

# Addressing Common Forms of Child Maltreatment:

Evidence-Informed Interventions and Gaps in Current  
Knowledge

Research Brief

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## Introduction

### Prevalence Rates of Child Maltreatment

Every year in the United States, about 702,000 children are confirmed as victims of child maltreatment,<sup>1</sup> and on any given day in 2010, nearly 408,000 children were living in foster care.<sup>2</sup> The victimization rate for FFY 2009 was 9.2 per 1,000 in the population.<sup>3</sup> With the exception of some forms of child neglect, there was a steady decline in the rates of substantiated child maltreatment in the mid- to late-1990s, and 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 were at or well above 1986 levels (NIS-2), and there was a five-fold increase in emotional neglect reported in NIS-4 compared to NIS-2.<sup>4</sup>

The National Child Abuse and Neglect Data System (NCANDS) data showed that, as in prior years, the greatest percentage of child victims suffered neglect. Child Protective Services (CPS) investigations<sup>5</sup> determined that:

- 78.0% of the victims suffered neglect.
- 17.8% of the victims suffered physical abuse.
- 9.5% of the victims suffered sexual abuse.
- 7.6% of the victims suffered from psychological maltreatment.

### Reasons for Child Placement

Nationally, in 2009 a total of 255,418 children were removed from their homes and entered foster care.<sup>6</sup> Most children were placed into out-of-home care because of some form of parental neglect, while others had experienced physical, sexual, or emotional abuse. Table 1 depicts why children entered foster care in FY09, some with multiple removal reasons.<sup>7</sup>

### The Need for More Evidence-Informed Practice Strategies

Across the country, the federal government, child welfare leaders, partners, and policymakers are committing themselves to improved policies and practices. Child welfare organizations are collaborating with new and traditional partners to improve the range and quality of services. Meanwhile, the child welfare field is becoming more research-based, with caseworkers, judges, and mental health providers seeking better assessment and intervention tools to serve vulnerable children and families. In some states, more evidence-informed interventions are being implemented. As a result, child welfare agencies are developing strategies and resources that help more children live in safe, nurturing, and permanent family homes.

Many public and private child welfare agencies across the country, including Casey Family Programs, support policies and practices that result in effective services for every child and every family. A primary goal for Casey Family Programs is to ensure that all children in America have safe, stable, and loving families that they can forever call their own. Retaining children safely in their family home and community eliminates the additional challenges and risks

children face when they are removed from their home of origin.<sup>8</sup> This paper reviews interventions for preventing the occurrence and recurrence of major types of child maltreatment.

**Table 1. Removal Reasons for Children Entering Foster Care (FY09)**

	All children	Age 0	Age 1-5	Age 6-12	Age 13-15	Age 16-17
Neglect	51.0%	59.9%	65.1%	59.0%	34.6%	26.2%
Parental Substance Abuse	24.5%	36.4%	32.0%	26.5%	13.1%	8.9%
Caretaker Inability to Cope	17.2%	19.1%	17.4%	18.5%	17.4%	15.8%
Child Behavior Problems	16.7%	1.0%	2.3%	9.3%	43.3%	54.5%
Physical Abuse	15.4%	16.7%	17.3%	18.8%	13.4%	9.2%
Inadequate Housing	9.4%	11.7%	12.5%	10.7%	5.4%	4.0%
Parent Incarceration	6.7%	6.5%	9.4%	8.3%	4.2%	2.8%
Abandonment/Relinquishment	5.4%	4.8%	4.4%	5.0%	7.1%	9.1%
Sexual Abuse	4.5%	0.8%	3.3%	7.2%	7.1%	4.9%
Child Substance Abuse	3.0%	4.2%	1.1%	1.1%	4.9%	8.3%
Child Disability	2.5%	3.5%	1.5%	2.8%	3.2%	2.8%
Parent Death	1.0%	0.6%	0.9%	1.3%	1.3%	1.3%

System reform strategies in the areas of practice, administration, and policy can improve conditions for maltreated children and accelerate permanency planning, thereby safely reducing the number of children in foster care.<sup>9</sup> Especially in times of fiscal constraint, we need programs to achieve these goals so that cost-savings resulting from foster care reductions at the state and county level can be reinvested in higher-quality interventions to reduce the need for foster care *and* provide better services for the children who require out-of-home care.

