



# New Directions for North Carolina

A Report of the NC Institute of Medicine  
Task Force on Child Abuse Prevention

*September 2005*

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North Carolina Institute of Medicine

 **Prevent Child Abuse**  
North Carolina

North Carolina Institute of Medicine  
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# Executive Summary

Child maltreatment is a devastating problem affecting the lives of tens of thousands of children in North Carolina annually. In our state, a child is mistreated every fifteen minutes by a parent or caretaker. Every two weeks a child dies from abuse. For those children who experience abuse or neglect, the effects of the maltreatment upon their emotional, cognitive, and physical development can be quite serious - including severe physical injuries, neurological damage, cognitive deficits, emotional/behavioral problems, and increased risk for depression, substance abuse, poor school performance, and juvenile delinquency/adult crime. Child maltreatment is an expensive social problem that costs North Carolina approximately \$3 billion annually.<sup>1</sup> Child protective services, court costs, and medical care account for some of the direct costs, while indirect costs include mental health treatment services and special education programs.

Despite the enormous social and economic costs of child maltreatment in North Carolina, comprehensive efforts to prevent child maltreatment have faced a number of challenges. These include a lack of direction and vision for prevention activities across the state, resulting in fragmented efforts across multiple systems, an absence of public leadership at the state level and insufficient funding that is not strategically focused on evidence-based or research-based programs shown to reduce maltreatment or strengthen families. North Carolina also has a limited measurement system that cannot accurately provide information on the true incidence of the problem. Such challenges have hindered the state's capacity to effectively reduce the maltreatment of its youngest citizens.

## NC Institute of Medicine Task Force on Child Abuse Prevention

In 2003, Prevent Child Abuse North Carolina (PCA North Carolina) launched the Gaining Ground Initiative, a multi-year effort to identify and implement strategies to reduce child maltreatment in North Carolina. Recognizing the challenges facing state and local efforts to prevent maltreatment, PCA North Carolina approached the NC Institute of Medicine about the possibility of convening a statewide Task Force on Child Abuse Prevention. The Task Force on Child Abuse Prevention was led by the Honorable Carmen Hooker Odom, Secretary of the NC Department of Health and Human Services, and Marian Earls, MD, FAAP, Medical Director of Guilford Child Health, Inc., and a leading advocate for child maltreatment prevention efforts across the state. The Task Force on Child Abuse Prevention, funded by the Duke Endowment, was comprised of fifty-one additional members including representatives from the departments of human services, education, juvenile justice, the NC General Assembly, healthcare providers, community-based service organizations, local businesses, universities, and the faith community. In addition, the work of the Task Force on Child

Abuse Prevention was supported by eleven individuals who served on a Steering Committee that guided the work of the entire project, twenty-five people who reviewed the research literature for evidence-based and research-based child maltreatment prevention programs, and fifteen people who worked on developing a child maltreatment monitoring/surveillance system. The Task Force on Child Abuse Prevention met over the course of nine months (October 2004 - June 2005).

## Child Maltreatment in North Carolina

Child maltreatment is an act or failure to act which results in significant harm or risk of harm to a minor.<sup>2</sup> Maltreatment may be committed by a family member, caregiver, or other adult. Typically, professionals recognize four types of child maltreatment: physical abuse, neglect, sexual abuse, and emotional/psychological abuse. In many cases, children experience multiple forms of maltreatment simultaneously. Child maltreatment also varies in terms of frequency, severity, and occurs with other forms of family violence such as domestic violence.<sup>3</sup>

Child maltreatment is a form of trauma and can have a significant adverse impact on a child's social, cognitive, and emotional development. Depending on a number of factors, including the age of the child and frequency/severity of abuse, the trauma associated with child maltreatment may negatively alter a child's neurological development, impairing his ability to develop normally and participate in higher cognitive functions.<sup>4</sup> Consequently, children who experience maltreatment may demonstrate attention deficits, problems with abstract reasoning and decision-making, and lower intelligence quotients that may lead to poor school performance and a need for special education services.<sup>5</sup> They may also demonstrate negative behavioral and emotional responses, such as higher rates of post-traumatic stress disorder, depression and mood disorders, alcohol and drug use, and personality disorders.<sup>6</sup> Other developmental effects include speech delays, deficits in interpreting language, gross motor delays, and sensory integration problems. Children who are maltreated may also have problems developing appropriate social relationships, trust, and attachments.<sup>7</sup> An estimated 30% of maltreated children will go on to abuse or neglect their own children later in life.<sup>8</sup>

Multiple factors at the individual, family, neighborhood, and societal levels interact to contribute to or protect against child maltreatment. The likelihood of maltreatment increases when risk factors outweigh protective factors that strengthen families.

The Central Registry tracks the number of children investigated and substantiated for child maltreatment by local departments of social services. In state fiscal year 2004-2004, it reported that 113,557 children were subject to an investigative or family assessment, and 27,310 children were substantiated or found in need of services. In addition, thirty children were the victims of child abuse homicides in 2004. The Central Registry does not collect data on every child who has been maltreated, only those that come to the attention of the departments of social services, were perpetrated by a caretaker (parent, guardian, or childcare provider), and meet the statutory definitions of abuse and neglect.

Other sources of data, including CarolinaSAFE - an anonymous, random telephone survey conducted with mothers of children aged birth to seventeen years in North and South Carolina - suggest that the actual incidence of maltreatment may be much higher than official estimates. CarolinaSAFE found that mothers self-reported physical abuse of their children at a rate more than forty times higher than the Central Registry substantiation rates in either state. This study also found sexual abuse to be fifteen times higher than official state-level statistics.<sup>9</sup>

Despite the limited data concerning incidence of maltreatment, there is a consensus among professionals and researchers that the number of children experiencing maltreatment constitutes one of the most serious public health issues in the state.

## Child Maltreatment Prevention

Child maltreatment prevention efforts include activities, strategies, or programs to reduce risk factors and increase protective factors associated with child maltreatment. These efforts are designed to increase the capacity of parents, caretakers, and communities to protect, nurture, and promote the healthy development of children. While a number of activities can comprise child maltreatment prevention, activities are typically placed into three categories:

- > **Universal strategies** target activities to the general population with the goal of preventing child maltreatment from ever occurring.
- > **Selective strategies** target activities to a group with specific risk factors with the goal of preventing child maltreatment from occurring in that group.
- > **Indicated strategies** target activities to a group that has experienced maltreatment with the goal of preventing its reoccurrence.

An effective statewide child maltreatment prevention initiative should provide an array of universal, selective, and indicated child maltreatment prevention activities. Historically, North Carolina has focused the majority of its efforts and resources on indicated strategies, targeting individuals or families that have experienced abuse with the goal of preventing its re-occurrence. Little state-level attention has been directed toward preventing child maltreatment from occurring in the first place.

To effectively reduce child maltreatment in North Carolina, state and local communities must shift attention and resources towards pregnancy and the early years of childhood (birth to five years) because those developmental periods offer the best “windows of opportunity” for helping families develop nurturing, responsive relationships that promote healthy child development.<sup>10</sup> This would require community and institutional support of parenting, including support and services for every expectant family and parents with young children. Services should then be added to this universal base of support through programs such as parent education and home visiting, which respond to the developmental needs of the child or the evolving parent-child relationship. Such a prevention system would help all parents and children before abusive/neglectful behaviors become established and difficult to modify; promote help-seeking behavior as a normal and expected activity for all parents; and provide more targeted services to higher-risk families.

An effective child maltreatment prevention system should integrate services across public and private agencies, and be culturally and linguistically appropriate. The system should be built around evidence-based and theory-based models that have been shown to work, in order to ensure that limited resources are used most effectively. Further, sufficient resources should be allocated to ensure the program staffing, training, technical assistance, and evaluations are adequate to successfully implement a child maltreatment prevention effort.

## Vision for Children, Families, and Communities

We envision that

- > Children are nurtured, supported, and protected within safe and stable homes and community environments.
- > Families recognize the rewards and responsibilities of raising children and have access to support within their own communities to help them meet those responsibilities.
- > Families are able to ask for and receive timely assistance without fear of being punished or blamed.
- > Communities are supported in their efforts to meet the diverse needs of families in raising their children.

## Core Issues for Child Maltreatment Prevention Efforts

In addition to using the aforementioned vision and principles as a guide for developing statewide prevention efforts, North Carolina must also address several critical challenges in order to be successful in reducing maltreatment among children.

### Leadership

While North Carolina has developed a coordinated system to respond to reports of child maltreatment, no comprehensive system currently exists to prevent maltreatment from occurring in the first place. Prevention efforts are fragmented across agencies with little shared planning and few measurable outcomes. There is no state agency with programmatic authority assuming leadership for child maltreatment prevention and being held accountable for statewide efforts. Creation of public, state-level leadership for child maltreatment prevention is critical to advancing prevention efforts statewide. To establish leadership, the Task Force on Child Abuse Prevention recommends:

- > **The NC General Assembly should establish a standing Child Maltreatment Prevention Legislative Oversight Council that has diverse membership representation and strong leadership from state and local agencies and community providers. (Recommendation 4.1 - Priority)**
- > **The NC Department of Health and Human Services - NC Division of Public Health should develop a Child Maltreatment Prevention Leadership Team to assist in supporting the work of the Child Maltreatment Prevention Legislative Oversight Council. (Recommendation 4.2 - Priority)**

### Measurement

North Carolina needs a comprehensive monitoring system to estimate the magnitude of the child maltreatment problem, provide information for program planning and implementation, and inform the public and policy makers of the effectiveness of prevention efforts. North Carolina currently relies on child fatality data and the Child Protective Services Central Registry as the primary sources of data on maltreatment incidence. However, there are limitations to these data. Development of a child maltreatment monitoring system that provides a more accurate picture of maltreatment in North Carolina is needed to effectively design, target, and evaluate a statewide prevention system. The Task Force on Child Abuse Prevention recommends:

- > **The NC Division of Public Health's Injury and Violence Prevention Branch should work with a Technical Advisory Committee to develop a North Carolina data collection system for monitoring child maltreatment prevention. (Recommendation 5.1 - Priority)**

### Social Norms and Policies

The larger social environment in which families raise children plays a significant role in the occurrence of child maltreatment. Community norms, social values, and the public's worldviews all influence the way in which individuals in the larger community support families who are raising children. Changing these community norms and social values to create more supportive and healthy environments in which to raise children is a key challenge for the state.

While child maltreatment prevention public awareness campaigns have been quite successful in raising awareness of the issue of child maltreatment, current research indicates that the public does not understand prevention nor believe that it is possible to prevent maltreatment. An important next step in public awareness efforts to reduce maltreatment includes strategically reframing the messages that we are providing to parents, families, and the public about child abuse prevention so that we create a community climate in which families are supported and strengthened, and parents can seek assistance without stigma.

A second issue closely associated with social norms and child maltreatment is the pervasiveness of violence within American culture. The glamorization of violence within the media, the public's tolerance of high levels of violence within communities, and social norms that reinforce violent responses to problems all contribute to a climate where violence is perceived as an appropriate response to family conflict. Public health experts recognize that the larger societal context of violence creates an environment that places healthy parenting and healthy child development in jeopardy. Supporting and encouraging comprehensive violence prevention efforts are critically linked to the success of efforts to prevent maltreatment.

- > PCA North Carolina, in partnership with the NC Division of Public Health, should take the lead in developing a public education and marketing campaign aimed at encouraging community members to support parents by promoting positive parenting behaviors and increasing public support for programs and resources aimed at strengthening positive family interaction. (Recommendation 6.1 - Priority)
- > PCA North Carolina, in collaboration with the NC Division of Public Health, the NC Division of Social Services, the NC Coalition Against Domestic Violence, the NC Domestic Violence Commission, the NC Partnership for Children, the NC Department of Public Instruction, and the NC Department of Juvenile Justice and Delinquency Prevention, should work with and support ongoing grassroots efforts to establish community norms that support families and healthy child development, and reduce social acceptance of violence as an appropriate response to interpersonal conflict. (Recommendation 6.2 - Priority)

### **Evidence-Based and Promising Practices**

Increasingly, policy-makers, researchers, and practitioners are focusing on the use of evidence-based and promising practices in community and state efforts to prevent maltreatment. Evidence-based programs are those programs that have scientific evidence of their effectiveness in reducing risk factors, increasing protective factors, and preventing maltreatment. Promising programs have some evidence of effectiveness, but this evidence includes evaluations with less rigorous designs or methodological limitations and additional experimental evaluations are needed in order to determine the program's effectiveness. Although the field of child maltreatment prevention does not yet have an extensive body of scientifically proven programs, it is critical to incorporate what is known into the practices of the thousands of practitioners who work with families and children daily. North Carolina should support the implementation of evidence-based and promising programs by prioritizing funding for those programs with strong research demonstrating their effectiveness. It should also engage in specific statewide efforts to implement programs that have a strong body of evidence such as the Nurse Family Partnership, Parent-Child Interaction Therapy, the Strengthening Families Program, and the Chicago Child-Parent Centers.

