

Addressing common forms of child maltreatment: evidence-informed interventions and gaps in current knowledge

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ABSTRACT

This paper reviews interventions for preventing the occurrence and recurrence of major types of child maltreatment. We begin with an overview of the challenges of establishing evidence-based interventions to prevent child abuse and neglect in many countries, and underscore the importance of this need with child maltreatment incidence rates in the USA, and how much each type and subtype contribute to child out-of-home placement. Next, we identify the *well-supported*, *supported* and *promising* interventions for each child maltreatment type and subtype, according to their level of research evidence using an evidence-based clearing house. The paper closes with a discussion of the implications for practice, evaluation, policy and agency management, including intervention knowledge gaps that showcase areas that need additional practice research.

SETTING THE CONTEXT

The need for more evidence-informed practice strategies

In many countries, policy-makers, child welfare leaders and community partners are improving policies and practices. In some countries, more evidence-informed interventions are being implemented and child welfare systems are becoming more research-based to serve vulnerable children and families. For example, caseworkers, agency leaders, judges and mental-health providers are examining trends in who is being served and with what services and outcomes, to seek better assessment and intervention methods. As a result, child welfare agencies are developing strategies and resources that help more children live in safe, nurturing and permanent family homes (McCauley *et al.* 2006; Cleaver *et al.* 2008; Field 2010; Allen 2011; Maluccio *et al.* 2011; Parton 2011; Simmonds 2011; Wade *et al.* 2011).

Practice, administrative, legislative policy and other system reform strategies exist that can improve con-

ditions for maltreated children and accelerate permanency planning, thereby safely reducing the number of children in foster care (Rogg *et al.* 2011). Especially in times of fiscal constraint, we need programmes to achieve these goals so that foster care cost savings resulting from foster care reductions can be reinvested in higher-quality interventions to reduce the need for foster care *and* provide better assessment, mental health, education, employment and other services for the children who require out-of-home care. The next sections illustrate the need for high-quality interventions for preventing child maltreatment and its recurrence after the initial child protective services (CPS) report by using data from the USA.

Incidence rates of child maltreatment

Every year in the USA, about 695 000 unique children are confirmed as victims of child maltreatment (US Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau 2011), and, on any given day in 2010, nearly

408 000 children were living in foster care (See the federal Adoption and Foster Care Analysis and Reporting System (AFCARS) data site: http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#afcars). The victimization rate for Federal Fiscal Year 2010 was 9.2 per 1000 in the population, using an unduplicated child count (US Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau 2011, p. ix). With the exception of some forms of child neglect, there was a steady decline in the rates of substantiated child maltreatment in the USA during the mid- to late 1990s, the Fourth National Incidence Study (NIS-4) found large declines in physical abuse and sexual abuse between 1993 (NIS-3) and 2004 (NIS-4). However, rates of all forms of child maltreatment in NIS-4 remain at or well above 1986 levels (NIS-2), and there was a fivefold increase in emotional neglect reported in NIS-4 compared to NIS-2. Some of these changes may be due to greater awareness of child maltreatment generally, the impact of mandatory reporting in certain US states and further understanding of what emotional neglect amounts to.

The National Child Abuse and Neglect Data System data showed that, as in prior years, the greatest proportion of child victims in the USA suffered neglect. Note that a child may have suffered from multiple forms of maltreatment and was counted once for each maltreatment type. CPS investigations determined that:

- 78.3% of the victims suffered neglect;
- 17.6% of the victims suffered physical abuse,
- 9.2% of the victims suffered sexual abuse; and
- 8.1% of the victims suffered from psychological maltreatment (US Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau 2011).

Reasons for child placement

In 2010, approximately one million children received post-response services following a maltreatment allegation in the USA. A total of 216 440 children received foster care services (and were removed from their homes). Note that some of the children and families in these counts may receive services under more than one funding stream and may be counted more than once (US Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's

Bureau 2011, p. 90). A total of 254 375 children were removed from their homes and entered foster care. Note that this is different than the total number of children who entered care following a maltreatment allegation as cited earlier in the paragraph. This is due to many reasons, most notably that there are children entering care who may not have a maltreatment allegation but who may have one or more serious emotional or behavioural disorders (See the federal AFCARS data site: http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#afcars). In summary, most children were placed into out-of-home care due to some form of parental neglect, while others had experienced physical, sexual or emotional abuse.