*Note that while this Casey research brief highlights child maltreatment prevention and treatment strategies with evidence of effectiveness, many large-scale county and state child welfare reforms experiencing success have implemented groups of evidence-based and promising strategies, such as alternative response/differential response, structured safety and risk assessment approaches, aggressive and repeated searches for relatives, family group conferences and family team decision making, community-based supports to strengthen families including economic and housing assistance, in addition to specific public policy reforms, court improvement projects, and specific intervention strategies.*

**What constitutes adequate research evidence of effectiveness?** While this issue is being debated vigorously, this research brief uses rating criteria from the California Evidence-Based Clearinghouse for Child Welfare (CEBC).<sup>10</sup> Programs 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 had a sustained effect for at least 6 months beyond the end of treatment. (See <http://www.cebc4cw.org/scientific-rating/scale#rating5> 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 had a sustained effect at least one year beyond the end of treatment.
3. **Well-Supported by Research Evidence:** Sample criteria include multiple-site replication. At least two rigorous 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 programs cited in the following databases but we screened the 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 (NCTSN; see [www.nctsn.org](http://www.nctsn.org))
- OJJDP Model Programs Guide (see <http://www.ojjdp.gov/mpg/>)
- OJJDP Children Exposed to Violence Evidence-Based Guide (see [http://www.safestartcenter.org/pdf/Evidence-Based-Practices-Matrix\\_2011.pdf](http://www.safestartcenter.org/pdf/Evidence-Based-Practices-Matrix_2011.pdf))
- SAMHSA National Registry of Evidence-Based Programs and Practices (NREP; see <http://nrepp.samhsa.gov/>)
- U.S. Department of Health and Human Services Home Visiting Evidence of Effectiveness (HomVEE) (see [http://www.acf.hhs.gov/programs/opre/other\\_resrch/home\\_visiting/index.html](http://www.acf.hhs.gov/programs/opre/other_resrch/home_visiting/index.html))

To recap, to be included in this review the intervention must have data linking it directly to reduction of some form of child maltreatment. This means that programs with indirect effects on child maltreatment, such as parental attachment or empathy with the child, and programs where studies were underway but not yet complete, were excluded (e.g., the Connected Families and the Attachment & Biobehavioral Catch-up programs).

## Cautions

This research brief and the full working paper identify evidence-based interventions, but because of space limitations, we do not provide details about each intervention or a critique of their implementation quality, design rigor, 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 these topics.<sup>11</sup> This research brief also does not describe the program's readiness for dissemination, including the availability of easy-to-understand manuals, program materials, program cost, etc. Such program features are included in SAMSHA's NREP, CEBC, and other registries.

Some of the programs mentioned in this research brief have been proven effective, but they lack an analysis of cost savings. Others may show promise, have been evaluated with a comparison group, but they have not yet been rigorously evaluated in randomized controlled trials. For example, we include some interventions for mental health problems that are evidence-based such as cognitive behavioral therapy (CBT) for parental depression. Yet we also include less well-researched engagement strategies such as Good Beginnings. Effective interventions for severe or chronic neglect will almost certainly include all of these types of strategies, some of which have modest evidence of effectiveness but are becoming recognized by practitioners as being helpful.

Finally, where possible, we have highlighted interventions that public child welfare agencies can implement themselves (e.g., Functional Family Therapy, Nurturing Parenting Program), versus those where specialized contract providers are usually needed (e.g., multi-dimensional treatment foster care). Some of the other interventions, however, can be provided by allied agencies that should be working closely with public child welfare, such as public health (e.g., Nurse-Family Partnership) or Mental Health (e.g., certain forms of substance abuse or mental health treatments such as brief strategic family therapy or trauma-focused cognitive behavioral therapy (TF-CBT). Ensuring that enough public child welfare staff or contract providers have the capacity to provide the necessary interventions remains a challenge.