- > PCA North Carolina, through its involvement with the Child Maltreatment Prevention Leadership Team, should convene an Expert Work Group on Evidence-Based Practice to identify, support, and disseminate information about evidence-based and promising programs in the field of child maltreatment prevention and family strengthening. (Recommendation 7.1 - Priority)
- > Public and private funders should place priority on funding evidence-based and promising child maltreatment prevention and family strengthening programs. When those programs are not available for a specific population, public and private funders should give funding priority to those programs that are theory-based and incorporate elements identified in the research literature as critical elements of effective programs. (Recommendation 7.2 - Priority)
- > PCA North Carolina should work with the NC Division of Medical Assistance, the NC Division of Public Health, and Community Care of North Carolina to implement the Nurse Family Partnership Program in two to three additional sites in North Carolina. (Recommendation 7.3)



- > PCA North Carolina and the NC Division of Public Health should work with the Education Begins at Home Alliance to develop a model of home visitation for families at high risk of maltreatment based on the most current research of perinatal and early childhood home visitation programs, and from an assessment of the current resources and infrastructure for home visiting programs in North Carolina. (Recommendation 7.4)
- > The Child Maltreatment Prevention Leadership Team should work to pilot or replicate promising child maltreatment prevention programs, such as Parent-Child Interaction Therapy, the Strengthening Families Program, and the Chicago Child-Parent Center, and to evaluate their effectiveness with a North Carolina population. (Recommendation 7.5 - Priority)
- > The Child Maltreatment Prevention Leadership Team should work to ensure community-based family resource centers offer or link to evidence-based and promising prevention programs; require use of social support and parent education programs that have been evaluated and show evidence/promise in preventing maltreatment; re-target funding for school-based child sexual abuse prevention programs to promising models; and develop an evaluation process for family support and child maltreatment prevention programs using a shared set of research-based intermediate indicators for child maltreatment, nurturing parent-child interaction, and healthy child development. (Recommendation 7.6)
- > The Child Maltreatment Prevention Leadership Team should work with the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and other agencies and private providers providing oversight or treatment for children who have experienced abuse or neglect to encourage the use evidence-based models identified by the Kaufmann Best Practice Initiative, Substance Abuse Mental Health Services Administration, and the Centers of Excellence. (Recommendation 7.7)

## Systems Changes

Public and private agencies/programs that currently serve families and children can be enhanced to incorporate child maltreatment prevention efforts. Infusing family strengthening and child maltreatment prevention strategies into those programs could help them more effectively target the risk and protective factors closely associated with child maltreatment. Three broad areas emerged as the most logical for organizing such efforts:

*Strengthening Families with Young Children:* Pregnancy and the first years of life (birth to five years) are critical periods in creating healthy and nurturing parent-child relationships. An effective family strengthening system should begin during these developmental periods. Consequently, a number of initiatives and programs that promote early childhood development and provide services to expectant families and families with young children should be involved in child maltreatment prevention efforts. These initiatives and programs include the Early Childhood Comprehensive System Initiative, early childhood home visiting programs, maternal and child health services, early intervention services, primary healthcare providers, early childhood mental health services and practices, and early childhood education.

- > The Child Maltreatment Prevention Leadership Team should work closely with the Early Childhood Comprehensive System Initiative in the development of an integrated and comprehensive early childhood system that promotes the health and well-being of young children birth through age five. Specifically, stakeholders from both initiatives should identify common outcomes and common areas of focus, and integrate efforts whenever possible to maximize resources and prevent duplication. (Recommendation 8.1)
- > The NC Division of Medical Assistance, the NC Division of Public Health's Women's and Children's Health Section, PCA North Carolina, and other appropriate partners should work with the Education Begins at Home Alliance to ensure a coordinated and effective system of prenatal and early childhood home visitation programs across North Carolina, which are voluntary and appropriately match services to families' risks and needs. (Recommendation 8.2)

- > The NC Division of Public Health and the NC Division of Medical Assistance should strengthen the Maternity Care Coordination and Child Service Coordination programs with regard to child maltreatment prevention by requesting that prevention is included as a major goal of the programs, strengthening intervention models, and increasing training on the issue. (Recommendation 8.3)
- > The NC Division of Public Health and the NC Division of Medical Assistance should support the Children’s Developmental Services Agencies in ensuring families who are maltreating and who are at high risk of maltreating their children continue to be served. (Recommendation 8.4 - Priority)
- > The NC Division of Medical Assistance – Office of Research, Demonstrations, and Rural Health Development and the NC Division of Public Health should work together to explore ways to enhance the role of primary care providers in child maltreatment prevention through the NC Medical Home Initiative and the Assuring Better Child Health and Development Project. (Recommendation 8.5)
- > The Child Maltreatment Prevention Leadership Team and the Early Childhood Comprehensive System Initiative should work together in identifying the needs of families and other caregivers in promoting young children’s social/emotional health, identifying effective strategies to meet these needs, and enhancing the capacity of multiple provider systems to coordinate and deliver services to those caregivers and children. (Recommendation 8.6)
- > The NC Division of Child Development, the NC Department of Public Instruction, and the NC Partnership for Children should work with the Early Childhood Professional Development Institute to develop a plan for increasing the training of childcare providers to better understand and to assist parents in understanding stages of child development and age appropriate child behavior, and to promote infant/child mental health and social/emotional development. (Recommendation 8.7)

*Building Services Developmentally According to Need:* Parents will continue to need support as children get older and they face new developmental challenges, or as certain environmental stressors (e.g., poverty, lack of adequate childcare) jeopardize the healthy parent/child relationship. As a result, parent support services for families with children of all ages should be available through public and community-based agencies. Such services could include parent education and training, parent support groups, and respite care. Additionally, the public school system and the social services system can strengthen universal and selective prevention strategies with existing resources and programs such as school health nurses or the Multiple Response System.

- > PCA North Carolina should work with family support organizations to increase the availability of respite care, parent support groups, and parent support strategies, and to ensure that families in need of support are able to access services within their communities. (Recommendation 8.8)
- > The NC Department of Health and Human Services should ensure that a strengthening parenting component is included across state programs that serve families, including culturally appropriate programmatic strategies that will support and strengthen parent-child relationships, especially during pregnancy and the first two years of the child’s life. (Recommendation 8.9)
- > The North Carolina State Board of Education and the NC Department of Public Instruction should identify strategies to increase support for children at risk of maltreatment and their families to ensure that children are able to fulfill their academic potential in traditional schools, alternative schools, or other educational settings. (Recommendation 8.10)

- > The NC Division of Social Services, the NC Association of County Directors of Social Services, and the Children’s Services Advisory Committee, in conjunction with community providers, should explore ways to strengthen universal/selective child maltreatment prevention efforts by expanding prevention services through the Multiple Response System for all children and developing family strengthening/child maltreatment prevention strategies for the Work First population. (Recommendation 8.11)

*Reducing Risk Factors at a Population Level:* A number of familial and environmental stressors increase a family’s risk for child maltreatment. To the extent that North Carolina can reduce these risk factors on a population basis, it can be expected that the incidence of child maltreatment will decrease. Specific risk factors include unwanted or closely spaced pregnancies, adolescent pregnancy, substance abuse, postpartum and maternal depression, domestic violence, and unavailable or inadequate childcare. Populations considered at higher risk for child maltreatment and needing targeted prevention efforts include families with children who have disabilities, communities experiencing natural disasters, communities with a strong military presence, and incarcerated parents.

- > The NC Division of Public Health and the NC Division of Medical Assistance should pursue a more rapid rollout of the federal Medicaid family planning waiver. (Recommendation 8.12)
- > The NC General Assembly should appropriate additional stable funding to the NC Division of Public Health to expand the Teen Pregnancy Prevention Initiative and revise G.S. 115C-81 (e3-8) to ensure that students are receiving medically accurate information and that schools are using evidence-based approaches to prevent unwanted pregnancies and the transmission of STD/HIV. (Recommendation 8.13)
- > The NC Division of Public Health should assess the potential costs and benefits to the state of providing some level of service to all pregnant adolescents and adolescent parents by reviewing evaluation data from programs serving these populations across the country. (Recommendation 8.14)
- > The Child Maltreatment Prevention Leadership Team should work with the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and other substance abuse treatment organizations to increase the number of substance abuse treatment programs with a particular focus on gender specific programs for pregnant women and women with children, and increase outreach to identify women in need of these services. (Recommendation 8.15 - Priority)
- > The NC Division of Public Health should work with the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the NC Division of Social Services, the NC Division of Medical Assistance, professional associations, and appropriate health professional training schools to jointly develop a strategy to assess the prevalence of maternal and postpartum depression for North Carolina women, and examine the issues regarding screening for, access to, and availability of services for this condition. (Recommendation 8.16 - Priority)
- > The Child Maltreatment Prevention Leadership Team should work with the NC Coalition Against Domestic Violence and other domestic violence advocates, PCA North Carolina, the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and the NC Division of Public Health’s Injury and Violence Prevention Branch to identify and pilot evidence-based or primary prevention strategies for domestic violence and child maltreatment. (Recommendation 8.17)
- > The NC Office of Education Services should work with PCA North Carolina to strengthen early intervention services with regard to parent-child interaction and child maltreatment prevention for families of children with special needs enrolled in their services. (Recommendation 8.18)

- > The Child Maltreatment Prevention Leadership Team should work with the Early Childhood Comprehensive System Initiative, the NC Partnership for Children, the NC Division of Child Development, and other appropriate organizations to identify strategies to increase the availability of affordable, quality childcare and request that the NC General Assembly increase funding for childcare subsidies to county departments of social services offices to ensure that 1% of additional families needing childcare subsidies are served each year until at least 50% of eligible families are being served. (Recommendation 8.19)
- > The Child Maltreatment Prevention Leadership Team should work with the State Emergency Management Team and other NC disaster response professionals and rapid response professionals to increase awareness of increased risk for child maltreatment in young children, particularly inflicted traumatic brain injury, occurring immediately after and up to six months following a natural disaster, and to ensure that appropriate parent support services are in place for those families at highest risk. (Recommendation 8.20)
- > The Child Maltreatment Prevention Leadership Team should work with state and local nonprofit organizations to increase the capacity of local communities to identify and implement research-based strategies focused on the primary prevention of child maltreatment among military families and communities. (Recommendation 8.21)
- > The Child Maltreatment Prevention Leadership Team should work with the NC Department of Corrections to examine whether incarcerated parents have a higher risk of future child maltreatment, and if so, develop recommendations to address this issue. (Recommendation 8.22)

## **Funding**

Child maltreatment prevention efforts require adequate funding to assure program effectiveness. A number of funding streams in North Carolina are being used to fund child maltreatment prevention and family strengthening activities, including funding streams through the NC Children’s Trust Fund, the NC Department of Health and Human Services, the NC Governor’s Crime Commission, the NC Partnership for Children, and the NC Department of Public Instruction. The Task Force on Child Abuse Prevention identified several strategies to increase funding for effective child maltreatment prevention efforts, including raising additional revenue for the NC Children’s Trust Fund, shifting current funding to support the Task Force on Child Abuse Prevention’s priority recommendations for preventing maltreatment, encouraging current programs to adopt research-based/evidence-based practice, and seeking new funding through federal, state and non-governmental resources.

- > The NC Department of Public Instruction should ensure that funds from the NC Children’s Trust Fund are used to support a full-time administrator for the NC Children’s Trust Fund whose responsibilities are solely dedicated to child maltreatment prevention efforts. (Recommendation 9.1)
- > The NC General Assembly should make necessary funds available to implement the recommendations of the Task Force on Child Abuse Prevention through the implementation of an additional fee on birth certificates, marriage licenses, and divorce decrees, or through a check-off on income taxes for the NC Children’s Trust Fund, and to appropriate funds to replicate specific programs identified as evidence-based or promising in preventing child maltreatment or strengthening families. (Recommendation 9.2 - Priority)
- > The Child Maltreatment Prevention Leadership Team should work to increase funds available to implement the recommendations of Task Force on Child Abuse Prevention with a specific focus on the support of evidence-based and promising child maltreatment prevention programs. (Recommendation 9.3)

In sum, North Carolina is poised to significantly enhance state and local efforts to prevent child maltreatment and to strengthen families. The Task Force on Child Abuse Prevention has made a number of recommendations to accomplish these goals including establishing leadership for child maltreatment prevention in North Carolina state government at the NC Division of Public Health, developing a comprehensive monitoring system for child maltreatment prevention, promoting community norms that support healthy parenting and strong families, increasing the number of evidence-based and promising practices implemented by local community-based agencies, strengthening the prevention efforts of existing systems that serve families and children, and increasing funding for maltreatment prevention and family strengthening programs. Members of the Task Force on Child Abuse Prevention look forward to working with each other and with multiple communities in the state to implement these recommendations and to make North Carolina a place where every child enjoys a happy and healthy childhood.

