programs implemented through child welfare agencies, substance abuse treatment programs, teen parent programs and home visitation (Cowen, 2001; Maher, Marcynyszyn, Corwin & Hodnett, 2011; Moore & Finkelstein, 2001). NPP programs are available for every level of prevention and post-involvement intervention. The programs aim to prevent child abuse and neglect while promoting positive, trauma-sensitive parenting practices.

How delivered: These programs allow for implementation in groups or one on one in family homes. Group sessions can include opportunities for parents to be with their children (called Family Nurturing Time) and interact with the facilitators separately. For home-based sessions, families meet with facilitators for 90 minutes, weekly for 15 weeks.

Availability/cost: The cost of implementing one of the *Nurturing Parenting Programs* varies greatly depending on the location, duration of the program, and type of program selected. The estimated range as of April 2010 is between $300 and $2,000 for curriculum materials, and $250 to $325 for facilitator training; this cost increases for "train the trainer" sessions and technical assistance or consultation, all of which are optional for programs.

Evidence-base: A thorough review of the programs was last completed in April 2010 by NREPP wherein the goals of the NPP are outlined:

1. Increase parents' self-worth, empathy, bonding and attachment;
2. Increase the use of alternative strategies to harsh and abusive discipline;
3. Increase parents' knowledge of developmentally-appropriate expectations; and
4. Reduce the rate of child abuse and neglect.

The Adult Adolescent Parenting Inventory (AAPI) is the most common tool used in measuring outcomes for adults who participate in the program. A few studies have examined families in the NPP program who were referred by the child welfare agency or another prevention program called *Parents Anonymous, Inc*. Results revealed positive changes in parenting attitudes and behaviors and reduced recidivism or subsequent allegations of maltreatment (Bavolek, Comstock, & McLaughlin, 1983; Bavolek, Henderson & Schultz, 1988; Hodnett, Faulk, Dellinger & Maher, 2009). Also noteworthy were results from a study conducted by Casey Family Programs for the state of Louisiana (Maher et al., 2011) where findings suggest that parents who attended more NPP sessions were significantly less likely to be reported for child maltreatment. Another study showed the positive effects of parenting attitudes and behaviors in families who were court-ordered to participate in the program. Using the Family Environment Scale (FES) a self-reporting questionnaire, data showed "significant positive changes in family interaction patterns from pretest to posttest. Family cohesion, expressiveness, organization, independence, achievement, reaction, and cultural and moral interactions increased, while family conflict and control decreased" (Bavolek et al., 1983, 1988).

24/7 Dad

Purpose: *24/7 Dad* is composed of a two-part curriculum designed to teach fathers how to care for themselves, their children, and manage important relationships in their lives. *24/7 Dad* has an "A.M." version that is a basic program for first-time fathers, and for fathers who need assistance with foundational knowledge of parenting and gender roles. The more in-depth "P.M." program is for men with more extensive fathering experience, or those who have completed the basic program. The three main goals for both components are: "1. Increase *awareness* among fathers about the elements to being good fathers; 2. Increase *knowledge* among fathers about the elements to being good fathers; and 3. Increase *capacity or skills* to carry out what fathers learn." The programs cover predefined topics such as: defining manhood, communicating with children, providing guidance and discipline, handling anger, articulating the father's role, learning about how children grow and develop, and working with a co-parent.

How delivered: *24/7 Dad* is delivered through a series of group sessions of no more than twelve participants. Each session consists of a twenty minute warm up activity, 80 minutes of hands-on and interactive activities and exercises, and 20 minutes of wrap up and debriefing.

Availability/Cost: There is no information on how extensively *24/7 Dad* is practiced. In March of 2015, National Father Institute will begin providing training for purchase for this program (http://store.fatherhood.org/). The *24/7 Dad A.M*. program kit is available for $549. The *24/7 Dad P.M.* (advanced) program kit is also available for $549. The manuals and handbooks for both courses are available for around $7.99 each.

Evidence base: There are currently no peer reviewed studies on this program, though there are several technical reports available. These reports are non-experimental and do not always employ a control group, yet they provide some information about methods of service delivery and working with specific target groups (e.g., Hispanic populations, incarcerated parents, separated families). There have been several studies, however, that have found that after completing the *24/7 Dad* basic program, participants showed improvement in pre and post test scores in self-awareness, caring for self, parenting skills, relationship skills, and fathering skills (da Rosa and Melby, 2011; Olshansky, 2006).