Specialized services are needed

Intervention developers need to articulate how their treatments address key risk and protective factors or other mechanisms predictive of child maltreatment (e.g. Stith *et al.* 2009). An excellent example is how Cicchetti *et al.* (2006) tested whether several caregiver interventions affected maladaptive parenting attitudes, parenting stress, family support, maternal sensitivity to infant or child needs and degree of secure attachment. In addition, community-based interventions are being recognized as essential. While this paper discusses parent-focused interventions, there is a growing body of research and advocacy supporting a broader approach to child abuse prevention that improves *community* norms, support systems and culture (Garbarino 1998; Hawkins *et al.* 2002; Bronfenbrenner & Morris 2006; Spoth *et al.* 2007).

Keeping children safe and preventing maltreatment therefore requires collaboration that extends well beyond the CPS system into various realms of community services, including mental health, education, employment, housing, health care and vocational rehabilitation. With this broad context setting, the next sections of the paper focus on evidence for treatment effectiveness and what parent-focused interventions can help prevent child abuse or neglect.

What constitutes adequate research evidence of effectiveness?

Agencies desire interventions that have the best research evidence, that provide clients with the best clinical experience and that are consistent with family and client values (Walsh *et al.* 2012). This section of the paper presents interventions that have moderate to strong degrees of research evidence for their ability to

prevent the occurrence or recurrence of child abuse or neglect. While the issue of adequate research evidence is being debated vigorously, this paper uses rating criteria from the California Evidence-Based Clearinghouse for Child Welfare (CEBC) (See <http://www.cebc4cw.org/>). Programmes selected for inclusion fall into the three highest levels of effectiveness for the CEBC classification system:

1. *Promising research evidence*: Sample criteria include at least one study utilizing some form of control (e.g. untreated group, placebo group, matched wait list) that has established the practice's benefit over the placebo, or found it to be comparable to or better than an appropriate comparison practice. In at least one randomized controlled trial (RCT), the practice has shown to have a sustained effect at least 6 months beyond the end of treatment (See <http://www.cebc4cw.org/ratings/scientific-rating/scale/> for more complete definitions).

2. *Supported by research evidence*: Sample criteria include at least one RCT in usual care or a practice setting that has found the practice to be superior to an appropriate comparison practice. The RCT has been reported in published, peer-reviewed literature. In at least one RCT, the practice has shown to have a sustained effect at least 1 year beyond the end of treatment.

3. *Well supported by research evidence*: Sample criteria include multiple-site replication. At least two RCTs in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published, peer-reviewed literature.

We also reviewed intervention programmes cited in the following databases, but screened interventions for their direct effects on child maltreatment prevention and level of evidence:

- Blueprints for Violence Prevention, a project of the Center for the Study and Prevention of Violence at the University of Colorado (See <http://www.colorado.edu/cspv/blueprints/>)
- National Child Traumatic Stress Network (see <http://www.nctsn.org>)
- The US Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programmes Guide (see <http://www.ojjdp.gov/mpg/>)
- The US OJJDP Children Exposed to Violence Evidence-Based Guide (see http://www.safestartcenter.org/pdf/Evidence-Based-Practices-Matrix_2011.pdf)
- The US Substance Abuse and Mental Health Administration, National Registry of Evidence-

Based Programs and Practices (see <http://nrepp.samhsa.gov/>)

- US Department of Health and Human Services Home Visiting Evidence of Effectiveness (see <http://homvee.acf.hhs.gov/>)

To recap, the intervention must have data linking it directly to reduction of some form of child maltreatment. This meant that programmes with indirect effects such as parental attachment or empathy with the child and programmes where studies were underway but not yet complete, were not included (e.g. *Connected Families*).

EVIDENCE-BASED INTERVENTIONS

Prevention and treatment strategies with some evidence for certain child maltreatment types

While certain types of child maltreatment such as physical abuse have been addressed by proven and promising interventions, fewer interventions have been developed for other child maltreatment types. Table 1 lists interventions for which there is moderate to strong evidence of effectiveness; they are listed by type and subtype of child maltreatment. The number of asterisks indicates how strong the evidence base is for the intervention according to criteria used by the CEBC.