## Prevention and Treatment Strategies with Some Evidence for Certain Child Maltreatment Types

While certain types of child maltreatment like physical abuse have been addressed by proven and promising interventions, other child maltreatment types have received less attention and fewer interventions have been developed for them. Table 2 lists interventions for which there is moderate to strong evidence of effectiveness; they are listed by type and sub-type of child maltreatment. Examples of where the program has been implemented are also provided, but the listing of states is not exhaustive. The number of asterisks indicates how strong the evidence base is for the strategy according to criteria used by CBEC.

**Table 2. Intervention Strategies with Evidence of Effectiveness by Types and Sub-Types of Child Maltreatment**

Sub-Type of Child Maltreatment	Prevention or Intervention Strategies (States or Large Counties Where Implemented)
<p><b>Neglect: General and undifferentiated, including severe and chronic neglect</b></p>	<ul style="list-style-type: none"> <li>• <b>Chicago Child-Parent Centers</b>*** (Illinois. See <a href="http://www.waisman.wisc.edu/cls/cbaexecsum4.html">http://www.waisman.wisc.edu/cls/cbaexecsum4.html</a>)</li> <li>• <b>Healthy Families America</b>*** (Over 35 states including Arizona, Florida, Iowa, Maryland, Massachusetts, Minnesota, New Jersey, Oregon, Virginia, and Vermont. See <a href="http://www.healthyfamiliesamerica.org/home/index.shtml">http://www.healthyfamiliesamerica.org/home/index.shtml</a>)</li> <li>• <b>Nurse-Family Partnership</b>*** (In over 33 states. See <a href="http://www.nccfc.org/nursefamilypartnership.cfm">http://www.nccfc.org/nursefamilypartnership.cfm</a>)</li> <li>• <b>Project Connect parent drug treatment programs</b>** (Rhode Island, Virginia. See <a href="http://www.cfsri.org/projectconnect.html">http://www.cfsri.org/projectconnect.html</a>)</li> <li>• <b>Triple-P Positive Parent Partnership</b>*** (Many states and countries, including South Carolina. See <a href="http://www.triplep.net">www.triplep.net</a>)</li> </ul> <p><b>Promising Interventions:</b></p> <ul style="list-style-type: none"> <li>• <b>Alternative/Differential Response practice strategies</b>* (Many states. See <a href="http://www.differentialresponseqic.org/">http://www.differentialresponseqic.org/</a>)</li> <li>• <b>Cognitive Behavioral Treatment (CBT)</b>* For anxiety or depression (nearly all states. See <a href="http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001848/frame.html">http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001848/frame.html</a>)</li> <li>• <b>Colorado Adolescent Maternity Program (CAMP) with home visiting</b>* (Colorado. See <a href="http://www.thechildrenshospital.org/news/pr/2009-news/Childrens-CAMP.aspx">http://www.thechildrenshospital.org/news/pr/2009-news/Childrens-CAMP.aspx</a>)</li> <li>• <b>Crisis nurseries</b>* (In many states including California, Florida, Oregon, and Utah. See <a href="http://www.archrespice.org/">http://www.archrespice.org/</a>)</li> <li>• <b>Dialectic Behavior Therapy for parent substance abuse</b>* (In most states. See <a href="http://behavioraltech.org/index.cfm">http://behavioraltech.org/index.cfm</a> and <a href="http://behavioraltech.org/resources/crd_results.cfm">http://behavioraltech.org/resources/crd_results.cfm</a>)</li> <li>• <b>Early Start – New Zealand</b>* (See <a href="http://www.msd.govt.nz/documents/about-msd-and-our-work/publicationsresources/evaluation/early-start-evaluation-report.pdf">http://www.msd.govt.nz/documents/about-msd-and-our-work/publicationsresources/evaluation/early-start-evaluation-report.pdf</a>)</li> <li>• <b>Family economic support strategies including stronger TANF and employment programs, and other anti-poverty interventions.</b>* (All 50 states. See <a href="http://www.nccp.org/">http://www.nccp.org/</a>)</li> <li>• <b>Good Beginnings</b>* (Virginia, Australia, and many other states. See <a href="http://www.goodbeginnings.org.au/">http://www.goodbeginnings.org.au/</a>)</li> <li>• <b>Nurturing Parenting Program</b>* (Many states, including Florida, Hawaii, and Louisiana. See <a href="http://www.nurturingparenting.com/">http://www.nurturingparenting.com/</a>)</li> <li>• <b>SafeCare</b>* (California, Colorado, Georgia, Indiana, Kansas, Maryland, Rhode Island, Oklahoma, Texas, and Washington. See <a href="http://chhs.gsu.edu/safecare/docs/safecare-fact-sheet.pdf">http://chhs.gsu.edu/safecare/docs/safecare-fact-sheet.pdf</a>)</li> </ul>
<p><b>Child Physical Abuse:</b></p>	<ul style="list-style-type: none"> <li>• <b>Chicago Child-Parent Centers</b>*** (Illinois. See <a href="http://www.waisman.wisc.edu/cls/cbaexecsum4.html">http://www.waisman.wisc.edu/cls/cbaexecsum4.html</a>)</li> </ul>