## CHAPTER 1

# Introduction

**C**hild maltreatment is a devastating social problem that affects the lives of millions of children in the United States each year. In North Carolina, a child is mistreated every 15 minutes by a parent or caretaker. Every two weeks a child dies from abuse. Effects of maltreatment on the social, cognitive, and emotional development of children can be far-reaching and, in many cases, irreparable. Children may suffer from serious physical injuries, neurological damage, cognitive deficits, problems with social relationships, behavior problems, aggression, depression, and increased risk for substance abuse, poor school performance, and juvenile delinquency/adult crime. While the human costs of child abuse and neglect are profound and tragic, the financial costs are equally staggering. Prevent Child Abuse America estimates that the annual cost of child maltreatment in the United States is \$94 billion annually.<sup>11</sup> North Carolina spends approximately \$3 billion each year, much of it are costs borne by the state's taxpayers.<sup>12</sup>

Despite the enormous social and economic costs of child maltreatment in North Carolina, child maltreatment prevention has received little attention or resources from state policy makers. As a result, North Carolina's prevention efforts lack adequate data for describing and understanding the problem and for developing a coherent vision and direction. Activities are carried out in fragmented efforts across multiple systems with little coordination or shared accountability, and suffer from insufficient funding that is not strategically focused on research-based programs or on shared outcomes across funding streams.

To address these problems, Prevent Child Abuse North Carolina (PCA North Carolina), with the support of The Duke Endowment, launched the Gaining Ground Initiative, a multi-year effort to identify and implement strategies to reduce maltreatment in North Carolina.<sup>13</sup> Early in its work, PCA North Carolina identified the development of a statewide task force or work group as a key strategy to achieving the Gaining Ground outcomes. In the fall of 2004, PCA North Carolina approached the NC Institute of Medicine (NC IOM) about the possibility of convening a statewide Task Force on Child Abuse Prevention. The NC IOM agreed to facilitate the Task Force on Child Abuse Prevention in partnership with PCA North Carolina. NC IOM staff helped to lead and facilitate the work of the Task Force on Child Abuse Prevention, and PCA North Carolina provided the research, background, and expertise in child maltreatment prevention.

## The Task Force on Child Abuse Prevention

Carmen Hooker Odom, Secretary of the NC Department of Health and Human Services and Marian Earls, MD, FAAP, Medical Director of Guilford Child Health, Inc., agreed to co-chair the Task Force on Child Abuse Prevention. Members of the Task Force on Child Abuse Prevention were chosen for their expertise in child maltreatment and prevention issues, as well as for their leadership among state and local programs and organizations that serve families and children. The Task Force on Child Abuse Prevention included representatives of state government from the NC Department of Health and Human Services, the NC Department of Juvenile Justice and Delinquency Prevention, and the NC Department of Public Instruction. Additionally, legislators, representatives of county agencies, non-profit service and advocacy organizations, health professionals, the faith community, university professionals, and the business community served as members. A list of the Task Force on Child Abuse Prevention members is included in the Appendix. The Task Force on Child Abuse Prevention met for six daylong meetings between October 2004 and June 2005.

## Charge of the Task Force on Child Abuse Prevention

The goal of the Task Force on Child Abuse Prevention was to develop a statewide plan that focused on preventing maltreatment before it occurs, rather than on responding to and intervening in maltreatment (e.g., the child protection system). To accomplish this, the Task Force on Child Abuse Prevention was charged with developing a statewide plan to prevent maltreatment that would:

- > Include different levels of intervention, including universal, selective, and indicated programs that target children, families, and communities that are based on empirical research (to the greatest extent possible).
- > Establish indicators and a timetable to measure our state's progress in implementing the statewide plan towards reducing child maltreatment.
- > Identify a state agency or agencies that have preventing child maltreatment as one of their principal responsibilities, along with a set of recommendations on the resources needed to carry out this responsibility.
- > Focus governmental and nongovernmental organizations on programs and systems of care that will reduce the incidence of child maltreatment.
- > Identify ways to maximize existing funding or retool existing programs to prevent child maltreatment.
- > Examine gaps in existing programs or resources needed to prevent child maltreatment along with identifying possible funding sources.
- > Identify additional measures and establish mechanisms for collecting data to more accurately assess and monitor the incidence of child maltreatment and effectiveness of prevention efforts.

## Staffing Of the Task Force on Child Abuse Prevention

Primary staff direction for the work of the Task Force on Child Abuse Prevention was the responsibility of Pam Silberman, JD, PhD, Vice President of the NC Institute of Medicine; Gordon H. DeFries, PhD, President and CEO of the NC Institute of Medicine; Kristen Dubay, MPP, Project Director, NC Institute of Medicine; Michelle Hughes, MA, MSW, Prevention Network Director of PCA North Carolina; Anne Sayers, MSW, Program Director of PCA North Carolina; and Jennifer Tolle Whiteside, MA, Executive Director of PCA North Carolina.

The Task Force on Child Abuse Prevention was supported by a multidisciplinary Steering Committee comprised of key program level staff from several state agencies serving families and children, as well as the Duke University Center for Child and Family Policy, PCA North Carolina, and the NC Institute of Medicine. The Steering Committee, whose members are listed in the Appendix, met on a monthly basis between scheduled meetings of the full Task Force on Child Abuse Prevention. The Steering Committee assumed responsibility for planning the Task Force on Child Abuse Prevention meetings, identifying the issues that needed to be addressed by the full membership, and arranging speakers to present key information on child maltreatment and prevention.

In addition, two subcommittees were formed to help address specific, complex issues related to child maltreatment that needed more intensive, in-depth discussion before Task Force on Child Abuse Prevention members could address the issues in full meetings. A Program Subcommittee was created to review evaluation research on child maltreatment prevention programs and make recommendations to the full Task Force on Child Abuse Prevention about programs that had sufficient evidence to be replicated in North Carolina. The Program Subcommittee members included researchers and policy analysts from the University of North Carolina at Chapel Hill, NC State University, and Duke University, as well as practitioners and state agency representatives. The Program Subcommittee was chaired by Michelle Hughes with PCA North Carolina and a full list of members is included in the Appendix of this report.

The second subcommittee created was a Measurement Subcommittee that examined issues related to measuring the incidence of child maltreatment in North Carolina. This is an exceedingly complex area and in order to make recommendations to the full membership, PCA North Carolina convened an expert group of researchers, policy analysts, and state agency representatives who work with data systems experts to provide guidance and insights into this issue. Anne Sayers of PCA North Carolina and Adam Zolotar, NRSA Primary Care Research Fellow and Clinical Instructor of Family Medicine at the University of North Carolina School of Medicine chaired the Measurement Subcommittee. A full list of members is included in the Appendix of this report.

## Organization of This Report

This report describes how North Carolina can begin to shift its focus and resources from responding to the tragedy of child maltreatment to preventing child maltreatment from ever occurring. Such a shift will not come easily. For many years, professionals and volunteers have been working toward preventing child maltreatment with limited resources and little federal or state guidance on the most effective prevention strategies. The creation of a strong child maltreatment system will require building a developmentally focused, integrated system at the neighborhood, community, and state levels. Such a system will help families meet the challenges of childrearing while changing social norms and environmental conditions to better promote healthy child development, effective parenting, and nurturing communities. While a challenge, the Task Force on Child Abuse Prevention believes promoting healthy child development among families, communities, and professionals is critical.

This report contains ten chapters:

- > Chapter Two provides information about child maltreatment including different forms of maltreatment, the impact of maltreatment on children, risk factors that contribute to maltreatment, and protective factors that can help strengthen families and reduce the likelihood of maltreatment.
- > Chapter Three provides background information about child maltreatment prevention efforts nationally and in North Carolina. It also proposes a set of critical principles to guide the development of a child maltreatment prevention system in our state.
- > Chapter Four covers state leadership issues including recommendations to create a leadership structure that supports child maltreatment prevention efforts across public and private agencies and organizations.
- > Chapter Five describes the limitations of the current system to monitor the incidence of child maltreatment and includes recommendations for a new system, which could provide better estimates of the extent of child maltreatment and be used to evaluate the effectiveness of North Carolina's program and policy initiatives aimed at reducing maltreatment.
- > Chapter Six focuses on efforts to change social norms and community attitudes to better support healthy parenting and child development through public awareness and community mobilization strategies.
- > Chapter Seven reviews evidence-based and promising practices to reduce child maltreatment.
- > Chapter Eight examines existing programs and systems and includes recommendations to restructure and enhance these programs to reduce risk factors and strengthen the protective factors in an effort to reduce the incidence of child maltreatment.



- > Chapter Nine provides an overview of funding issues related to child maltreatment prevention and provides recommendations to strengthen financing efforts for prevention in North Carolina.
- > Chapter Ten concludes the report with a table outlining the Task Force on Child Abuse Prevention's recommendations and lead agencies for implementation.

More in-depth information about many of these issues can be found in a series of publications produced by PCA North Carolina as background for the Task Force on Child Abuse Prevention. The titles of these publications are included in the Appendix and they can be obtained by visiting [www.preventchildabusenc.org](http://www.preventchildabusenc.org).

This report should be seen as a strategic guide for North Carolina's future child maltreatment prevention efforts. Chapters include long-term goals and strategic recommendations to achieve those goals. We fully expect additional strategies will be developed as this work continues and that some of the existing recommendations may change direction as new collaborations and partnerships flourish.

## Conclusion

The work of the Task Force on Child Abuse Prevention has been groundbreaking. It is the first time that the state has systematically and comprehensively addressed the issue of child maltreatment prevention using both research and professional judgment as guideposts for action. It is the first time that state agencies serving families and children have come together to collectively review and discuss their efforts to prevent child maltreatment and to identify ways to strengthen what they do. It is also the first time that North Carolina has targeted state-level barriers to providing effective child maltreatment prevention efforts and recommended significant changes to funding streams, program directions, and leadership to remove those barriers.

While groundbreaking, the work of the Task Force on Child Abuse Prevention represents just a first step in the on-going work to reduce child maltreatment in North Carolina. The recommendations produced by the Task Force on Child Abuse Prevention should be seen as an attempt to align state systems such that community-level practitioners can more effectively implement research-based, quality child maltreatment prevention activities. However, there is much more to do. Implementation of several of the Task Force on Child Abuse Prevention recommendations will be challenging, requiring a serious commitment - financial and otherwise - to support prevention activities. Translating the recommendations for use at the community level will require an enormous amount of attention and effort among multiple stakeholders, but is a necessary precursor to successfully reducing child maltreatment in North Carolina's communities.

## CHAPTER 2

# Overview of Child Maltreatment

**C**hild maltreatment is an act or failure to act that results in significant harm or risk of harm to a minor.<sup>14</sup> It may occur by commission (actively doing something that harms a child) or omission (failure to do something that would prevent harm). Child maltreatment may be committed by a family member, caregiver, or other adult. While the exact medical, legal, and psychological definitions of child maltreatment sometimes differ, professionals typically recognize four types of child maltreatment: physical abuse, neglect, sexual abuse, and emotional/psychological abuse.