Cautions

As shown in Table 1, this paper identifies evidence-informed interventions for preventing child maltreatment, but because of space limitations, this does not provide details about each intervention or a critique of their implementation quality, design rigour, sample size, effect sizes across similar interventions, intent-to-treat analyses or other issues related to the quality of the research because recent meta-analyses have discussed many of these topics (e.g. MacMillan *et al.* 2009; Reynolds *et al.* 2009; Slack *et al.* 2009).

Space limitations precludes describing each programme's readiness for dissemination, including the availability of easy-to-understand manuals, programme materials, programme cost, etc. Such programme features are included in the CEBC and other registries. Finally, some of the programmes in Table 1 have been proven effective, but they lack an analysis of cost savings. Others may show promise, but they have not yet been rigorously evaluated in RCTs. And some programmes may have strong evidence for improving child well-being but have no data on prevention of child abuse or neglect.

Table 1 Intervention strategies with evidence of effectiveness by type and subtype of child maltreatment

| Subtype of child maltreatment | Prevention or intervention strategies | Website link |
|--|---|---|
| Neglect: general and undifferentiated, including severe and chronic neglect | Supported and well supported: Chicago Child-Parent Centers*** | http://www.waisman.wisc.edu/cls/cbaexecsum4.html |
| | Healthy Families America Home Visiting for Child Well-Being*** | http://www.healthyfamiliesamerica.org/home/index.shtml |
| | Nurse Family Partnership*** | http://www.nursefamilypartnership.org/ |
| | Project Connect parent drug treatment programmes** | http://www.cfsri.org/projectconnect.html |
| | SafeCare** | http://publichealth.gsu.edu/968.html |
| | Triple P Positive Parent Partnership*** | http://www.triplep.net |
| | Promising: Alternative/Differential Response practice strategies* | http://www.differentialresponseqic.org/ |
| | Chicago Child-Parent Centers* | http://www.waisman.wisc.edu/cls/cbaexecsum4.html |
| | Cognitive Behavioural Treatment (CBT) for anxiety or depression* | http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001848/frame.html |
| | Colorado Adolescent Maternity Program (CAMP) with home visiting.* | http://www.thechildrenshospital.org/news/pr/2009-news/Childrens-CAMP.aspx |
| | Crisis nurseries* | http://www.archrespice.org/ |
| | Dialectic behaviour therapy for parent substance abuse* | http://behavioraltech.org/index.cfm and http://behavioraltech.org/resources/crd_results.cfm |
| | Early Start – New Zealand* | http://earlystart.co.nz/ |
| | Family economic support strategies including stronger TANF and employment programmes and other anti-poverty interventions.* | http://www.nccp.org/ |
| | Good Beginnings* | http://www.goodbeginnings.org.au/ |
| | Nurturing Parenting Program* | http://www.nurturingparenting.com |
| | Child physical abuse: undifferentiated | Supported and well supported: Chicago Child-Parent Centers*** |
| Healthy Families America*** | | http://www.healthyfamiliesamerica.org/home/index.shtml |
| Incredible Years*** | | http://www.incredibleyears.com/ |
| Nurse Family Partnership*** | | http://www.nursefamilypartnership.org/ |
| Parent Child Interaction Therapy (PCIT)*** | | http://pcit.phhp.ufl.edu/efficacy.htm or http://pcit.phhp.ufl.edu/ |
| Triple P Positive Parent Partnership*** | | http://www.triplep.net |
| Promising: Alternative/Differential response practice strategies* | | http://www.differentialresponseqic.org/ |
| Chicago Child-Parent Centers* | | http://www.waisman.wisc.edu/cls/cbaexecsum4.html |
| Crisis nurseries* | | http://www.archrespice.org/ |
| Dialectic behaviour therapy for parent substance abuse* | | http://behavioraltech.org/index.cfm and http://behavioraltech.org/resources/crd_results.cfm |
| Enhanced Pediatric Care for Families at Risk* | | http://www.umm.edu/pediatrics/seek_project.htm |
| Family economic support strategies including stronger TANF and employment programmes, and other anti-poverty interventions.* | | http://www.nccp.org/ |
| Good Beginnings* | | http://www.goodbeginnings.org.au/ |
| Healthy Start Program, Enhanced Model*** | | http://www.healthystartassoc.org/ |
| Nurturing Parenting Program* | | http://www.nurturingparenting.com/ |
| Safe Environment for Every Kid (SEEK) Project* | | http://www.umm.edu/pediatrics/seek_project.htm |
| Neglect: emotional maltreatment | | Attachment and Biobehavioral Catch-up* |