Active Parenting Now

Purpose: *Active Parenting Now*, also called *Active Parenting* is a parent development program targeting the parents of two- to twelve-year-olds who want to improve their parenting skills. The program is based on the Adlerian parenting theory, which is to assure that all family members are heard and respected.

How delivered: Through a video-based education program, parents are taught how to build their child's self-esteem with strategies such as encouragement, active listening, honest communication, and problem solving. *Active Parenting* also teaches parents how to use natural consequences to reduce unacceptable behaviors. *Active Parenting* is made up of one two-hour class per week over the course of six weeks.

Availability/cost: *Active Parenting* is widely available and has been translated into several languages. This program is used in home, school, and community settings, and the standard curriculum (kit) is required for implementation is $400. The website http://www.activeparenting.com/ has numerous resources to supplement the core curriculum, costs varying and depending on the number of participants and the levels of training. For example, a one-day leader training costs $139 per person, and a three-day "train the trainer" session costs $449.

Evidence-base: Numerous studies have been done for the *Active Parenting* program, including an evaluation of the Spanish translation and the *Active Parenting of Teens* version. Parents who participated in the *Active Parenting* programs were much more likely to perceive their children's behaviors as more favorable and showed significantly more confidence in their parenting skills than those who had not taken the course (Mullis, 1999; Boccella, 1998; Mullis, 2006; Urban, 1991).

When applied to the specific issue of eating behaviors, *Active Parenting* may also help reduce the occurrence of obesity in children, as cited in a study completed by the Department of Nutrition and Food Science at the University of Vermont. *Active Parenting* was used in an obesity prevention program with Native American children; these children had significantly reduced their caloric intake and their mothers had engaged in less restrictive feeding practices over time as a result (Berino, 2003). The program has been shown to work for parents of all income and education levels (Brown, 1988).

CHILD SEXUAL ABUSE PREVENTION SERVICES

Child sexual abuse arises out of a complicated mix of cultural, social, political environmental, interpersonal and individual factors (Lyles, Cohen & Brown, 2009). The Prevention Institute states that prevention of child sexual abuse must have a focus on larger systems change rather than attempting to address individual change in order to successfully prevent child sexual abuse before it occurs (ibid). Given the complex interplay of family systems, inherent risk factors, and the potential threat of adverse experiences, prevention programs in general have a daunting task and must be far-reaching. Complicated by more recent challenges posed by widely-available technology, perspectives on appropriate sexuality and behavior are blurred where the previous boundaries seemed so clear. For example, it is easier now to expose children to, and include them in web-based sexual exploitation where perpetrators have a shield of anonymity (ibid, p. 4).

Community education programs, such as those examined here, can provide information, knowledge, and resources to large and diverse groups of people. These programs also bring child sexual abuse out into the public as a topic that can be discussed openly, making people aware of what exactly is inappropriate and damaging to children. This form of advocacy and education allows for a better understanding of how to prevent abuse from happening as well as an increased willingness to speak up if abuse occurs.

This report divides Child Sexual Abuse Prevention programs into two categories based on the target population and the service-delivery methods: School-based or adult education-focused. School-based programs target children and youth within the schools and may include a parent/guardian aspect as well. Adult education-focused programs target adults as a means of child sexual abuse prevention, teaching them to recognize signs and how to react, and what to do if abuse occurs. There is a third type of child sexual abuse prevention commonly called tertiary level programming, which due to the limited availability of evidence-based programs will not be reviewed here. Tertiary programs are those specifically designed for children and families who are already involved with child protective services as a result of prior (sexual) abuse reports; the goal of these programs is to prevent further abuse.

No child sexual abuse prevention programs have been evaluated in randomized trials for actual abuse prevention outcomes, however quasi-experimental studies have led to mixed findings of some benefit as well as concerning findings that children who have been through these programs and experience abuse may be more likely to be injured (Finkelhor, Asdigian & Dziuba-Leathermann, 1995 as cited in Chaffin & Friedrich, 2004).

The following programs are summarized. Child Sexual Abuse Prevention programs are not included in the SAMHSA National Registry (NREPP) as the prevention programs reviewed above may be; therefore the NREPP column is not included in this table.