### Diagram 2.1 Type of Child Maltreatment

- > **Physical abuse** includes physical injuries that result from actions including punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting with a hand or other object, or burning. Child physical abuse may occur as a single incident or repeated incidents. Consequences can range from minor bruises to death.<sup>15</sup>
- > **Neglect** includes a wide variety of behavior. Neglect is a failure to provide for a child's basic needs - physical, educational, or emotional. Physical neglect can include refusal of or delay in healthcare; abandonment; expulsion; inadequate supervision; inadequate nutrition, clothing, or hygiene; conspicuous inattention to avoidable hazards in the home; and reckless disregard for a child's safety and welfare. Educational neglect can include permitted chronic truancy, failure to enroll a child in school; or inattention to special education needs. Emotional neglect can include inadequate nurturing or affection; exposure to chronic or extreme domestic violence; and refusal or delay in psychological care.<sup>16</sup>
- > **Sexual Abuse** is any sexual activity with a child where consent is not or cannot be given.<sup>17</sup> It can involve touching and non-touching activities. Child sexual abuse can include fondling of the genital area or breasts; masturbation; or oral, vaginal, or anal penetration by a finger, penis, or other object. Child sexual abuse also includes exhibitionism, child pornography, internet crimes, or sexually suggestive behaviors or comments.<sup>18</sup>
- > **Emotional/Psychological Abuse** is defined by the American Professional Society on the Abuse of Children (APSAC) as "a repeated pattern of caregiver behavior or extreme incident(s) that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another's needs." The terms emotional and psychological abuse are often used interchangeably. APSAC guidelines refer to six categories of psychological maltreatment that include spurning, terrorizing, isolating, exploiting/corrupting, denying emotional responsiveness, and mental health, medical, and educational neglect.<sup>19</sup>

Child maltreatment exists on a continuum of frequency and severity. In 30% to 60% of the cases, it overlaps with other forms of family violence, such as domestic violence.<sup>20</sup> Often children simultaneously experience multiple forms of maltreatment, such as a physical and emotional abuse.<sup>21</sup>

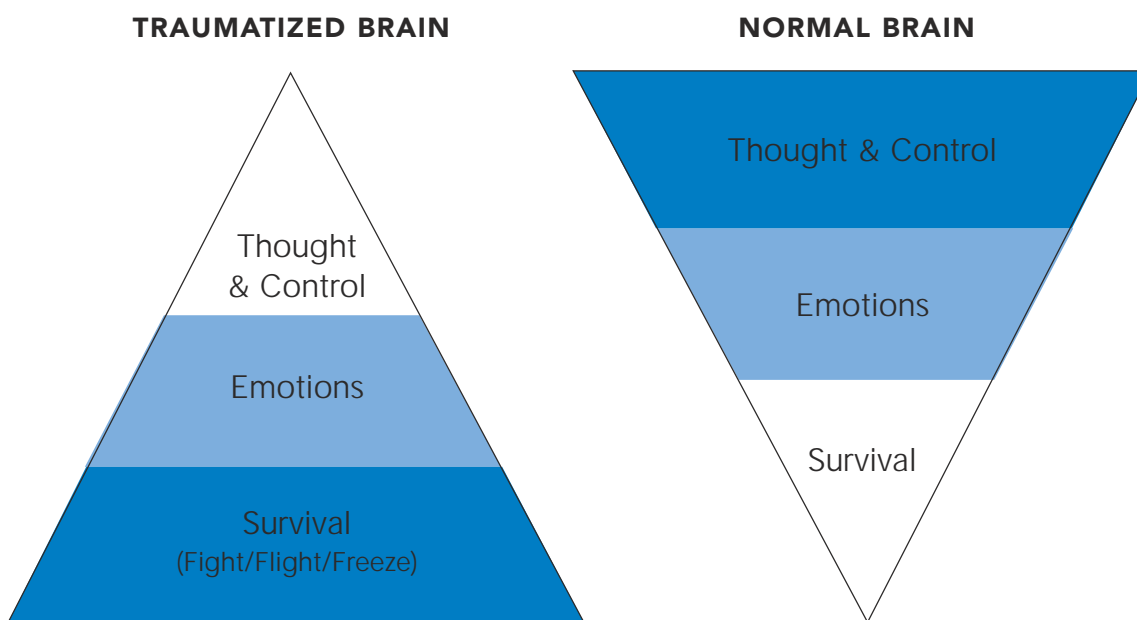
## Consequences of Child Maltreatment

Child maltreatment is a form of trauma. Trauma is an experience or exposure that is sudden, uncomfortable, uncontrollable, and negative.<sup>22</sup> The impact of child maltreatment trauma on child development can be significant and lead to altered brain activity and structure among some children. Multiple factors determine the effects of maltreatment and trauma on a child's development, including the age of the child when the trauma occurred, frequency and severity of trauma, and the existence of other protective factors that may buffer the child from adverse effects.<sup>23</sup>

As children are exposed to traumatic situations, their neuroendocrine and immune systems respond to the stressful stimuli by releasing various hormones into the bloodstream that produce arousal and stress responses to the situation.<sup>24</sup> Children who are repeatedly maltreated experience a prolonged stress response that may alter the brain's activities and structure. That is, the brains of some maltreated children look physically different from the brains of non-maltreated children. Several studies using magnetic resonance imaging (MRI) with healthy children and children exposed to trauma, including abuse and neglect, have shown adverse brain development because of maltreatment. In one study of forty-four maltreated children and adolescents with post-traumatic stress disorder and sixty-one matched control individuals, researchers found intracranial volume decrease by 7% and total brain volume decrease by 8% in the maltreated children with post-traumatic stress disorder as compared to the control group.<sup>25</sup>

These studies suggest that recurrent and chronic maltreatment may have a harmful effect on brain development and on children's cognitive abilities. For example, healthy children who are not maltreated have significant brain activity in the frontal cortex - the part of the brain that deals with the ability to understand consequences and that regulates impulse control, higher-level thinking, and connections to memory. A healthy child can usually make good decisions and has good impulse control. In an abused child, there is often significantly less activity in the frontal cortex. Brain activity is instead concentrated in the brain stem and mid-brain; this more primitive part of the brain controls survival functions and emotions - fight, flight, or freeze responses. Diagram 2.1 illustrates the difference in brain activity between a non-maltreated child and a maltreated child.

**Diagram 2.1** Brain Activity Differences



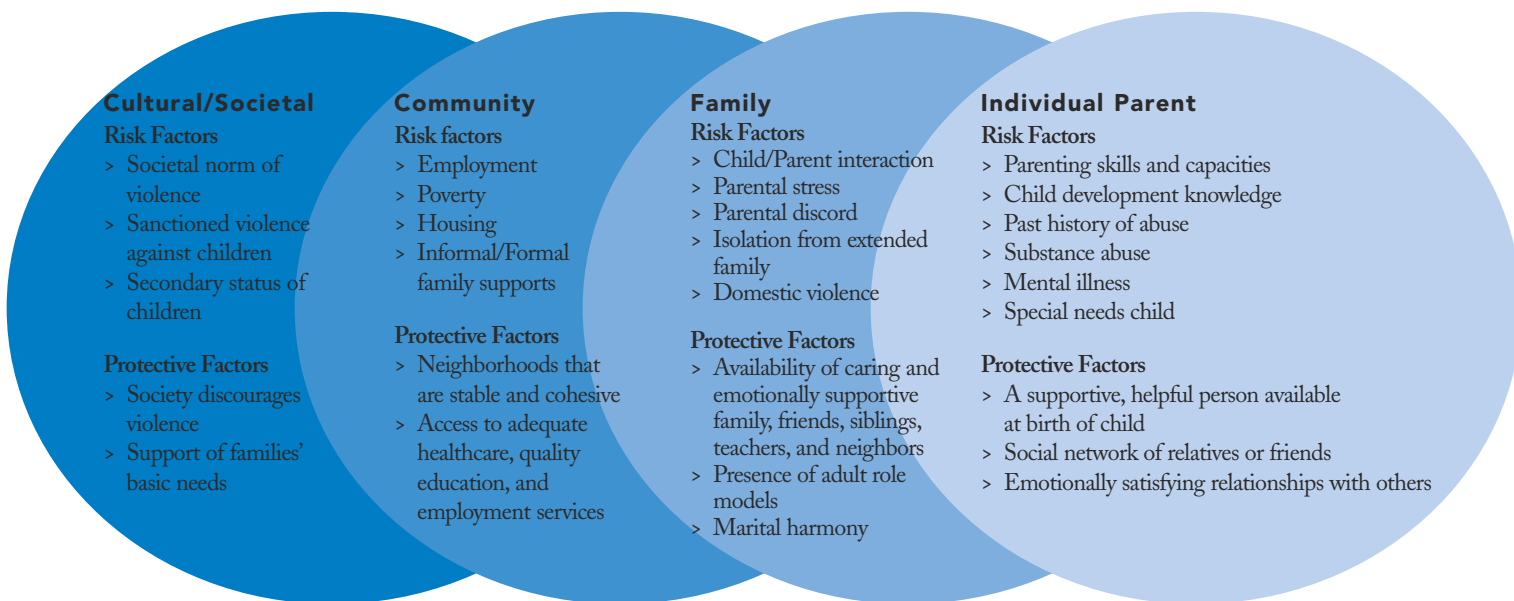
Overall, maltreated children are less able to perform in school or problem-solve and have little impulse control. They make poor choices with peers in school and life situations. Specifically, developmental impacts of maltreatment include:

- > **Behavioral and emotional effects:** Maltreated children have a higher disposition to post-traumatic stress disorder; depression and mood disorders; suicidal ideation, gestures, or attempts; aggression; alcohol, drug and nicotine dependence; and personality disorders.<sup>26</sup>
- > **Cognition effects:** Maltreated children are more likely to have attention deficits, problems in abstract reasoning and executive functioning, memory deficits, and lower IQs. This results in poor academic performance, grade repetition, and a high demand for special education.<sup>27</sup>
- > **Developmental effects:** Maltreated children are more likely to have speech delays or deficits in interpreting language, gross motor delays, poor fine motor coordination, and sensory integration problems.<sup>28</sup>

## Why Does Child Maltreatment Happen?

Child maltreatment is a complex phenomenon. Current models of child maltreatment suggest there are multiple personal and environmental factors that interact to contribute to child maltreatment. One such model is an ecological model of child abuse and neglect that theorizes that factors at the individual, family, community, and societal levels interact to contribute to child maltreatment.<sup>29</sup> Diagram 2.2 is an ecological model of child abuse and neglect.

**Diagram 2.2** An Ecological Model of Child Maltreatment



The factors included in the model above are typically grouped as either risk factors or protective factors.

- > Risk factors increase the likelihood of negative outcomes occurring.
- > Protective factors are those characteristics that protect individuals or families from stress and other negative influences, and increase the likelihood of positive outcomes occurring.

Rather than one single risk factor that leads families to maltreat their children, the ecological model asserts that it is multiple factors interacting at different levels - individual, family, community, and societal - that lead to abusive or neglectful behavior in families.<sup>30</sup> Specifically, when risk factors outweigh protective factors, negative outcomes, such as child maltreatment, are more likely to occur.<sup>31</sup>

## **Risk Factors**

Research has identified numerous risk factors that increase the likelihood of child maltreatment.<sup>32</sup> It should be noted that there are multiple pathways leading to child maltreatment. Risk factors should not be viewed as direct causal links to child abuse or neglect. In other words, many families with multiple risk factors never maltreat their children. It is important to view a specific risk factor or a combination of risk factors as characteristics that increase the likelihood of maltreatment occurring, but do not necessarily cause it to happen. While we may not be able to establish causality, the consideration of risk and protective factors in program and policy development is critically important to successful prevention efforts.

### *Child Risk Factors*

- > Young children (under thirty-six months) are at the highest risk for physical maltreatment, neglect, and homicide. Pubescent children are at highest risk for sexual abuse reporting, although case histories suggest that the abuse may start earlier.<sup>33</sup>
- > There are few gender differences in physical abuse and neglect, however, girls are at higher risk for sexual abuse.<sup>34</sup>
- > Conduct problems and children with difficult temperaments have been identified as higher risk. However, this risk factor should be viewed with caution as many children may develop behavioral problems because of maltreatment.<sup>35</sup>
- > Children with disabilities (physical handicaps, developmental disabilities, birth complications) have a higher probability of abuse or neglect.<sup>36</sup>

### *Parental Risk Factors*

- > Single parenting, low education levels, and teen parenting all seem to increase risk for maltreatment. Maltreatment occurs among all socio-economic levels; however, there is still relatively higher risk for maltreatment among families with low-income, low socioeconomic status.<sup>37</sup>
- > There is a higher risk of maltreatment among parents who were past perpetrators of maltreatment and those who have a history of being maltreated as a child (although two-thirds of victims do not maltreat their own offspring).<sup>38</sup>
- > Maltreating parents often have inadequate knowledge of child development leading to unrealistic expectations of what children know or can do. Other risk factors include parental beliefs about child rearing, negative affect in the parent-child relationship, substance abuse problems, depression, and loneliness.<sup>39</sup>
- > Child sex offenders may demonstrate cognitive distortions, lack of empathy, negative affect, poor social skills, alcohol or substance abuse problems, and deviant sexual interests.<sup>40</sup>

### *Family Risk Factors*

- > Lack of resources, a large number of children (four or more), closely spaced pregnancies, current stressors (financial, job, health, loss of loved ones), marital conflict or violence, social isolation from other families, other family members with a history of maltreatment, and inadequate monitoring by other family members are all risk factors for maltreatment.<sup>41</sup>
- > Family disruption, separation, and divorce are risk factors. As well, children living with a mother and non-biological father have an increased risk for child sexual abuse.<sup>42</sup>

### *Community Risk Factors*

- > Neighborhoods with high mobility, unemployment, poverty, and a lack of monitoring and connectedness show greater rates of maltreatment.<sup>43</sup>
- > Communities with a military presence, natural disasters or crises, inadequate financing of human services, or inadequate human service coordination also demonstrate higher rates of maltreatment.<sup>44</sup>

### *Cultural Risk Factors*

- > The risk for child maltreatment is higher in those cultures where it is the societal norm to spank or victimize children or corporal punishment is legally allowed. Societies in which children have poor legal status or children are

viewed as possessions also have higher risk factors for maltreatment. Finally, children are at greater risk for maltreatment in cultures where understanding of child development is weak or media portrayal of violence is common.<sup>45</sup>

## **Protective Factors**

Although the literature is not as extensive with regard to factors that protect against maltreatment, there are some characteristics that have been identified as both protecting against maltreatment and contributing to general child and family well-being.