Sub-Type of Child Maltreatment	Prevention or Intervention Strategies (States or Large Counties Where Implemented)
<p><b>Undifferentiated</b></p>	<ul style="list-style-type: none"> <li>• <b>Healthy Families America</b>*** (Over 35 states including Arizona, Florida, Iowa, Maryland, Massachusetts, Minnesota, New Jersey, Oregon, Virginia, and Vermont. See <a href="http://www.healthyfamiliesamerica.org/home/index.shtml">http://www.healthyfamiliesamerica.org/home/index.shtml</a>)</li> <li>• <b>Nurse-Family Partnership</b>*** (Over 33 states. See <a href="http://www.nccfc.org/nursefamilypartnership.cfm">http://www.nccfc.org/nursefamilypartnership.cfm</a>)</li> <li>• <b>Parent Child Interaction Therapy (PCIT)</b>*** (California, Washington. See <a href="http://pcit.phhp.ufl.edu/efficacy.htm">http://pcit.phhp.ufl.edu/efficacy.htm</a> or <a href="http://pcit.phhp.ufl.edu/">http://pcit.phhp.ufl.edu/</a>)</li> <li>• <b>Triple-P Positive Parent Partnership</b>*** (Many states and countries, including South Carolina. See <a href="http://www.triplep.net/">http://www.triplep.net/</a>)</li> </ul> <p><b>Promising Interventions:</b></p> <ul style="list-style-type: none"> <li>• <b>Alternative/Differential Response practice strategies</b>* (Many states. See <a href="http://www.differentialresponseqic.org/">http://www.differentialresponseqic.org/</a>)</li> <li>• <b>Crisis nurseries</b>* (Many states including California, Florida, Oregon, and Utah. See <a href="http://www.archrespice.org/">http://www.archrespice.org/</a>)</li> <li>• <b>Dialectic Behavior Therapy for parent substance abuse</b>* (In most states. See <a href="http://behavioraltech.org/index.cfm">http://behavioraltech.org/index.cfm</a> and <a href="http://behavioraltech.org/resources/crd_results.cfm">http://behavioraltech.org/resources/crd_results.cfm</a>)</li> <li>• <b>Enhanced Pediatric Care for Families at Risk</b>* (Baltimore, MD. See <a href="http://www.umm.edu/pediatrics/seek_project.htm">http://www.umm.edu/pediatrics/seek_project.htm</a>)</li> <li>• <b>Family economic support strategies including stronger TANF and employment programs, and other anti-poverty interventions.</b>* (All 50 states. See <a href="http://www.nccp.org/">http://www.nccp.org/</a>)</li> <li>• <b>Good Beginnings</b>* (Virginia, Australia, and many other states. See <a href="http://www.goodbeginnings.org.au/">http://www.goodbeginnings.org.au/</a>)</li> <li>• <b>Healthy Start Program, Enhanced Model</b>*** (Many states. See <a href="http://www.healthystartassoc.org/">http://www.healthystartassoc.org/</a>)</li> <li>• <b>Nurturing Parenting Program</b>* (Many states, including Florida, Hawaii, and Louisiana. See <a href="http://www.nurturingparenting.com">http://www.nurturingparenting.com</a>)</li> </ul>
<p><b>Neglect: Educational neglect and child truancy</b></p>	<p>No research-based interventions were identified with direct effects on this type of child maltreatment.</p>
<p><b>Neglect: Emotional maltreatment</b></p>	<ul style="list-style-type: none"> <li>• No programs were found as the <b>Attachment and Biobehavioral Catch-up</b> studies are underway. (Delaware. See <a href="http://icp.psych.udel.edu">http://icp.psych.udel.edu</a> or <a href="http://www.cebc4cw.org/program/145/detailed#relevant-research">http://www.cebc4cw.org/program/145/detailed#relevant-research</a>)</li> </ul>
<p><b>Neglect: Poverty as a major factor.</b></p>	<ul style="list-style-type: none"> <li>• <b>Family economic support strategies including stronger TANF and employment programs, and other anti-poverty interventions</b>* (All 50 states. See <a href="http://www.nccp.org/">http://www.nccp.org/</a>)</li> </ul>