Title of Program or Curriculum	In Iowa Now?	Program Category	Target Population[11]	Effectiveness Score[12]
School-based Programs				
Talking About Touching	✓	School-based sexual abuse prevention	Children preschool to 3rd grade	Supported
Child Lures		School-based sexual abuse prevention	School- age students	Supported
Kid&TeenSAFE		School-based sexual abuse prevention	Youth with disabilities (K-12th grade),teachers and families	Promising
Adult Education-focused Programs				
Darkness to Light: Stewards of Children	✓	Adult-focused sexual abuse prevention	All adults	Exemplary
Stop It Now!		Adult-focused sexual abuse prevention	All adults	Exemplary

SCHOOL-BASED PROGRAMS

School-based education initiatives mainly focus on providing children and youth with the skills and knowledge necessary to help them identify and prevent abuse. By teaching youth to identify boundary violations, how to refuse approaches and end interactions, and how to summon help, youth are in a better position to understand negative and abusive sexual interactions. Additionally these programs help reduce negative consequences of abuse by helping youth understand that it is not their fault and they should not feel guilty or shameful. Parent-child communications improve after participation in prevention education programs (Finkelhor, 2009, p 180).

[11] Description of specific target group included.
[12] Using criteria developed by the National Alliance of Children's Trust and Prevention Funds, Evidence-Based Practice Committee 2009.

Talking About Touching

Purpose: *Talking About Touching* targets children in preschool through third grade and aims to provide children with the skills to deal with dangerous situations. The program also provides support to families and teachers in discussing sensitive topics with their children or students.

How delivered: Two versions of the curriculum exist, one for preschool and kindergarten, the other for grades first through third, as a means to better teach the topic in a way that is understandable to each set of children. Through the use of fourteen lessons varying in length from ten to thirty minutes, teachers use photo-lesson cards, videos, a book, and posters to teach children about safety. Divided into three sections, the first reviews traffic, water, and fire safety; the second includes safety in relationships with older people and appropriate touching, talking, and feelings; the third section teaches children how to stand up for themselves if they are being bullied or touched inappropriately. *Talking About Touching* is a school-based program, but parental-involvement is highly encouraged and a parent education video is included as part of the curriculum.

Availability/cost: *Talking About Touching* materials can be purchased online. The full kit costs $249 for Preschool/Kindergarten or $289 for grades first through third. Supplemental materials such as DVDs and posters range in price from $15 to $79.

Evidence-base: At least three studies have been completed to evaluate the effectiveness of the *Talking About Touching* curriculum. Statistically significant improvement in the areas of knowledge and application of the skills taught during the *Talking About Touching* program were shown for the children who participated in the course (Sylvester, 1997; Madak & Berg, 1992). An evaluation using a post-test survey of the parent education video demonstrated that the video can increase communication on these topics between parents and children (Burgess & Wurtele, 1998).

Child Lures

Purpose: *Child Lures*, a targeted child sexual abuse prevention program for Pre-K to high school children and youth, provides information to prevent sexual exploitation, abduction, internet crime, substance abuse, and school violence.

How delivered: The program includes discussion topics, presentations, age- appropriate classroom activities, posters, and handouts. Student evaluations are included and are intended to be completed as pre and post tests for educators to evaluate effectiveness. The program revolves around nine to eleven classroom lesson plans (depending on the age group).

Availability/cost: Available for purchase through the *Child Lures* website, the cost of the *Child Lures* curriculum is $489 for one school or $2,500 for an entire school district. Additional supplements, including workbooks and DVDs, vary from $1 to $39.

Evidence-base: One evaluation conducted by Campbell-Bishop and Robles Pina at Sam Houston State University compared fourth grade students at two schools during the fall semester of 2002. Students at one school participated in the *Child Lures* prevention program for approximately the previous five years (no more than five years but students had possibly had less exposure) while the comparison group at the other school included students who did not use the program. The study showed that children who did not receive the *Child Lures* prevention program were more likely to be unsure about what constitutes inappropriate touching and children who received the training were more likely to know they should tell their parents where they are at all times. Overall scores showed there was an increased growth of knowledge for the children who received the program training. The control group experienced minimal growth; however the authors attributed this to the study raising awareness and possible increasing family discussions on the issues as a result.