### *Child Protective Factors*

- > Children with easy temperaments, high cognitive abilities, and competence in normative roles have decreased risk of maltreatment.<sup>46</sup>

### *Parent Protective Factors*

- > Psychological health and maturity enables parents to form positive attachments to their children and to others. Social competence, self-esteem, and self-efficacy are parental qualities that help protect against child maltreatment.<sup>47</sup>
- > Additionally, a parent's own childhood experiences and family history contribute to the parent's ability to function effectively. The nurturing, stimulation, and appropriate care that a parent received as a child serves as an enduring protective factor.<sup>48</sup>

### *Family Protective Factors*

- > Supportive relationships with family, friends, and neighbors are critical in helping parents navigate and overcome the daily stresses of parenting. Social support networks help parents do a better job of parenting through sharing of resources and information, offering temporary or permanent alternative shelter for children when needed, and providing collective standards of parenting behavior.<sup>49</sup>
- > The family strengths literature points to a number of characteristics that contribute to family well-being. These characteristics include regular and consistent household routines, shared parent-child activities, respectful and trusting communication, monitoring, supervision and involvement, parent-child warmth and supportiveness, good quality relationship between parents, children's participation in extracurricular school activities, and parents' involvement in religious and volunteer activities.<sup>50</sup>

### *Community Protective Factors*

- > Access to adequate healthcare, quality education, and employment services benefit adult caretakers and protect children. Families will find support for raising their children in neighborhoods where there is friendship among neighbors, watchfulness for other families, physical safety of the environment, common knowledge of community resources, and perhaps most critically a sense of "belonging" that fosters feelings of ownership and responsibility.<sup>51</sup>

### *Societal Protective Factors*

- > There is some evidence that cultures that discourage violence, support basic family needs, and discourage physical punishment do a better job of preventing maltreatment.<sup>52</sup>

## **Incidence and Prevalence of Child Maltreatment**

The following section provides basic information about the incidence and prevalence of child maltreatment in North Carolina. There are many difficulties getting an accurate count of the number of children who have been mistreated. For a full discussion of the many issues associated with measuring incidence of maltreatment, please see Chapter Five - Monitoring the Problem of Child Maltreatment.

In North Carolina, the principal means of collecting data on the incidence of maltreatment is the Central Registry. The Central Registry tracks information from each county department of social services on the number of children who are investigated for child maltreatment; the number of children who are substantiated; the types of maltreatment reported and substantiated; race, gender, and age of the child victims; and race, gender, and age of perpetrators. In 2003-04, the Central Registry reported that 113,557 children were subject to an investigative or family assessment, and 27,310 children were substantiated or found in need of services. Thirty children were the victims of child abuse homicides in 2003. The Central Registry does not collect data on every child who has been maltreated; just those that come to the attention of the department of social services, were perpetrated by a caretaker (parent, guardian, or childcare provider), and meet the statutory definitions of abuse and neglect.

Between 1996 and 2003, the number of North Carolina children investigated by child protection agencies increased by 29%, from 83,257 to 107,218. Even taking into consideration North Carolina's increase in the child population and fluctuations in the investigation rate over time, the rate of children who were investigated for maltreatment increased from 45.8 per 1,000 children to 51.8 per 1,000 children for those same years. However, it is unclear whether the increase in the numbers of investigations is due to increased incidence of child maltreatment, increased public awareness of the issue and reporting, or another factor. While the investigation rates have been increasing over time, the substantiation rates have been moving in the opposite direction with the rate of children substantiated for maltreatment decreasing during the period 1996-2003 from 15.75 per 1,000 children to 14.52 per 1,000 children.<sup>53</sup>

Despite these trends, North Carolina's child victimization rate (14.52 per 1,000 children) remains higher than the national average (12.3 per 1,000 children in 2002) with approximately 1.4% of North Carolina's child population having been substantiated as victims of maltreatment in each year.

### **Characteristics of Children Abused and Neglected in NC**

According to the Central Registry, the majority of child maltreatment victims in North Carolina suffer from:

- > Neglect 90.9%
- > Sexual abuse 3.5%
- > Physical abuse 3.2%
- > Psychological/emotional maltreatment 0.2%

This differs substantially from the national average, where 60.5% of child maltreatment victims are classified as having been subject to neglect, 18.6% physical abuse, 9.9% sexual abuse and 6.5% from psychological/emotional maltreatment.<sup>54</sup> The high percentage of children substantiated as neglected in North Carolina and the low percentage of children substantiated as physically abused may be due, in part, to the state's legal definition of neglect, which includes maltreated children with injuries not characterized as "serious" and result from inappropriate care, supervision, or discipline.

North Carolina's youngest children are at greatest risk of maltreatment with almost half, 48.5%, of the children substantiated as victims being birth-six years of age.<sup>55</sup> Boys and girls are represented almost equally as victims of maltreatment, although national studies show that girls are more frequently reported and investigated.<sup>56</sup>

Data from North Carolina also indicates differences in substantiation rates of racial groups in the state. However, there are many complex issues that may contribute to such differences; this data should not be interpreted to mean that any specific racial or ethnic group has a higher rate of maltreatment than any other does. In fact, despite the overrepresentation of minority children in the child welfare system in North Carolina and in the rest of the country, national population-based studies that identify child victims who may or who may not have been reported to child protection agencies have not found significant differences between races.<sup>57</sup> In North Carolina, data indicates that Caucasian children comprise 60% of

all children investigated and substantiated for maltreatment (59% and 57% respectively) and make up approximately 72% of the population. African American children comprise on average about 36% of all children investigated and 38% of all children substantiated despite the fact that they only make up 21.6% of the population. Hispanic children comprise just over 7% of the children investigated and almost 8% of the children substantiated, more than their representation in the general population (4.7%).<sup>58</sup> Minority families are more likely to be reported to the Child Protective Services system and more likely to have their cases substantiated.

### **Child Fatalities**

Child fatalities are rare, but they have been increasing slowly. In 2003, thirty children died from child abuse in North Carolina at a rate of 1.52 per 100,000 children.<sup>59</sup> While North Carolina's child abuse fatality rate seems lower than the national average of 2 per 100,000 children, it should be noted that in North Carolina only deaths from physical abuse are included in child fatality data. While many other states include children who die from physical abuse and neglect in their child maltreatment fatalities statistics, North Carolina reports only child abuse homicides. Nevertheless, the NC Division of Social Services issues a report of children who die from abuse or neglect within one year of the child or family being involved with county department of social services. In state fiscal year 2003-2004, there were thirty-eight such deaths, thirty-two from suspected neglect and six from suspected abuse.<sup>60</sup>

Calculating the numbers of child abuse homicides over a longer period also provides a more accurate rate. Between 1985 and 2002, 445 children in North Carolina were killed by their parent or a caretaker at a rate of 2.2 per 100,000 children over the nineteen year period. Children in North Carolina are killed by a parent or caregiver at a rate of slightly more than two each month.<sup>61</sup>

### **CarolinaSAFE**

Other sources of data about the incidence of maltreatment lead researchers to believe that the incidence of maltreatment is much higher than what is reported in the Central Registry. For example, CarolinaSAFE was an anonymous, random telephone survey conducted with mothers of children aged birth to seventeen years. Over 50% of the mothers interviewed had achieved some college level education or beyond; 83% were married; the vast majority was the biological mother of the child; and nearly 70% reported an annual household income of more than \$40,000.<sup>62</sup>

Mothers were asked about community support and potentially abusive behaviors by either themselves or their husband or partner in the context of other disciplinary practices. They were also asked about any possible sexual abuse their child may have experienced. The results were then statistically weighted so that the surveyed sample would accurately reflect the socioeconomic status and racial/ethnic balance of North and South Carolina.

The study found the following:

- > Mothers self-reported physical abuse of their child (by either themselves or their husband or partner) at a rate more than forty times higher than the official substantiated rate of physical abuse in either state. While previous reports from North and South Carolina to the National Center on Child Abuse and Neglect estimated the rate of physical abuse at one per 1,000, CarolinaSafe found the rate to be forty-three per 1,000.
- > The estimate of sexual abuse was over fifteen times higher than official state-level statistics. Official substantiated rates of sexual abuse for both states were .6 per 1,000; CarolinaSAFE found the rate of sexual abuse to be 10.5 per 1,000. One possible explanation for this difference is that this study asked the mother if she had knowledge of any adult or older child sexually abusing her child, not just an adult in a caretaker role.
- > For every child under two years of age who sustains a serious head injury because of shaking or other abusive head trauma, another 152 children may be shaken by their caregivers, sustaining brain trauma that goes undetected.
- > Other results more closely related to neglect were equally disconcerting with twenty out of 1,000 families responding that they were unable to provide enough food for their child in the past month; two per 1,000 children aged birth-six



being left alone; seventy-five per 1,000 children (all ages) being injured due to lack of supervision; and 8.5% of children unable to access medical care when needed in the past year.

> Finally, a very high number of families, almost 50%, indicated intimate partner violence in the home.<sup>63</sup>

Thus, CarolinaSAFE results indicate that the true incidence of child maltreatment may be significantly higher than what is reported by the Central Registry. Caution should be taken when using Central Registry data because it most likely significantly underestimates the number of children who are impacted by child maltreatment in North Carolina.

## Conclusion

While multiple disciplines utilize a specialized definition of child maltreatment for the purposes of their profession, child maltreatment should be understood as an exposure or experience introduced by an adult through omission or commission that results in significant harm or risk of harm to a minor. Children experience child maltreatment as a form of trauma that can cause serious, damaging effects on their neurobiological development. Child maltreatment can physically alter the activity and structure of the brain resulting in impaired social, cognitive, and psychological development for a child. The costs of maltreatment are staggering, both in terms of human costs and economic costs. A significant portion of our country's most pressing social issues - substance abuse, school drop-outs, juvenile delinquency and adult crime, special education services, adults with chronic health problems and mental health issues, and welfare dependency - are outcomes associated with child maltreatment. Finally, while official statistics of child maltreatment convey a tragic picture, they most likely greatly underestimate the actual incidence of maltreatment in North Carolina.

# Child Maltreatment Prevention

**C**hild maltreatment prevention efforts include activities, strategies, or programs to reduce risk factors and increase protective factors identified in the research literature as associated with child maltreatment. These efforts are designed to increase the capacity of parents, caretakers, and communities to protect, nurture, and promote the healthy development of children. Prevention efforts operate at the individual, family, community, or societal levels in order to decrease the likelihood of child maltreatment.

Child maltreatment prevention activities vary tremendously and may take the form of public policy initiatives, public awareness campaigns, screening, and assessment activities by professionals or agencies serving families, informal parent support groups, or intensive, multi-faceted home visitation programs. Child abuse prevention programs can be universal programs, selective programs, or indicated programs. Table 3.1 offers a detailed discussion of types of child maltreatment prevention strategies.

## Table 3.1 Types of Child Maltreatment Prevention Strategies

**Universal Strategies** target activities to the general population with the goal of preventing child abuse and neglect from ever occurring. Universal strategies are available to everyone, rather than targeting populations based on risk factors or specific characteristics. Examples include broad-based public awareness campaigns on positive discipline, developmental screenings for children in primary healthcare settings, and postpartum home visits for all parents of newborns.

**Selective Strategies** target activities to a group with specific risk factors with the goal of preventing child abuse and neglect from occurring in that group. Programs may target services to individuals, families, or communities based on risk factors such as parent age, poverty, substance abuse, domestic violence, or maternal depression. Examples of programs include: intensive home visitation programs for first time, low-income mothers; parent training for adolescent mothers; respite care for parents of children with special needs; and parent support groups for single parents.

**Indicated Strategies** target activities to a group that has experienced abuse or neglect with the goal of preventing child abuse and neglect from reoccurring in that group. Examples include parent training for department of social services substantiated parents; and parent support groups for non-offender parents of children who have been sexually abused.

Over the past forty years, local communities have developed and sustained a wide array of child maltreatment prevention programs based on local needs, resources, and expertise, but have done so with limited federal and state guidance, and without the benefit of a significant body of research literature identifying effective strategies.

An effective, statewide child maltreatment prevention initiative should provide an array of universal, selective, and indicated child maltreatment prevention programs. Historically, the state has focused its prevention efforts on indicated strategies, targeting individuals or families that have experienced abuse or neglect with the goal of preventing it from reoccurring. The state has focused less on universal or selective strategies that aim to prevent maltreatment before it occurs. The primary goal of this Task Force on Child Abuse Prevention was to promote greater attention to primary prevention efforts, trying to prevent child maltreatment from occurring in the first place. The Task Force on Child Abuse Prevention determined that an effective child maltreatment prevention initiative should incorporate a number of approaches including legislative changes, media campaigns, community mobilization, implementation of evidence-based child abuse prevention programs, and the infusion of child abuse prevention approaches in systems already serving children and families.