Sub-Type of Child Maltreatment	Prevention or Intervention Strategies (States or Large Counties Where Implemented)
<b>Neglect: Improper or lack of supervision</b>	<ul style="list-style-type: none"> <li>• <b>SafeCare*</b> (California, Colorado, Georgia, Indiana, Kansas, Maryland, Rhode Island, Oklahoma, Texas, Washington. See <a href="http://chhs.gsu.edu/safecare/docs/SafeCare-fact-sheet.pdf">http://chhs.gsu.edu/safecare/docs/SafeCare-fact-sheet.pdf</a>)</li> </ul>
<b>Neglect: With maternal depression or other forms of mental health disorders</b>	<ul style="list-style-type: none"> <li>• <b>Cognitive Behavioral Treatment (CBT) for anxiety or depression***</b> (Nearly all states. See <a href="http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001848/frame.html">http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001848/frame.html</a>)</li> </ul>
<b>Neglect: Medical or lack of proper health care</b>	<ul style="list-style-type: none"> <li>• <b>Enhanced Pediatric Care for Families at Risk*</b> (Baltimore, MD. See <a href="http://www.umm.edu/pediatrics/seek_project.htm">http://www.umm.edu/pediatrics/seek_project.htm</a>)</li> <li>• <b>SafeCare*</b> (California, Colorado, Georgia, Indiana, Kansas, Maryland, Rhode Island, Oklahoma, Texas, and Washington. See <a href="http://chhs.gsu.edu/safecare/docs/SafeCare-fact-sheet.pdf">http://chhs.gsu.edu/safecare/docs/SafeCare-fact-sheet.pdf</a>)</li> </ul>
<b>Neglect: Substance abuse as a major risk factor</b>	<ul style="list-style-type: none"> <li>• <b>Dialectic Behavior Therapy for substance abuse treatment*</b> (Multiple states. See <a href="http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=72">http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=72</a>)</li> <li>• <b>Family Drug Courts and Benchmark Hearings*</b> (Some states. See <a href="http://www.ojp.usdoj.gov/BJA/grant/DrugCourts/DefiningDC.pdf">http://www.ojp.usdoj.gov/BJA/grant/DrugCourts/DefiningDC.pdf</a>)</li> <li>• <b>Project Connect parent drug treatment programs*</b> (Rhode Island, Virginia. See <a href="http://www.cfsri.org/projectconnect.html">http://www.cfsri.org/projectconnect.html</a>)</li> </ul>
<b>Physical Abuse: Abuse accompanied by domestic violence</b>	<ul style="list-style-type: none"> <li>• <b>Nurse-Family Partnership***</b> (In over 33 states. See <a href="http://www.nccfc.org/nursefamilypartnership.cfm">http://www.nccfc.org/nursefamilypartnership.cfm</a>.)</li> </ul>
<b>Physical Abuse: Abuse due to parent-child conflict</b>	No research-based interventions were found with direct effects but we believe that functional family therapy should be tested for this outcome.
<b>Physical abuse: Abusive head injuries such as shaken baby syndrome</b>	<ul style="list-style-type: none"> <li>• <b>Healthy Start Program, Enhanced Model***</b> (Many states. See <a href="http://www.healthystartassoc.org/">http://www.healthystartassoc.org/</a>)</li> <li>• <b>Hospital-Based Education Programs*</b> (New York. See <a href="http://www.eric.ed.gov/ERICWebPortal/search/detailmini.jsp?_nfpb=true&amp;_ERICExtSearch_SearchValue_0=EJ377564&amp;ERICExtSearch_SearchType_0=no&amp;accno=EJ377564">http://www.eric.ed.gov/ERICWebPortal/search/detailmini.jsp?_nfpb=true&amp;_ERICExtSearch_SearchValue_0=EJ377564&amp;ERICExtSearch_SearchType_0=no&amp;accno=EJ377564</a>)</li> </ul>
<b>Psychological Abuse</b>	<ul style="list-style-type: none"> <li>• <b>Healthy Families America***</b> (Over 35 states including Arizona, Florida, Iowa, Maryland, Massachusetts, Minnesota, New Jersey, Oregon, Virginia, and Vermont. See <a href="http://www.healthyfamiliesamerica.org/home/index.shtml">http://www.healthyfamiliesamerica.org/home/index.shtml</a>)</li> </ul>
<b>Sexual Abuse</b>	<ul style="list-style-type: none"> <li>• <b>Circles of Accountability and Support*</b> (To prevent re-victimization. California, Canada, Minnesota, and other states. See <a href="http://www.csc-scc.gc.ca/text/prgrm/chap/circ/proj-guid/index-eng.shtml">http://www.csc-scc.gc.ca/text/prgrm/chap/circ/proj-guid/index-eng.shtml</a>)</li> </ul>