Kid&TeenSAFE

Purpose: *Kid&TeenSAFE* focuses on youth with disabilities, kindergarten through grade twelve, and their teachers and families. There are four main goals to the program:

1. Reduce the risk of sexual, physical, and/or emotional abuse or exploitation faced by many children and youth with disabilities;
2. Increase the ability of children and youth to identify, prevent, and report abuse;
3. Enhance awareness and strengthening skills of family members, teachers and other professionals to prevent, detect, and report abuse of children with disabilities;
4. Promote ongoing abuse prevention education for children and youth with disabilities (*Kids&TeenSafe: An Abuse Prevention Program for Youth with Disabilities* handbook)

How delivered: *Kid&TeenSAFE* uses classroom presentations, professional and family trainings, and a National Resource Library to teach youth and their families about child sexual abuse, how to prevent it, and what to do if it occurs. The program is made up of three to four sessions, held at school for thirty to sixty minutes each. *Kid&TeenSAFE* includes an evaluation checklist for staff to collect data on each student's knowledge and skills during the course, a student feedback survey, and a family/professional survey.

Availability/cost: The *Kid&TeenSAFE* guidebook is available online, free of charge. Cost of the program is unknown.

Evidence-base: While no evaluations could be found showing the strength of this program, the Child Welfare Information Gateway recommends *Kid&TeenSAFE* as a program that has proven to be successful in imparting information and enhancing protective strategies. (www.childwelfare.gov/preventing/programs/types/sexualabuse.cfm)

Darkness to Light: Stewards of Children 

Purpose: *Darkness to Light: Stewards of Children* is a targeted program that teaches adults how to prevent, recognize, and react responsibly to child sexual abuse.

How delivered: Both an online and a facilitator-led version are available. The *Darkness to Light: Stewards of Children* program has been proven to increase knowledge, improve attitudes and change child-protective behaviors through numerous studies. Topics covered during the two to three hour *Stewards of Children* training include the types of situations where child sexual abuse may occur, an overall discussion of the problem of child sexual abuse, the importance of talking about the prevention of sexual abuse with children and adults, signs of sexual abuse, and how to interact and intervene. *Darkness to Light* offers *Stewards of Children* to all adults and organizations that serve youth, such as after school programs, sports leagues, and church groups to name just a few.

Availability/cost: *Stewards of Children* training sessions are available either as web-based training or with an on-site facilitator. Online training is $10; facilitator-led training depends on the location and the facilitator but typically ranges from $10-25 per attendee. A training calendar is maintained on the *Darkness to Light* website, details can be found at http://www.d2l.org/.

Evidence-base: Qualitative and quantitative studies have been completed on the *Darkness to Light: Stewards of Children* program. One such study was completed by Trisha Folds-Bennett, Ph.D. in 2005; it used an initial and follow up survey of 447 adults participating in the *Stewards of Children* training to examine whether knowledge increased and what the long-term effects of the program were. The evaluation showed the *Stewards of Children* training was effective in a number of areas including acquisition of new knowledge regarding child sexual abuse, potential to change attitudes about child sexual abuse, and critical issues for organizations and individuals concerned about the protection of children, to name just a few areas (Folds-Bennett, 2005). Additionally the follow-up surveys, conducted two months after the training, showed that participants decreased their knowledge gain by less than ten percent. After the training, participants were more likely to discuss issues of sexual abuse with children and other adults, recognize signs of abuse, and drop in unexpectedly when a child was under the care of another adult as a safety precaution. Further evaluations reached the same conclusions (Rheingold, 2010; Center for Child and Family Studies at the University of South Carolina, 2007, 2009).

Stop It Now! ❄❄❄❄

Purpose: *Stop It Now!* is an evidence-based child sexual abuse prevention resource that focuses on perpetration prevention through promoting awareness and information to the public. The program aims to mobilize adults, families, and community organizations to prevent child sexual abuse. Through the use of public opinion surveys, focus groups, and other market research techniques, interventions and effectiveness have been measured to provide the best information and preventative measures to adults as a means to keep children safe.

How delivered: *Stop It Now!* uses a public health model in an effort to change the social climate through the use of education materials, media messages, training tools (including online trainings and webinars), and community-based program strategies. It is generally used to promote specific messages and awareness of child sexual abuse alongside other prevention curricula or efforts.

Availability/cost: *Stop It Now!* is a free program as the developers would like it to be widely available. Additional resources such as guidebooks and tip sheets can be purchased for $7 to $8 each. Selected guidebooks and tip sheets are also available as free downloads, however *Stop It Now!* appreciates donations if users find these resources helpful as their continued work relies on financial contributions.