## Child Maltreatment Prevention Efforts in the United States

Public attention on child abuse began to rise during the 1960s after the publication of Henry Kempe's article "The Battered Child Syndrome" in the *Journal of the American Medical Association*.<sup>64</sup> Passage of the Child Abuse Prevention and Treatment Act in 1974 brought both public and policy recognition of child maltreatment as a major social issue in the United States.<sup>65</sup> Early prevention efforts focused on increasing public awareness and understanding of the problem.<sup>66</sup> These efforts were incredibly successful. The number of child maltreatment reports in the United States rose from fewer than 100,000 in 1976 to more than one million by the early 1980s.<sup>67</sup>

During the 1980s there was dramatic growth in child abuse prevention services and grassroots efforts to enhance community engagement and response. Numerous prevention programs targeting different segments of the population were developed in local communities. Thousands of parent education programs, parent support groups, school-based programs for children, home visiting programs, and other family support activities began to spring up in communities across the country. Without clear empirical guidance of the most effective approach to preventing child maltreatment, each child abuse prevention program was seen as important.<sup>68</sup>

While significant gains were made in creating a diverse array of support services for families and many families benefited from these services, they still had not touched a great number of families. In particular, many families experiencing domestic violence, substance abuse, and mental health issues were not receiving services despite the fact that those individual and environmental risk factors put them most at risk for child maltreatment. Unfortunately, the current service array may not successfully assist many families who most need assistance.<sup>69</sup>

As a result of this recognition, the past decade has seen an emerging re-conceptualization of what constitutes an effective, community-based child abuse prevention system. This new conceptualization is discussed in detail later in this chapter, but first it is important to review North Carolina's response to child maltreatment.

## Child Maltreatment Prevention in North Carolina

Historically, North Carolina's efforts to address child maltreatment have mirrored those across the nation. The focus has been on responding to the problem, not preventing it from happening in the first place. As a result, most of North Carolina's policy initiatives and reform efforts addressing child maltreatment have targeted the child welfare system. For example, since Governor Martin's administration (1985-1993) there have been numerous commissions and task forces looking at the child welfare system, several studies of the child protection system, and several child welfare reform efforts,

such as Families for Kids and the Multiple Response System. However, little state-level attention has been directed toward the prevention of maltreatment.

In addition to the lack of attention on prevention efforts, several other barriers have hampered the state's child maltreatment prevention efforts. These include the lack of state-level leadership focused on prevention, an inability to adequately monitor the impact of the state's prevention efforts, little information at the state or national level about program effectiveness, and insufficient funding. There are multiple state agencies involved in programs consistent with child maltreatment prevention activities, including public health, mental health, public instruction, juvenile justice and delinquency prevention, and early childhood education. However, there is no single agency coordinating activities across agencies and being ultimately held accountable for prevention outcomes. Determining the success of prevention efforts is difficult because of shortcomings in the state's child maltreatment monitoring system. Further, historically there has been an absence of research about the effectiveness of prevention efforts. While this situation is changing, and more research is being focused on programmatic effectiveness, the past lack of outcomes data has led to a number of diverse, but not necessarily scientifically-based programs across communities. Another hurdle is the lack of stable, dedicated funding for child maltreatment prevention. While the costs attributable to child maltreatment in North Carolina are estimated at \$3 billion, only \$650,000 in state funding from the NC Children's Trust Fund, is dedicated to maltreatment prevention. Some other federal and state funds do support programs that are consistent with child abuse prevention efforts, but they need to be integrated into a coordinated system that focuses attention on child maltreatment prevention as a main goal. As a result of these problems, one cannot speak of a specific child abuse prevention system in North Carolina.

A principal goal of the Task Force on Child Abuse Prevention was to address the weaknesses identified above, particularly at the state level. Although much of child maltreatment prevention actually occurs at the local level in neighborhoods, homes, pediatrician's offices, schools, and community-based agencies, state agencies still have significant influence on prevention because they establish funding availability and priorities and the programmatic direction for state-sponsored or state-funded family support and child maltreatment prevention activities. In other words, weaknesses at the state level, such as lack of leadership, unclear programmatic priorities for effective practice, and insufficient funding, diminish the capacity of local communities to do quality, effective child maltreatment prevention. Aligning state systems is the first step in creating an environment in which the state and local communities can increase attention, resources, and energy to implementing what is known to work in preventing maltreatment.

## Vision of a Child Abuse Prevention System in NC: Critical Elements

In the past, the array of prevention services offered were all considered equal in importance and impact. However, that system has had limited success in preventing child maltreatment on a wide-scale basis. Rather, North Carolina should build a more intentional set of services for families beginning with a strong foundation of support for every parent and child that is available when a child is born or a woman is pregnant.<sup>70</sup> Services should then be added to this universal base of support - through programs such as parent education, home visiting, or parent support groups - in response to the developmental needs of the child or the evolving parent-child relationship.<sup>71</sup> The system should target families for support during periods in which child maltreatment is more likely to arise, such as the postnatal attachment period, family structure changes (loss of a parent, divorce, etc.), and the development of conflict/violence between parents. The system should also provide support in a way that influences parenting behavior before abusive/neglectful patterns become established.<sup>72</sup> Help-seeking behavior then becomes "normative," that is, parents can routinely ask for help and it is seen by the community and professionals as acceptable, rather than being stigmatizing. Table 3.2 on the following page outlines the Task Force on Child Abuse Prevention's vision for North Carolina's prevention efforts.

While child abuse prevention constitutes a critical goal of such a system, maltreatment prevention is placed within the larger context of positive child development and healthy parent/child relationships.<sup>73</sup> The establishment of this type of comprehensive prevention system will require the support and active participation of multiple agencies and disciplines, including early childhood development and education, public health, social services, and public instruction. Other integral partners with overlapping outcomes and intervention strategies for promoting healthy child development include the Early Childhood Comprehensive System Initiative, spearheaded through the NC Division of Public Health and focusing on the integration of multiple services and agencies to create a comprehensive system supporting early childhood development, and the Assuring Better Child Development Project, part of Community Care of North Carolina and promoting developmental screening and referrals of all children during regular pediatric visits.

**Table 3.2**

### Vision for Children, Families, and Communities

We envision that ...

- > Children are nurtured, supported, and protected within a safe and stable home and community environment.
- > Families recognize the rewards and responsibilities of raising children and have access to support within their own communities to help them meet those responsibilities.
- > Families are able to ask for and receive timely assistance without fear of being punished or blamed.
- > Communities are supported in their efforts to meet the diverse needs of families raising their children.

### Key Principles of North Carolina's Child Maltreatment Prevention System

The following key principles should guide the development of a comprehensive child abuse prevention system for North Carolina.<sup>74</sup>

*North Carolina's child maltreatment prevention efforts will...*

- > **Promote the healthy development of the parent/child relationship through community and institutional support of parenting.** The goal of child abuse prevention should not be just the avoidance of “harmful parenting,” but the creation of a community wide system in which all parents are provided the support they need to nurture their children and foster their cognitive and social/emotional development.
- > **Consist of normative, universal efforts to promote healthy parenting among all North Carolina families, as well as more targeted efforts directed towards higher risk families.** Child abuse prevention efforts must be linked to universal family and parenting support initiatives that make parental help-seeking behavior normative. All families - regardless of socioeconomic status, family structure, or other environmental challenges - need support in raising children. Parenting is a very difficult job that poses many demands and challenges. Nevertheless, few parents feel comfortable admitting that they need help. North Carolina will be successful in reducing maltreatment when the larger community recognizes that good parents are made, not born, and that all parents want to be good parents. Child abuse prevention efforts must also include intensive strategies for families experiencing multiple risk factors and needing additional support.
- > **Target the developmental stages of pregnancy and the first years of a child's life as the foundation of our commitment to prevention.** Research on parenting indicates that the best opportunities to encourage nurturing, healthy parental behavior are during pregnancy and the first years of a child's life.<sup>75</sup> During this time, parents express interest and willingness to learn new information and change behaviors that might be harmful to

their children. Early intervention and support have great promise in helping parents develop nurturing behaviors and positive parenting skills for dealing with stressful parent/child interactions.

- > **Add services at different developmental stages to support the healthy formation of the parent/child relationship.** As children grow and challenges emerge during different developmental stages, different preventive services should be available for families to access without stigma. Again, the more North Carolina is able to provide parents and families with services that are seen as normative (e.g. childbirth classes during pregnancy, immunizations during well-child visits), the more successful the state will be in preventing abusive behavior early on in a child's life.
- > **Match family needs with an appropriate level of support.** Not all families need the same level of support to provide healthy, nurturing environments for their children. Families that have financial resources, support from an extended network of family and friends, and psychological resources, such as emotional maturity and problem-solving skills, may not need extensive support. Families who do not have these assets and who are struggling with issues such as intimate partner violence, mental health issues, substance abuse, or childhood histories of violence and maltreatment, may need intensive services to help them overcome these challenges as parents. An effective child abuse prevention system will include equally strong universal, selective, and indicated prevention services and will have the capacity to link those services so that families requiring intensive services can access them as needed.

*To be effective, prevention efforts will need to...*

- > **Integrate prevention and support services across public and private agencies.** Child abuse prevention is a function of multiple agencies and organizations at the state and local levels serving families and children. Strong and effective partnerships among state and community agencies are needed so families and prevention programs are able to access a wide range of resources and support. Strong and effective partnerships mean coordinated planning for high-risk families across agencies, joint funding initiatives, shared training resources, and the provision of empirically-based services that target multiple risk factors at the individual, family, and community levels.
- > **Enhance the role of community institutions and informal supports in helping families raise children.** All segments of a community have a role to play in preventing maltreatment. Community institutions, civic groups, and neighborhood supports have important roles in developing support systems for families and children. Support can include respite care, neighborhood centers, babysitting cooperatives, mentoring relationships, sources of support for new parents (e.g. making dinners, babysitting children, helping with transportation), recreational opportunities, and organized, safe events where parents can have fun with their children and with other families. Effective prevention requires that all segments of a community - professionals and parents, public agencies, nonprofits, businesses, and informal community groups - participate in planning, developing, and implementing activities to support nurturing parenting and healthy families.
- > **Use family support principles in program planning, implementation, and governance.** Prevention programs should emphasize a strengths-based approach to working with families and children to increase the likelihood of positive outcomes. Family support principles can help guide staff in emphasizing family strengths, focusing on developing informal supports and resources, and partnering with community resources. Family Support America leads our nation's effort to infuse family support principles into systems and programs serving families and children, and has published *Guidelines for Family Support Practice*.<sup>76</sup>
- > **Be linguistically and culturally accessible and responsive.** Programs, services, and messages must be tailored to the families and communities they intend to serve. In order to ensure that families take advantage of these programs, they must be linguistically and culturally accessible and responsive.
- > **Incorporate strong theory-based and empirically-based strategies into program planning and implementation.** Scientific research has demonstrated the effectiveness and/or promise of several prevention programs, such as the Nurse Family Partnership, Parent-Child Interaction Therapy, Nurturing Program, and Chicago Child-Parent Centers, and confirmed the effectiveness of several treatment programs for children who have been physically or sexually abused. When strong empirical evidence is not available, programs should be developed using research-based risk and protective factors, and should be guided by a theoretical understanding of how those risk and protective factors can be influenced.

**Table 3.3**

## Principles of Family Support Practice

- > Staff and families work together in relationships based on equality and respect.
- > Staff enhances the family's capacity to support the growth and development of all family members - adults and children.
- > Families are resources to their own members, to other families, and to communities.
- > Programs affirm and strengthen the family's cultural, racial, and linguistic identities while enhancing their ability to function in a multicultural society.
- > Programs are embedded in communities and contribute to the community building process.
- > Programs advocate for families for services and systems that are fair, responsible, and accountable to families served.
- > Practitioners work with families to mobilize formal and informal resources to support family development.
- > Programs are flexible and continually responsive to emerging family and community issues.
- > Principles of family support are modeled in all program activities including planning, governance, and administration.

- > **Evaluate programmatic efforts and ensure that training, quality assurance, and technical assistance resources are available.** While federal agencies and academic institutions have the resources and research expertise to identify model child abuse prevention programs, state and local agencies must ensure that they are implementing these models according to their original intent and achieving measurable outcomes for the families involved. Measuring change at the parent-family level should be required of child abuse prevention programming to the greatest extent possible.
- > **Ensure that sufficient resources are available to successfully implement prevention strategies and programs.** Adequate resources are integral to ensuring the success of child maltreatment prevention programs. Staff must be trained and supervised, workloads and caseloads must be reasonable, and programs must have stability in order to adequately serve children and families.