**Note:** The interventions are grouped by the child maltreatment types and sub-types where there is some evidence of effectiveness. The number of asterisks indicates how strong the evidence base is for the strategy according to the California Evidence-Based Clearinghouse for Child Welfare.

**Evidence of effectiveness levels:**

- \***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 had a sustained effect at least 6 months beyond the end of treatment. (See <http://www.cebc4cw.org/scientific-rating/scale#rating5> for more complete definitions.)
- \*\***Supported by Research Evidence:** Sample criteria include at least one rigorous 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 had a sustained effect at least one year beyond the end of treatment.
- \*\*\***Well-Supported by Research Evidence:** Sample criteria include multiple-site replication: At least two rigorous 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.

## Discussion

### Addressing Gaps in Evidence Regarding Effective Interventions

This review found key gaps in research-based evidence and a lack of effective wide-spread implementation, even where we have such evidence. There are many promising practices. While these practices need to be fully evaluated to the evidence-based practice (EBP) level, many are gaining recognition among practitioners as being helpful. In addition, there are programs that have been proven effective but that 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 affect a jurisdiction's ability to reinvest foster care savings. Also, sample sizes in many studies limit our understanding about how programs might have differentially beneficial effects for families facing different kinds of challenges.

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 as well as underlying conditions that affect parenting such as substance abuse, mood disorders, and parenting skill deficits. There are two dilemmas to address: (1) where to begin with supportive and therapeutic interventions, and (2) how to organize a sequence of interventions that does not overwhelm family members.

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 the following areas:

1. **Child neglect:** Chronic neglect combined with co-occurring substance abuse and mental health disorders remains a difficult therapeutic challenge. 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 incorporating a strong substance abuse treatment component. For example, Casey Family

Programs worked with the University of Oklahoma to determine what aspects of the SafeCare intervention were associated with effective treatment of American Indian families involved with CPS.<sup>12</sup> The SafeCare developers are also planning to integrate a substance abuse treatment component into their home-visiting intervention.