Evidence-base: *Stop It Now!* has strong evidence-based support. An evaluation conducted by the Kansas University Workgroup for Community Health and Development for *Stop It Now!* Minnesota examined three areas of change: community and system change, widespread behavior change, and population-level change. Levels of change were determined through the examination of new or modified programs, policies or practices within the community, a review of calls to the Stop It Now! Minnesota helpline, and a review of annual child welfare reports to the Minnesota Department of Human Services. Results of the evaluation showed positive changes. Meaningful community and system change occurred throughout the state and the efforts of *Stop It Now!* Minnesota contributed to a reduction in reported occurrences of child sexual abuse in Minnesota (Schober et al., 2008). Additionally, the call review revealed an increase in the number of preventative reporting calls at a higher rate than "reactive" calls regarding child sexual abuse that had already occurred (ibid.).

Similarly, a random digit-dial telephone survey of 200 Vermonters conducted in 1995, 1997 and 1999 of the *Stop It Now!* Vermont program showed a change in the way adults talked about sexual abuse, an important first step in changing the way people respond to the issue. After four years, there was a forty percent increase in the number of people who could explain and define what child sexual abuse is (Coffman, 2003). This survey also showed an increase in skills such as being able to name warning signs of an adult or juvenile with sexual behavior problems, rising from 27.5 percent in 1995 to 38 percent in 1999, an increased knowledge of where to report child sexual abuse if they know or suspected to be occurring (ibid). Over 54 percent of respondents knew where to refer someone with sexual behavior problems as a result of *Stop It Now!*

RESPITE OR CRISIS CARE SERVICES

Very little formal, evidence-based programs exist in the area of respite or crisis care services, though some are in the process of field-testing evaluation materials to help demonstrate positive outcomes. There are common barriers for families in need of respite care who can access appropriate services including: a lack of trust in respite care providers (either with the agency as a whole or the individual provider), a shortage of respite care providers, and the location of available service. There are also currently no national standards for respite and crisis care services (Dougherty et al., 2002). However, National Respite Guidelines are available from the *ARCH National Resource Center* which aims to establish quality respite services to meet the needs of families in need of care. The guidelines apply to all forms of respite, for all ages including care in the family's home, care in a residential facility or any other location. This resource provides specific guidance for respite services in the areas of: family involvement (biological, adoptive, foster, or any other type of family relationship), care providers, community involvement, service delivery, administration and evaluation of the respite care services. Some of the key elements are summarized here.

Family involvement: Family involvement guidelines provide information on how to assure practices are family-centered, and each child is treated as an individual. Children may have entirely different needs, and a respite provider must tailor its care to each individual, within the context of their family.

Care providers: Care provider guidelines include ensuring respite providers have the support they need both in terms of fair wages and access to peer support that is important to this challenging work.

Community involvement: Guidance for community partnerships includes suggestions for working with other community organizations and ensuring the respite agencies or providers are knowledgeable of the services available in their communities.

Service delivery: Service delivery guidelines are meant to ensure respite services are providing the necessary services to their clients as well as being able to deal with the changing needs of the families they work with. It is essential that respite agencies have advisory boards or committees as a means to provide oversight, develop policies and procedures, and address other issues as they arise.

Administration and evaluation: Lastly, evaluation is a key component to providing successful respite care services as it allows agencies and providers to ensure intended goals are being reached and provides feedback on how to better serve their clients. More information can be found on the ARCH National Respite Network website (www.archrespite.org).

CONCLUSION

Research on the effectiveness of child abuse prevention programs has become more abundant over the last two decades, particularly in the area of home-based services. Substantial research for the other program types is still relatively limited. While there are many articles and studies, most reflect small-scale efforts, yet these can help programs make decisions when considered in context of what is needed and already in place in the community. Searching for the common elements in successful programs invariably leads to fairly broad concepts and generalizations. Nonetheless, they are useful to consider in refining the approach or curricula selected. According to Barth, 2009, and Karoly et al., 2005, the most successful programs share the following characteristics:

- **Early intervention (services to women and families prior to the birth of their babies);**
- **Carefully structured curricula with more than one method of delivery;**
- **Development of benchmarks for quality assessment;**
- **Professionally-trained staff who have good support and guidance;**
- **Program design to match unique needs of families and community characteristics (e.g., different levels or steps);**
- **Community-focused approach aimed to strengthen capacity of parents;**
- **Defined targeted population that is likely to experience difficulty parenting (e.g., parents of infants, parents who are affected by substance abuse)**