## Conclusion

Child maltreatment prevention efforts increase the capacity of parents, caretakers and communities to nurture and promote the healthy development of children. Prevention strategies are diverse and include public awareness initiatives, policy advocacy, family support and family strengthening programs, and community mobilization. North Carolina, like the rest of the nation, has historically focused the vast majority of its resources and energy on responding to child maltreatment after it has occurred. With a growing recognition that child protection strategies are critically important, but insufficient, in the struggle to prevent maltreatment, members of the Task Force on Child Abuse Prevention have defined a new vision for the state's child maltreatment prevention efforts. This new vision is strengths-based, family-centered, and developmentally-focused. It recognizes that good parents are made, not born, and that normative, universal efforts to promote healthy parenting among all North Carolina families are vitally important in reducing child maltreatment. North Carolina's first step in translating this vision to practice is to align state systems with the principles articulated in this chapter so that local communities, who receive direction and resources from state-level agencies and funders, can begin to shift their focus and energy to creating a universal, comprehensive, and normative system of support for all parents raising children in our state.

## Leadership for Child Maltreatment Prevention

**N**orth Carolina has developed a coordinated system to respond to child maltreatment, which has been guided by years of federal and state legislation and funding targeted at this problem.<sup>77</sup> However, there are no federal or state policies guiding child maltreatment prevention efforts or agency initiatives. As a result, there has not been a similar mandate to develop a system to ensure the safety and well-being of children before they are reported to local departments of social services for maltreatment. Prevention efforts are fragmented across agencies with little shared planning and few shared outcome measures. Numerous public and private agencies provide prevention services, however no state agency with programmatic authority assumes leadership and accountability for child maltreatment prevention efforts in the state. Lack of leadership for child maltreatment prevention is a significant barrier to advancing prevention efforts statewide.

The Task Force on Child Abuse Prevention recognized the importance of identifying a leadership structure to ensure that the state moves forward in its child maltreatment prevention efforts. State-level leadership would ensure collaboration between public, non-profit, and community based agencies; unite these agencies and programs through planning and implementation; maximize existing resources to prevent child maltreatment; oversee the implementation of the Task Force on Child Abuse Prevention recommendations and plan; and continually monitor the effectiveness of different strategies in decreasing maltreatment and reducing risk factors. These leadership responsibilities include:

- > **Collaboration** - Child maltreatment prevention efforts require the participation of multiple public, non-profit, and community-based agencies. To guide such efforts, the leadership entity will need to build strong collaborative partnerships across state and local NC departments and agencies, the non-profit community, and universities. The leadership structure should help develop strategies to prevent child maltreatment that involve these different agencies and organizations and include shared planning and accountability.
- > **Planning and implementation** - A key function of the leadership entity will be to unite agencies and existing programs to identify needs, establish priorities for action, and assure quality and success in implementing program strategies to prevent child maltreatment, reduce risk factors, and strengthen protective factors.
- > **Maximizing resources** - Adequate funding of child maltreatment prevention services is an essential component of effective programs and initiatives. The leadership entity will need to develop and pursue strategies to leverage state and



federal funding, identify new resources, promote shared resources across organizations, and reallocate resources to evidence-based programs.

- > **Oversight** - One of the most essential functions of the leadership entity will be to oversee implementation of the final Task Force on Child Abuse Prevention plan, including development of realistic implementation schedules, monitoring, and accountability among agencies involved in the plan.
- > **Evaluation** - The leadership entity should be charged with continuing the work of the Task Force on Child Abuse Prevention Program Subcommittee in evaluating the effectiveness of strategies in decreasing maltreatment and reducing risk factors, and in modifying programs or strategies in light of the evolving evidence about successful prevention efforts.

The state agency or leadership structure charged with developing and overseeing the state's child maltreatment prevention efforts, must have sufficient influence and authority to ensure the plan is implemented and child maltreatment prevention is considered a priority in the state. The leadership organization must be able to bring together multiple, diverse partners within governmental departments, non-profit organizations, and the private sector to review and act on strategies to reduce child maltreatment and share accountability. In addition, the leadership organization must have the resources needed to ensure effective implementation, monitoring, and evaluation of the Task Force on Child Abuse Prevention plan and its recommendations.

To address the issue of leadership for child maltreatment prevention, the Task Force on Child Abuse Prevention suggests the creation of a two-tiered system of leadership: a Child Maltreatment Prevention Legislative Oversight Council staffed by the NC Division of Public Health, and an interdepartmental Child Maltreatment Prevention Leadership Team housed and staffed within the NC Division of Public Health. The Child Maltreatment Prevention Legislative Oversight Council will oversee the implementation and evaluation of the Task Force on Child Abuse Prevention plan and would ensure that visibility and attention are brought to these issues. Specifically, the Task Force on Child Abuse Prevention recommends:

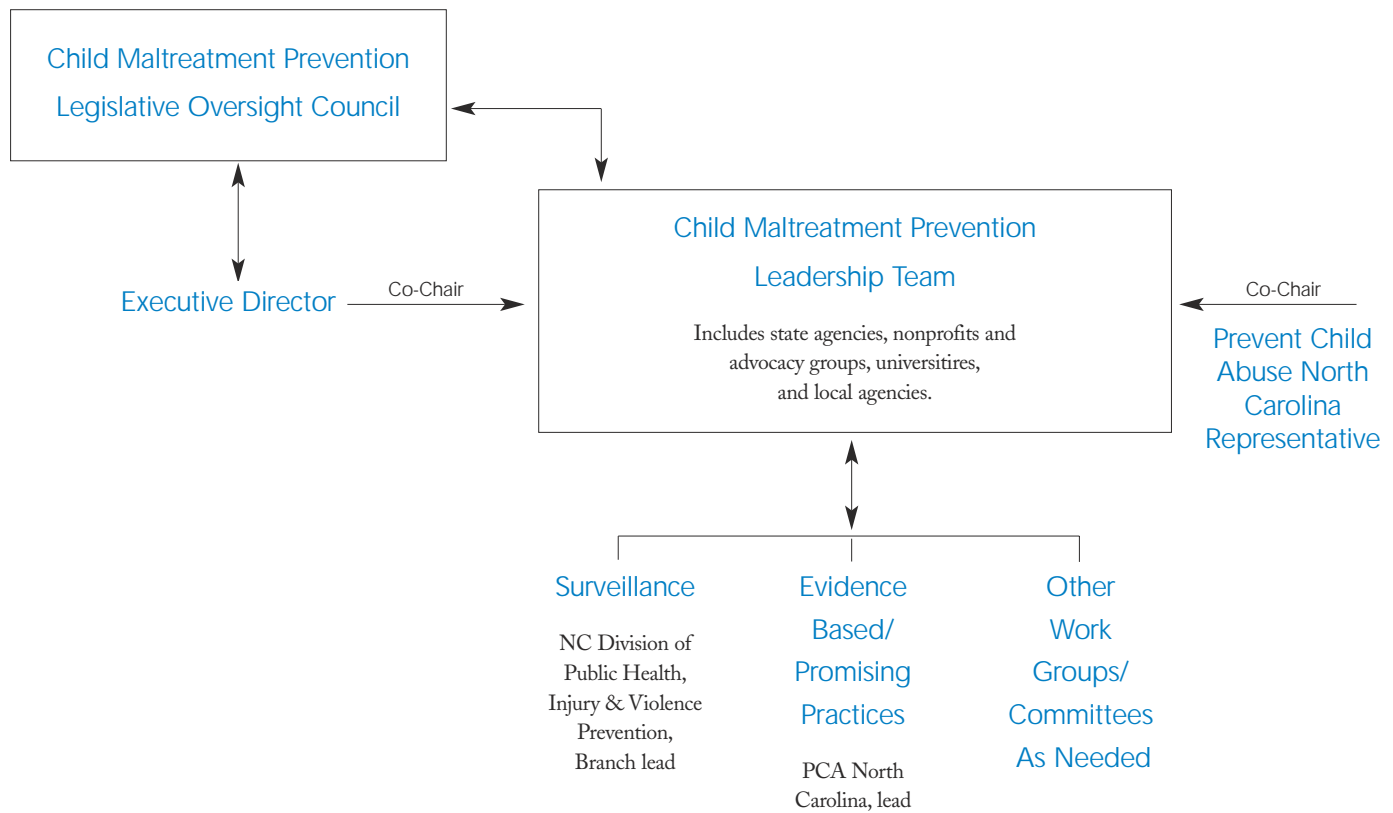
- Rec. 4.1.** The NC General Assembly should establish a standing Child Maltreatment Prevention Legislative Oversight Council with diverse membership representation and strong leadership from state and local agencies and community providers. The Child Maltreatment Prevention Legislative Oversight Council should specifically focus on preventing maltreatment before it occurs. The Task Force on Child Abuse Prevention supports SB 871/HB 1530 *Establish Child Maltreatment Prevention Council* which outlines membership and responsibilities of the Child Maltreatment Prevention Legislative Oversight Council.
- A. Responsibilities of the Child Maltreatment Prevention Legislative Oversight Council should include:
    - i. Oversee implementation and evaluation of the Task Force on Child Abuse Prevention plan.
    - ii. Ensure high visibility and attention to the issue of child maltreatment prevention.
    - iii. Ensure shared planning, implementation, and accountability for child maltreatment prevention efforts among appropriate North Carolina governmental agencies.
    - iv. Identify additional opportunities to enhance child maltreatment prevention efforts in existing state and local systems that serve families and children.
    - v. Establish and oversee mechanisms to support evidence-based and promising child maltreatment prevention and family strengthening programs in North Carolina.
    - vi. Ensure sufficient funding for child maltreatment prevention activities identified in the Task Force on Child Abuse Prevention plan and in the Child Maltreatment Prevention Legislative Oversight Council's ongoing work.

- B. The NC General Assembly should appropriate \$250,000 per year for the staffing and operational support of the Child Maltreatment Prevention Legislative Oversight Council. Staffing for the Child Maltreatment Prevention Legislative Oversight Council will reside in the NC Division of Public Health and will include an executive director and staff support.

The interdepartmental leadership team will be responsible for the day-to-day work in implementing these recommendations; coordinating the work of different state, local, and non-profit agencies and organizations; ensuring that the state focuses on implementing evidence-based or promising practices to prevent child maltreatment; and ensuring that programs are evaluated to determine their impact on strengthening families, reducing risk factors, and reducing child maltreatment. The Task Force on Child Abuse Prevention recommends:

- Rec. 4.2 The NC Department of Health and Human Services - NC Division of Public Health should develop a Child Maltreatment Prevention Leadership Team to assist in supporting the work of the Child Maltreatment Prevention Legislative Oversight Council.
  - A. The Child Maltreatment Prevention Leadership Team should be a true public-private partnership between state and local agencies, non-profits, and other community organizations, that works to coordinate efforts, maximize funding, and promote shared accountability among governmental and private organizations.
  - B. The Child Maltreatment Prevention Leadership Team will have primary responsibility for:
    - i. Providing expertise, technical assistance, and support to the Child Maltreatment Prevention Legislative Oversight Council.
    - ii. Implementing and evaluating the Task Force on Child Abuse Prevention plan and recommendations from the Child Maltreatment Prevention Legislative Oversight Council.
    - iii. Ensuring shared decision-making, planning, implementation, funding, and accountability of child maltreatment prevention efforts among appropriate state governmental agencies.
    - iv. Developing strategies to collaborate with local community providers in implementing the recommendations of the Task Force on Child Abuse Prevention.
    - v. Developing strategies to ensure collaborative decision-making, planning, implementation, and accountability at the state and local levels.
    - vi. Identifying and promoting funding strategies for child maltreatment prevention activities outlined in the Task Force for Child Abuse Prevention plan and its ongoing activities.
    - vii. Identifying trends, emerging issues, and best practices and bringing them to the attention of the Child Maltreatment Prevention Legislative Oversight Council.
    - viii. Reporting to the Child Maltreatment Prevention Legislative Oversight Council and the Secretary of the NC Department of Health and Human Services about its progress in achieving these goals. These reports should also be provided to the Superintendent of Public Instruction and to the Secretary of the NC Department of Juvenile Justice and Delinquency Prevention.
  - C. The Child Maltreatment Prevention Leadership Team should include diverse representation from the NC Department of Health and Human Services, various state agencies and departments, universities, local agencies, non-profits, other private organizations, and families.
  - D. The Executive Director of the Child Maltreatment Prevention Legislative Oversight Council and a representative of PCA North Carolina should serve as co-chairs of the Child Maltreatment Prevention Leadership Team.