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.<sup>13</sup>
3. **Domestic violence:** While there has been slow but steady progress in understanding the link between domestic violence and child maltreatment publicizing the need for cross-systems collaboration, and some promising programs exist,<sup>14</sup> there is little research evidence of programs for perpetrators of domestic violence that also reduce child maltreatment recurrence rates.
4. **Substance abuse treatment:** While some promising programs exist,<sup>15</sup> 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. Are there certain groups of families for which we should combine or sequence substance abuse treatment or domestic violence interventions with parenting skills programs with strong research evidence of effectiveness? How should that be done?
5. **Maternal depression and co-morbid disorders:** Are there cognitive-behavioral 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 number of areas.<sup>16</sup> But what programs are most effective for parents with co-occurring substance abuse and mental health disorders? Certain innovations such as the combined SafeCare family behavior 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 for these types of situations 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 their own victimization. For example, trauma-focused cognitive behavioral treatment for parents with PTSD can help speed healing and improve parent functioning.<sup>17</sup> 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 TF-CBT can reduce child maltreatment recurrence.
7. **Parents with cognitive impairment:** The research literature regarding programs 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-behavioral techniques will only be effective if special modifications are made for parents with limited cognitive functioning.

8. **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? Do they address family dynamics and parents' early histories?

### Implications for Practice

Recommended guidelines for child maltreatment prevention in child welfare include:

- Intervene earlier with an emphasis on community-based and home-based services. But don't underestimate the power of a positive relationship. For example, therapeutic relationships are critical in helping parents struggling with child maltreatment. While concrete assistance with life tasks is not part of the therapeutic design, Prinz and Miller (1994) found that families whose treatment focused exclusively on parent training and child behavior dropped out more often than families who had opportunities to discuss life concerns beyond child management, particularly among families facing greater adversity. The parents seemed to appreciate the therapists who provided them with help in their "real lives," beyond the limited therapeutic milieu (Personal communication, Lucy Hudson, April 5, 2011).
- Embrace a child development perspective and consider which child well-being goals are most important to address first.
- Carefully target families that can truly benefit from skill-focused parenting education programs that are evidence-based.
- Collaborate with substance abuse and mental health agencies to sustain long-term case management programs for parents with substance abuse and mental health problems.
- Support early childhood education programs or therapeutic child development programs for children age 0-5 in low-income families referred to CPS.

Prevention programs that serve children and families over several years and time-limited parenting education programs are based on different theories regarding how and why behavior change occurs. These parenting programs aim to develop specific skills and achieve a narrow range of well-defined goals. Long-term prevention programs 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 programs.

Individual programs/interventions can be very helpful but are not, by themselves, the answer. Parents who find themselves connected to the child welfare system are in deep trouble. They are extremely likely to have been raised in families where their own needs were not met and, in fact, where they were preyed upon in one or more ways. While staff may focus on domestic violence, substance abuse, and depression, these conditions are in fact only the symptoms of far more pervasive and painful problems lurking below the surface. What these parents need is 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, treatment providers interact with them. They need to be seen as the experts on their children.<sup>18</sup> The specific interventions may be less

important than the context in which they are offered. The programs listed in this research brief 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 programs cannot hope to achieve long-term repair for these families (Personal communication, Lucy Hudson, April 22, 2011).

### Implications for Agency Leaders

The strategies and programs described in this paper 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 state and federal policies that support states to improve outcomes for all children who have entered or at risk of entering the child welfare system should be implemented:

1. **State 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-based 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.<sup>19</sup>
2. **Federal and state fiscal support for new business models:** States should have the flexibility to use federal 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 Medicaid payments for clinical services needed by 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 healthy child development and reduce the likelihood that the child 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:** Implemented programs may benefit from a stronger focus on key principles of effectiveness such as being of higher intensity and/or longer duration, professional and well-trained staff, and comprehensive family services. As mentioned earlier, some interventions may also require specialized contract providers, while others require the participation of allied agencies such as public health or mental health.
5. **Program planning and implementation:** Program implementation has varied substantially due to such factors as inadequate planning, variation from the core model parameters, and jurisdiction or contextual uniqueness. Program administrators and evaluators need to monitor fidelity to the program model and should employ randomized control groups or other rigorous research designs to determine program impact. Concerns have been raised about the scaling up of innovative services and their implementation 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.<sup>20</sup>