Table 1 *Continued*

| Subtype of child maltreatment | Prevention or intervention strategies | Website link |
|---|---|---|
| Neglect: poverty as a major factor | Family economic support strategies including stronger public assistance (TANF) and employment programmes, and other anti-poverty interventions.* | http://www.nccp.org/ |
| Neglect: improper or lack of supervision | SafeCare** | http://publichealth.gsu.edu/968.html |
| Neglect: with maternal depression or other forms of mental health disorders | Behavioral Activation Treatment for Depression (BATD)*** (Note that BATD does not target any specific form of maltreatment but is effective for lowering depression.) | http://www.addiction.umd.edu |
| | Cognitive Behavioral Treatment (CBT) for anxiety or depression*** | http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001848/frame.html |
| | Cognitive Therapy for Anxiety or Depression*** | http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001848.pub4/abstract;jsessionid=5A5FD868A6AD72C90D830E9F178EDE13.d02t04 |
| | Incredible Years*** | http://www.incredibleyears.com/ |
| | Intensive Short-Term Dynamic Psychotherapy (ISTDP)** (Note that ISTDP does not target any specific form of maltreatment but is effective for lowering depression.) | http://www.istdp.com |
| Neglect: medical or lack of proper health care | Mindfulness-Based Cognitive Therapy (MBC)*** | http://www.mbct.com/ |
| | Supported and well supported: Enhanced Pediatric Care for Families at Risk* SafeCare** Promising: Safe Environment for Every Kid (SEEK) Project | http://www.umm.edu/pediatrics/seek_project.htm http://publichealth.gsu.edu/968.html |
| Neglect: substance abuse as a major risk factor | Dialectic behaviour therapy for substance abuse* | http://behavioraltech.org/index.cfm and http://behavioraltech.org/resources/crd_results.cfm |
| | Family drug courts and benchmark hearings* | http://www.ndci.org/sites/default/files/nadcp/PCP%20FINAL.PDF |
| | Project Connect parent drug treatment programmes* | http://www.cfsri.org/projectconnect.html |
| Physical abuse: abuse accompanied by domestic violence | Nurse Family Partnership*** | http://www.nursefamilypartnership.org/ |
| Physical abuse: abuse due to parent-child conflict | No research-based interventions were found with direct effects but we believe that Functional Family Therapy should be tested for this outcome. | |
| Physical abuse: abusive head injuries such as shaken baby syndrome | Supported and well supported: Healthy Start Program, Enhanced Model** Promising: Hospital-based education programs.* | http://www.healthystartassoc.org/ http://dontshake.org/ ; http://www.wchob.org/shakenbaby/ |
| | | |
| Psychological abuse | Healthy Families America Home Visiting for Child Well-Being*** | http://www.healthyfamiliesamerica.org/home/index.shtml |
| Sexual abuse | Circles of Accountability and Support to prevent re-victimization.* | http://www.csc-scc.gc.ca/text/prgrm/chap/circ/proj-guid/index-eng.shtml |

Note: Interventions are grouped by child maltreatment type and subtype where there is some evidence that the intervention is effective for preventing particular forms of child abuse or neglect. The number of asterisks indicates the strength of the evidence base for the strategy according to the California Evidence-Based Clearinghouse for Child Welfare, defined earlier in the paper.

Evidence of effectiveness levels:

*Promising research evidence.