By responding to the family's unique needs in the context of their community, programs can contribute to helping parents develop skills in child rearing, reducing isolation by nurturing personal connections, and strengthening and building on the family's existing abilities and protective factors. Professionals in early intervention (e.g., home visiting nurses, early childhood educators, and clinicians) have a unique opportunity to work with children and families in their natural environment and help parents capitalize on their inherent skills and available resources. The validation and support provided to the family unit can contribute not only to the reduced risk of abuse and neglect, but to the overall wellness and optimal child development, particularly when combined with early education and regular health assessments (Benedetti, 2012; Bridgman, 2009; Bronfenbrenner, 1979; Daro, 2006; Family Strengthening Policy Center, 2007; Gomby, 2005; Jones Harnden, 2010; Kahn & Moore, 2009; Smith, 1995; Stagner & Lansing, 2009; Zigler, Pfannensteil & Seitz, 2008).

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APPENDIX A: RESEARCH SOURCE LIST

General Resources

California Evidence-Based Clearinghouse for Child Welfare http://www.cebc4cw.org/

Child Welfare Information Gateway https://www.childwelfare.gov/

FRIENDS National Resource Center www.friendsnrc.org

National Alliance of Children's Trust and Prevention Funds www.ctfalliance.org

National Center for Children in Poverty (NCCP) http://www.nccp.org

National Registry of Evidence Based Programs and Practices (NREPP)

http://nrepp.samhsa.gov

Prevent Child Abuse America http://www.preventchildabuse.org/

Prevent Child Abuse Iowa http://www.pcaiowa.org/programs/cbcap/

US Department of Health and Human Services, ACF www.acf.hhs.gov

Home Visiting

Nurse Family Partnerships (NFP) www.nursefamilypartnership.org

Parents as Teachers (PAT) www.parentsasteachers.org

Healthy Families America www.healthyfamiliesamerica.org/research/index.shtml

Child First http://www.*ChildFIRST*.com/

Circle of Security-Home Visiting-4 http://circleofsecurity.net/

Family Thriving Program https://labs.psych.ucsb.edu/bugental/daphne/ftp-tapes/index.html

SafeCare and SafeCare Augmented http://safecare.publichealth.gsu.edu/

Step by Step Parenting http://www.cebc4cw.org/program/step-by-step-parenting-program/detailed

Exchange Parent Aide https://www.preventchildabuse.com/content/exchange-parent-aide-model

Parent Development or Education

Active Parenting www.activeparenting.com

24/7 Dad http://www.fatherhood.org/

Families and Schools Together http://familiesandschools.org/ or

http://cfsproject.wceruw.org/fastprogram.html

The Incredible Years www.incredibleyears.com

Iowa Behavioral Alliance – Positive Behavior Support (PBS)
www.educ.drake.edu/rc/aboutpbs.html

Nurturing Parenting Program www.nurturingparenting.com

Parents Anonymous, Inc. www.parentsanonymous.org/pahtml/research.html

Positive Behavior Support (PBS) www.pbis.org/family/default.aspx

Promoting First Relationships http://pfrprogram.org/

Strengthening Families Program www.strengtheningfamiliesprogram.org

Strengthening Families Program for Parents and Youth 10-14
www.extension.iastate.edu/sfp/index.php

Respite Care and Crisis Nurseries

ARCH National Respite Network and Resource Center www.archrespite.org

Child Welfare Information Gateway

Google Scholar (limited to 1990-present, full-text publications)

Sexual Abuse Prevention

Child Lures www.childluresprevention.com

Child Welfare Information Gateway
https://www.childwelfare.gov/preventing/programs/types/sexualabuse.cfm

Darkness to Light: Stewards of Children www.d2l.org

Google Scholar (limited to 1990-present, full-text publications)

Kids&TeenSAFE www.vawnet.org/Assoc_Files_VAWnet/NRC_KTSafe-full.pdf

Prevent Child Abuse Iowa http://www.pcaiowa.org/sexual-abuse-prevention/

National Children's Advocacy Center www.nationalcac.org

Speak Up, Be Safe http://www.speakupbesafe.org

Stop It Now! www.stopitnow.org

Talking About Touching http://www.cfchildren.org/talking-about-touching.aspx

University of Calgary "School-Based Violence Prevention Programs: A Resource Manual" www.ucalgary.ca/resolve/violenceprevention/English/pdf/RESOURCEMANUAL.pdf