6. **Support of innovative forms of practice:** This can be accomplished by setting a policy goal of eliminating intergenerational transmission of child maltreatment, by paying greater attention to helping parents and children heal, and by reforming child welfare federal finance mechanisms.<sup>21</sup>
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 and supervisors. The Federal Administration for Children, Youth and Families (ACYF), 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 United Kingdom model of making knowledge available to child welfare practitioners. For more than two decades, the Department of Health (the English counterpart to ACYF) has produced research summaries on foster care and child protection written for practitioners by distinguished scholars. Apart from an occasional practitioner-oriented research review paper and some federal “user guides,” there are few publications similar to these reports in American scholarship – especially those where high standards of methodological rigor are used as the rubric for study inclusion.

### Implications for Research

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 program group differences. Effects of some prevention programs may only become apparent 5 years or more after program entry.
2. When evaluating preventive programs, regular collection of official data on child maltreatment is needed. After several decades of research on child maltreatment prevention, many studies of programs with a goal of preventing maltreatment do not collect official records of maltreatment or receipt of child welfare services.
3. Preschool and home-visiting programs should examine their outcomes related to child maltreatment prevention. A few programs were highlighted in this review (e.g., Chicago Parenting Centers, Healthy Start, and Healthy Families America). Preschool education programs are expanding rapidly across the United States as an approach to promoting school readiness.<sup>22</sup> Some of these programs may also have child maltreatment prevention benefits.
4. Research on different and innovative intervention models is needed. For example, Reynolds and his colleagues (2009) noted that it is possible that home visitation programs alone may not be the most effective intervention strategy for preventing child maltreatment. Interventions that combine different elements need further investigation. For example, we should test hybrid approaches, such as preschool programs with parenting components, two- or multi-generation programs such as Sunset Park in Brooklyn, and programs that provide more comprehensive health services (along with parenting classes or preschool education).<sup>23</sup>

To help address the knowledge gaps, more child maltreatment researchers, child welfare agency-university partnerships, and innovative funding mechanisms are needed.<sup>24</sup> The federal government should make child welfare

research a higher priority and encourage high standards for methodological rigor, with a recognition that mixed methods studies may be essential.

### Conclusions

This research brief and the full working paper demonstrate 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 program 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 program 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, and an array of effective family support agencies offering evidence-based services.

The child welfare field needs more research on family strengthening and child placement prevention strategies that will be cost-effective, replicable, and culturally and linguistically appropriate. Public-private collaborations need to work with non-partisan groups such as the Annie E. Casey Foundation, the Center for Evidence-Based Policy, the MacArthur Foundation, the Pew Foundation, the Society for Cost-Benefit Analysis, and the W.T. Grant Foundation to evaluate policy, program, and research initiatives to help ensure that cost-benefit and other economic analyses are conducted.

States, counties, and tribal nations will benefit from scaling up child abuse and neglect prevention strategies with strong evidence base – 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 maltreatment prevention programs. As mentioned earlier, a recent paper on child welfare finance reform provides a rationale for those investments and describes a range of cost-effective practice, administrative, policy, and other system reform strategies.<sup>25</sup> These types 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.

## Reference Notes

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- <sup>2</sup> 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](http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#afcars)
- <sup>3</sup> The victimization rate was computed by dividing the number of total unduplicated victims by the child population for the 51 states that reported these data and multiplying by 1,000. The rate for duplicated victims is 10.1 per 1,000. See <http://www.acf.hhs.gov/programs/cb/pubs/cm09/cm09.pdf#page=9>, p. ix.
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- <sup>7</sup> Source for these data is the Adoption and Foster Care Analysis and Reporting System (AFCARS). The FY09 data used in this paper were made available by the National Data Archive on Child Abuse and Neglect, Cornell University, Ithaca, NY, and have been used with permission. The AFCARS data were originally collected by the U.S. Children's Bureau.
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