**Supported by research evidence.

***Well supported by research evidence.

DISCUSSION

Targeting interventions for families at risk of child maltreatment with co-occurring risk factors

While many interventions are listed in Table 1, gaps in evidence-informed services exist and there are practice complexities that remain to be addressed. For example, a substantial fraction of families with open child welfare cases have histories of multiple types of child maltreatment and/or have multiple co-occurring risk factors such as substance abuse, depression, family violence, parenting skill deficits, inadequate income and substandard housing. Effective treatment plans in these cases must address concrete needs and barriers to engagement (Mendez *et al.* 2009), as well as underlying conditions that affect parenting such as substance abuse, mood disorders and parenting skill deficits. Caseworkers must also address two core dilemmas when working with these hard-to-serve families: where to begin with supportive and therapeutic interventions and how to organize a sequence of interventions that does not overwhelm family members.

Evidence-based parenting interventions such as the *Incredible Years* teach a fairly narrow range of skills in a limited time frame (e.g. 12–20 weeks is typical for many programmes). A key question that must be answered for effective case planning is whether family members can benefit from skills-based programmes before making significant progress in substance abuse or mental-health treatment, and/or before domestic violence has ceased. Some parents with substance abuse disorders or depression can benefit from skill-based programmes in an early phase of treatment, while others need to be in recovery before they are able to apply new parenting skills. As a practical matter, family assessments that address when and how to initiate skill-based parenting interventions for families with substance abuse, mental-health and family violence issues are needed to effectively align interventions with the capacity of parents to benefit from these programmes, thus research is needed on how to sequence substance abuse treatment, mental-health services or domestic violence interventions with evidence-based parenting skills programmes.

Treatment planning for multiple forms of child maltreatment must also consider the erosion of social norms around parenting among many at-risk families. It is not enough to teach parenting skills to parents who have lost touch with widely accepted community norms around parenting (e.g. recognizing that

pre-school children must be consistently supervised and nurtured). Additional research that accounts for family dynamics, cultural and ethnic norms and the early history of the parents that may itself have involved multiple forms of child abuse and neglect is needed to inform treatment planning for these families (Rodríguez *et al.* 2011).

Prevention and intervention programmes are needed that not only help maltreating parents develop individual knowledge and skills, strengthen support networks and provide concrete services, but also influence deeply ingrained caregiver cultural norms or values that may contribute to child maltreatment (Rodríguez *et al.* 2011). For example, the *Nurturing Parents Program* has been adapted to specialized populations such as Hmong immigrants who have resettled in certain US communities and *Triple P* has shown strong results in influencing whole communities made up of different ethnic groups in Australia and South Carolina (Prinz *et al.* 2009). Can some of the existing evidence-based interventions be successfully adapted to other cultures? If so, which ones should we consider? What would a culturally competent and evidence-based intervention or prevention programme look like? How do we move beyond intervening in a 'culturally responsive manner' to providing culturally competent, evidence-based interventions and programmes? These are questions that researchers and practitioners are actively trying to address.

Addressing gaps in evidence regarding effective interventions

Macdonald (2001, p. 167) reviewed the evidence for child maltreatment prevention a decade ago and had these insightful comments:

Given the paucity of studies, and the methodological problems that accompany many of them (e.g., small sample sizes, high drop-out rates, inadequate outcome indicators, no follow-up) it is difficult to conclude anything other than that the available evidence base underpinning . . . therapeutic (as opposed to administrative or legal) interventions is wafer-thin. It is all the more serious then that the evidence that is available is so rarely advocated, so rarely acted on, and the requisite practice skills so rarely taught on professional courses. . . . One of the points of consensus in all the reviews to date is that behavioral and cognitive behavioral approaches have much to offer to the problems which need to be addressed if abuse and neglect are to be prevented from recurring in a range of circumstances . . .

One might question whether research since 2001 gives reason to arrive at a different conclusion from Macdonald. Our current review found key gaps in

research-based evidence and a lack of effective widespread implementation, even where we have such evidence. The good news since 2001 is that there are many more promising practices that have yet to be fully evaluated to the evidence-based practice level but are gaining recognition among practitioners as being helpful. These newer (and, thus, untested) models in the field are ready to be evaluated more rigorously. In addition, there are programmes that have been proven effective, but have not been validated with evidence using a child welfare population. Furthermore, many models with existing evidence of effectiveness lack an analysis of benefit/cost, and how that might benefit a jurisdiction's ability to reinvest foster care savings. Also, sample sizes in many studies limit our understanding about how programmes might have differentially beneficial effects for families facing different kinds of challenges. Finally, many community-based interventions which are vital for families do not fit the RCT paradigm, so other methods are needed to test their efficacy or these promising interventions will not qualify for government funding.

Family and intervention complexities illustrate additional gaps

While there has been encouraging progress in the development and testing of evidence-based interventions in recent years, there continues to be a dearth of effective interventions for some groups of maltreating parents in relation to these areas:

1. *Chronic child neglect*: Chronic child neglect remains an under-researched area in terms of what can make a difference in these families, particularly when accompanied by substance abuse and mental-health disorders.
2. *Combating poverty as a major risk factor*: The potential benefits of various poverty-related services for addressing neglect have not been adequately tested, even though the experimental evaluations of differential response systems in Minnesota and Ohio have provided encouraging evidence that concrete services can have a direct effect in reducing maltreatment recurrence rates and out-of-home placement of children referred to CPS. Promising results have also been found in a community network-based approach to preventing child abuse recurrence and accelerating permanency in Los Angeles (McCroskey *et al.* 2010).
3. *Domestic violence*: While there has been slow but steady progress in understanding the link between domestic violence and child maltreatment, and the need for cross-systems collaboration, other than the

Nurse Family Partnership, there is little or no research evidence of programmes for perpetrators of domestic violence that also reduce child maltreatment recurrence rates (Hovmand & Ford 2009; MacMillan *et al.* 2009).

4. *Substance abuse treatment*: While there are some promising programmes (US Government Accountability Office 2011, appendix II; Eienbinder 2010), the field lacks evidence on effective community-based models for working with child welfare-involved parents with substance abuse issues – a leading cause for neglect and chronic neglect. Research is needed regarding how to combine or sequence substance abuse treatment, whole family treatment approaches or domestic violence interventions with parenting skills programmes with strong research evidence of effectiveness. Some interventions that have evidence of effectiveness, and that families and caseworkers view as culturally competent, are ready to take the next step in intervention refinement by adding a strong substance abuse treatment component. For example, the University of Oklahoma and a US foundation (Casey Family Programs) worked to determine what aspects of the *SafeCare* home-visiting intervention were associated with effective treatment of American Indian families involved with CPS (Chaffin *et al.*, 2012). The *SafeCare* developers are also planning to integrate a substance abuse treatment component into their home-visiting model.

5. *Maternal depression and co-morbid disorders*: Are there cognitive-behavioural treatment strategies proven to be effective that could be combined with group-work interventions and then scaled up for more widespread use in child welfare? Group work models of treatment have been shown to be cost-effective across a wide number of areas (Cohen *et al.* 2008). But what programmes are most effective for parents with co-occurring substance abuse and mental-health disorders? Certain innovations such as the combined *SafeCare*/family behaviour therapy substance abuse treatment approach may be able to shed some light on the extent of this co-occurrence, and the effectiveness of the home-visiting approaches. But these models have not yet been tested sufficiently to know their true value.

6. *Parent trauma treatment*: There continues to be a dearth of evidence-based interventions for some groups of parents who are struggling with child abuse or neglect. For example, trauma-focused cognitive-behavioural treatment for parents with post-traumatic stress disorder can help speed healing and improve parent functioning. This is becoming a more widely

available intervention because of the research evidence and multiple ways for practitioners to become trained in the model, but we did not locate any evidence that *Trauma-Focused Cognitive Behavioral Treatment* can reduce child maltreatment recurrence (For more information about trauma-focused cognitive-behavioural treatment, see <http://tfcbt.musc.edu/>.)

7. *Multiple forms of maltreatment*: There has been little or no research in recent years concerning therapeutic interventions for parents engaged in multiple types of child maltreatment, for example, neglect combined with physical abuse and/or sexual abuse. What sequence of interventions would be most cost-effective, using practitioners who have an understanding of family dynamics and parent early histories?

8. *Parents with cognitive impairment*: The research literature regarding programmes for severely cognitively impaired parents who are struggling with child maltreatment is scant. Front-line caseworkers urgently need a range of interventions effective for working with developmentally disabled parents. Sometimes interventions like those based on cognitive-behavioural techniques will only be effective if special modifications are made for parents with limited cognitive functioning.

Implications for practice

Prevention programmes that serve children and families over several years and short-term parenting education programmes are based on different ideas regarding how and why behaviour change occurs. These parenting programmes aim to develop specific skills and achieve a narrow range of well-defined goals. Long-term prevention programmes aim to improve parental functioning, broadly considered, and support families in ongoing efforts to promote child development and school readiness. Ongoing relationships and sustained parental participation are important factors in long-term prevention programmes.

Implications for agency leaders

The strategies and programmes described in this paper and in a broad range of publications (e.g. McCauley et al. 2006; Allen 2011) demonstrate that there currently are a limited number of proven and promising practices that can help prevent child maltreatment and help parents safely avoid child placement. The following government policies that support local jurisdictions to improve outcomes for all chil-

dren who have entered or are at risk of entering the child welfare system should be implemented:

1. *Local agency use of research-informed practice approaches*: Legislators and agency leaders need to demand that the services provided directly by public agencies or purchased by them use evidence-informed practices whenever possible. Such mandates must, however, be tempered with an understanding of the current research limitations; the practical considerations of implementation related to model fidelity, cost and geographic distribution; and the need to support the evaluation of innovations and adaptations (Bond et al. 2009).

2. *Government fiscal support for new business models*: Local jurisdictions should have the flexibility to use government funds to provide the support necessary to ensure that these families remain strong. Additional reforms should also include performance-based contracts with private providers and government payments for clinical services needed by the children or parents – even when the child is not living with the family. Support should follow the child to ensure that families have what they need to ensure the healthy development of children and reduce the likelihood that they will re-enter care.

3. *Workforce development and support*: To implement effective family support strategies, agencies are learning that they need to supplement traditional training workshops with ongoing coaching and clinical support of line staff and supervisors. Organizational culture, climate and rewards for using effective practices need to be aligned to ensure full implementation and maintenance of high-fidelity practice approaches.

4. *Organizational capacity building*: Certain programmes may benefit from a stronger focus on key principles of effectiveness such as higher intensity, longer duration, professional and well-trained staff and comprehensive family services. These principles, of course, may vary by intervention or the family's situation. As mentioned earlier, some interventions may require specialized contract providers, while others require the participation of allied agencies such as public health or mental health.

5. *Programme planning and implementation*: Programme implementation has varied substantially due to such factors as inadequate planning, variation from the core model parameters and jurisdiction or contextual uniqueness. Programme administrators and evaluators need to monitor fidelity to the programme model, and should employ randomized control groups or other rigorous research designs to

determine programme impact. Concerns have been raised about the scaling up of innovative services and implementation of them without ensuring fidelity. Obstacles to implementation of models originally developed in university settings must be considered. These are becoming core principles in the development of evidence-based and evidence-informed interventions for child welfare services (Fixsen *et al.* 2005). Ensuring that enough public child welfare staff and other community service providers have the capacity to provide the necessary interventions remains a challenge.

6. *Support innovative forms of practice:* This can be accomplished by setting a policy goal of eliminating intergenerational transmission of child maltreatment, paying greater attention to helping parents and children heal from their childhood trauma (Samuels 2011), and by reforming child welfare federal finance mechanisms (Casey Family Programs 2010).

7. *Dissemination of research findings to practitioners:* As important as it is to supplement current knowledge regarding what services are effective in reducing child maltreatment and maltreatment recurrence, it is equally important to develop means of systematically communicating findings from research to child welfare caseworkers, supervisors and community service providers (Saul *et al.* 2008). Government agencies, universities, policy think tanks and foundations might consider joining together to produce a series of 'lessons from research' papers on various child welfare subjects, or working with universities to produce these papers utilizing the UK model of making knowledge available to child welfare practitioners. For more than two decades, the UK Department of Health has produced research summaries on foster care and child protection written for practitioners by distinguished scholars.

Implications for research

Various reviews of the existing research base have highlighted some key areas for improvement:

1. Longitudinal follow-up studies that extend beyond 1 or 2 years are needed with sample sizes that are large enough to reliably detect programme group differences. Effects of some prevention programmes may only become apparent 5 years or more after entry into the programme.
2. When evaluating preventive programmes, regular collection of official data on child maltreatment is needed. After several decades of research on child maltreatment prevention, many studies of pro-

grammes with a goal of preventing maltreatment do not collect official records of maltreatment or receipt of child welfare services.

3. Pre-school and home-visiting programmes should examine their outcomes related to child maltreatment prevention. A few programmes were highlighted in this review (e.g. *Chicago Child-Parent Centers*, and *Healthy Start*). Pre-school education programmes are expanding rapidly across many countries as an approach to promoting school readiness (Zigler *et al.* 2006; Allen 2011). Some of these programmes may also have child maltreatment prevention benefits.

4. Research on different and innovative intervention models is needed. For example, Reynolds *et al.* (2009) noted that it is possible that home visitation programmes alone may not be the most effective intervention strategy for preventing child maltreatment. However, interventions that combine different elements need further investigation. For example, we should test hybrid approaches, such as pre-school programmes with parenting components, two- or multi-generation programmes such as *Sunset Park* in Brooklyn (Hess *et al.* 2003) and programmes that provide more comprehensive health services (along with parenting classes or pre-school education) (Petras & Ward 2011).

To help address the knowledge gaps, more child maltreatment researchers, child welfare agency–university partnerships and innovative funding mechanisms are needed (Institute for the Advancement of Social Work Research 2010). National governments should make child welfare research a higher priority and encourage high standards for methodological rigour, with recognition that mixed methods studies to establish both evidence-informed and evidence-based programs will be essential (Gambrill 2007; Nevo & Slonim-Nevo 2011).

CONCLUSIONS

This paper demonstrates that it would be worth investing community and agency resources in certain child maltreatment prevention strategies. If implemented carefully, these strategies should result in stronger families and improved child safety, while inappropriate use of foster care is decreased. But we must be realistic about the impact of any one programme because only a small number of child maltreatment reports are substantiated or seen as valid; and an even smaller percentage of children are placed in care. The child welfare field is beginning to recognize that there are certain programme essentials

that must be in place to help ensure strong families and safe child-rearing environments. These include research-based and culturally competent safety and risk assessment methods, highly trained CPS intake staff, strong networks of alternative/differential response agencies, timely assessments and treatment and an array of effective family support agencies offering other evidence-based services.

Individual programmes/interventions can be very helpful but are not, by themselves, the answer. Parents who find themselves connected to the child welfare system are often in deep trouble. They are extremely likely to have been raised in families where their needs were not met and, in fact, where they were preyed upon in one or more ways. When staff members focus on domestic violence, substance abuse and depression, these may only be symptoms of far more pervasive and painful problems. What these parents need are nurturing relationships and the possibility of staying connected to their children – whether they are able to retain custody or not. They need to find respect in the way the child welfare workers, lawyers, judges, foster parents and treatment providers interact with them. They need to be seen as the experts on their children (Mann *et al.* 2011). The programmes described in this paper can be important parts of the system's response to these parents. However, unless we reconfigure the way the system interacts with parents, the individual programmes cannot hope to achieve long-term repair for these families (personal communication, Lucy Hudson, 22 April 2011; Turnell 2012).

The child welfare field also needs more research on family strengthening and child placement prevention strategies that will be cost-effective, replicable culturally and linguistically appropriate. Public-private collaborations need to work with non-partisan groups to evaluate policy, programme and research initiatives to help ensure that cost-benefit and other economic analyses are conducted. Agencies and communities will benefit from scaling up child abuse and neglect prevention strategies with strong evidence; while large-scale trials are launched for those promising and affordable strategies with less evidence of effectiveness. Strong, consistent agency leadership is essential, along with clearly communicating a compelling rationale for why this approach is so vital to meeting the needs of children and their families.

Finally, funding streams that do not require inordinate agency 'braiding' of different funding sources are essential to sustain and grow the best of these child abuse prevention programmes. Recent papers on child

welfare program and finance reform provide a rationale for those investments, and describe a range of cost-effective practice, administrative, policy and other system reform strategies (Cleaver *et al.* 2008; Allen 2011; Casey Family Programs 2010). These kinds of reforms may help ensure that child welfare agencies and community-based psychological, social, education, mental-health and employment services can better meet the needs of vulnerable children and their families.

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