**Table 4.1** Child Maltreatment Prevention Oversight Committee Model



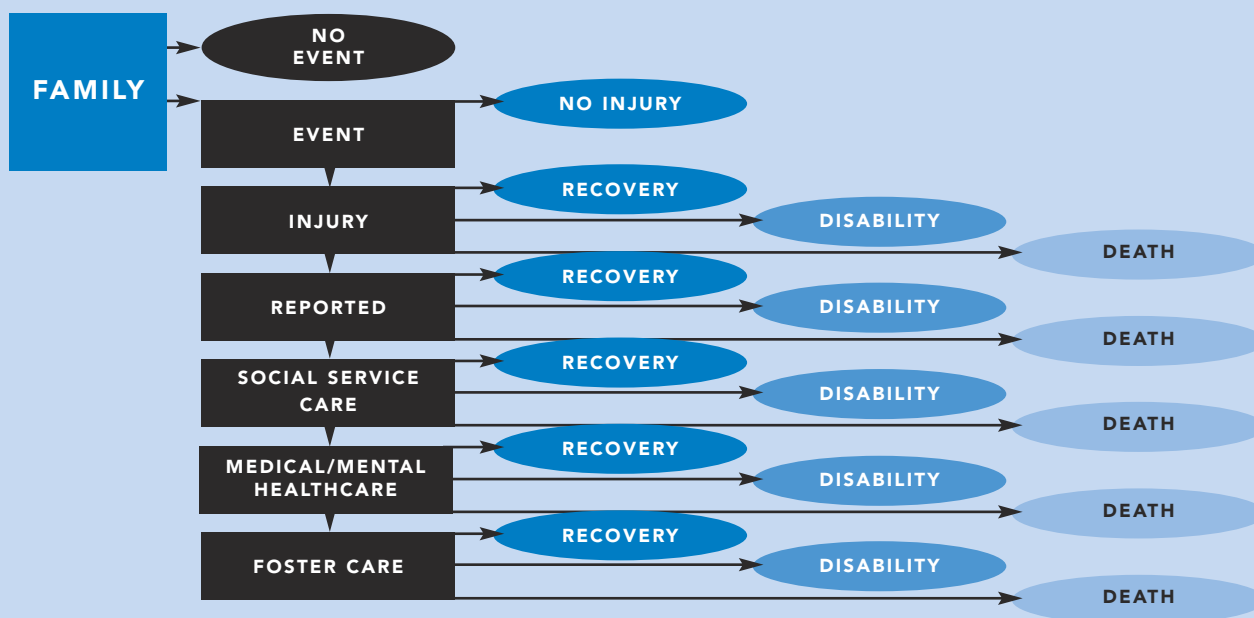
# Monitoring the Problem of Child Maltreatment

**N**orth Carolina needs a comprehensive monitoring system to estimate the magnitude of the child maltreatment problem, provide information for program planning and implementation, evaluate system successes and failures, and inform the public and policy makers of the status of child maltreatment and child maltreatment prevention efforts in North Carolina. Without monitoring or “surveillance” data, the ability to design, target, and evaluate the state prevention system is significantly limited.<sup>78</sup>

## Challenges to Child Maltreatment Surveillance

There are a number of opportunities to count incidents of maltreatment in the child population. Diagram 5.1 illustrates the many points at which child maltreatment could be counted, beginning with the initial exposure to potential maltreatment, and ending with the case of death in a foster care community.

**Diagram 5.1. Opportunities for Counting Maltreatment**



Currently, the only data about the extent of child maltreatment that is collected on an ongoing basis is through the Central Registry. Unfortunately, there are significant limitations with relying on this data as the sole source of information about child maltreatment. Reports to Child Protective Services only include cases of maltreatment by caretakers, not similar maltreatment caused by non-caretakers. In addition, reported cases of abuse and neglect are only considered official if they are substantiated, meaning there is sufficient evidence to show that the mistreatment meets the statutory definition of abuse and neglect. There is evidence to suggest that child maltreatment is under-reported and there are wide variations in investigation and substantiation rates of child maltreatment cases. A detailed explanation of these issues follows:

- > **Child maltreatment is significantly under-reported.** Child maltreatment typically occurs within a child's own home making it difficult to detect. Children may not demonstrate visible signs of physical abuse or neglect or report maltreatment; and behavioral changes that result from maltreatment may be difficult to interpret or may occur later in life. In addition, strongly held beliefs about family privacy, the public's hesitancy to intrude in families' lives, and lack of knowledge of child abuse reporting laws can hinder child abuse reporting. Other North Carolina-specific data suggests that the true incidence of child maltreatment may be as much as ten to twenty times higher than what is reported to the Child Protective Services system.<sup>79</sup>
- > **Policies and procedures, which vary among communities, contribute to wide variations between counties in terms of investigation and substantiation rates for maltreatment.** In 2002-2003, the rate of substantiation ranged from 44.17 children per 1,000 in Rutherford County to 2.98 children per 1,000 in Camden County. Such variations in rates of substantiation are not easily understood and raise questions about the reliability of the data when interpreting incidence of maltreatment.
- > **The Central Registry contains information on children who are maltreated by caretakers; children maltreated by non-caretakers are not included.** North Carolina statute defines caretakers as parents, guardians, custodians, individuals who care for children in residential settings (foster parents, residential care staff), and individuals who care for children in childcare facilities (childcare providers). If a child is sexually abused by a teacher, a family friend, relative, or a boyfriend who does not have responsibility for the child's care, the victim is not included in the Central Registry. In fact, North Carolina has no systematic method of gathering data, and no available statistics, on the population of children who are maltreated by a non-caretaker.
- > **Multiple forms of abuse are typically summarized by the most graphic type of maltreatment.** The instances of many types of abuse will be underrepresented because cases are typically only classified under one category of abuse. In the case of a child who experiences sexual abuse and emotional abuse, the report is generally coded as sexual abuse within government registries and no instance of emotional abuse is recorded.
- > **Multiple events of child maltreatment are summarized as a single event.** Child maltreatment rarely occurs as a single event. Rather, it often occurs at multiple points in time, and varies in severity. Nevertheless, years of maltreatment are captured as a single event within government registries.

## Measurement Methods

The limitations of the Central Registry necessitate the development of additional data collection strategies. The Task Force on Child Abuse Prevention created a Measurement Subcommittee to identify ways that North Carolina could develop a system to more accurately monitor the incidence of maltreatment. Developing such a system is difficult because there are differing conceptualizations of what constitutes maltreatment (e.g. is leaving a young child at home alone for an hour neglect? Is corporal punishment that leaves bruises abuse?). In addition, maltreatment usually occurs in private, and there is a tendency to capture only the most egregious incidents (e.g. fatalities, serious abuse). Capturing data on emotional abuse

and less severe, but perhaps more chronic, cases of neglect is important for a monitoring system in North Carolina.

There are various ways in monitoring to capture different types of information about the extent of child maltreatment. Diagram 5.2 shows the potential levels of surveillance.

**Diagram 5.2**  
Potential Levels of Surveillance

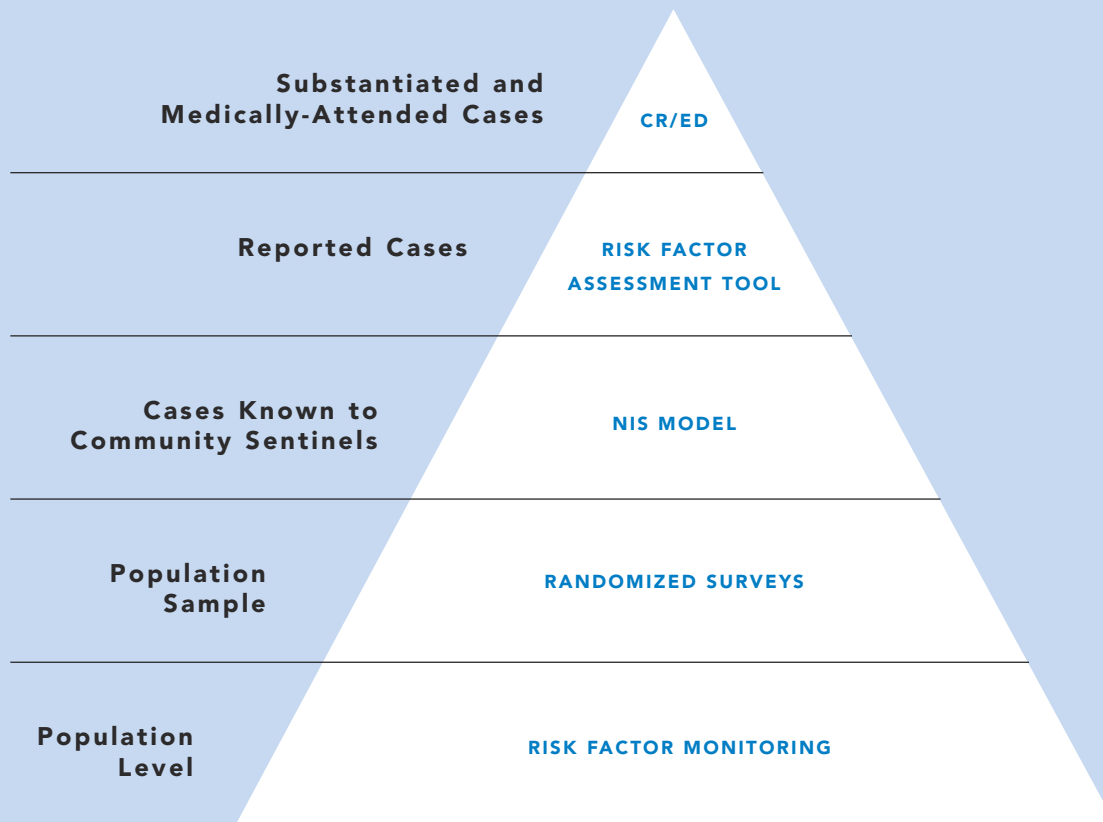


Diagram 5.2 illustrates one way to consider monitoring systems for abuse and neglect. The top of the diagram includes central registry (CR), emergency department (ED), and child fatality data. These are cases already being counted by three different surveillance systems in North Carolina.

The Family Risk Assessment and Assessment of Strengths and Needs captures extensive information on a family's risk and protective factors associated with child maltreatment. These assessments are conducted with all families who are subject to an investigation or family assessment. Currently, the data is not computerized and cannot be accessed; however, the implementation of NC Fast will address this issue. Using data from this assessment tool would allow North Carolina to generate and aggregate information on all children reported to local departments of social services, without regard to substantiation of report. It would also allow for a more detailed description of the child and household characteristics than is currently available through the Central Registry.

In addition to using existing data, North Carolina could collect information at the next level of the pyramid. The National Incidence Study surveys providers who have professional contact with children (doctors, teachers, social workers, etc.) to ascertain the incidence of abuse and neglect that may or may not be reported to child protection agencies. The state should examine these data and consider collecting an even more comprehensive level of information by using randomized surveys to directly ask a sample of parents about their parenting practices.

The base of the diagram represents an additional layer of information that may be useful to examine in concert with the different measures of child maltreatment. We know a great deal about risk and protective factors for child abuse and neglect and that an accumulation of risk in the absence of adequate protective factors is highly predictive of maltreatment. In fact, the thrust of primary prevention programs is to reduce risk and increase protection. Evaluation of programs or policies to prevent maltreatment typically looks first at changes in risk and/or protective factors as intermediate outcomes. Furthermore, recent research suggests that risk factors for child maltreatment tend to be associated with the same adverse outcomes as maltreatment itself.

In terms of monitoring the incidence or prevalence of child maltreatment in the state or a local community, it makes sense to look also at available trend data for risk and protective factors (e.g. the percent of children living in poverty, single parent homes, homes characterized by domestic violence, homes with substance abusing parents; the prevalence of maternal depression in the population; the availability of services in a community and the degree to which they are accessed by high risk families). If the trend for a number of these factors indicated positive change, the likelihood of an associated decrease in maltreatment increases.

Risk factor data are most meaningful when examined in concert with data from other sources. Because all data sources for child maltreatment are fraught with limitations, it is important to triangulate data sources, or look at data from all layers of the pyramid together. To the extent that all the data sources are telling the same story, one can have increased confidence that the story is true.

## Available Data to Use in a Surveillance System

There is currently data available, or which could be made available, to help monitor the occurrences, consequences, and risk factors of child maltreatment.

### Occurrences

- > **Central Registry:** The Central Registry provides information on the number of children investigated and substantiated, the types of maltreatment experienced, and other demographic data on the victims and perpetrators. This data can be augmented with risk assessment data collected by social workers on families who encounter the child protection system once the data is automated and available for analysis.
- > **Child Fatality Data:** North Carolina has one of the strongest child fatality data collection systems in the country. Nevertheless, a limitation of this data is that it includes only children who die from physical abuse and not other types of maltreatment. National statistics indicate that the number of children who die from neglect is far greater than those who die from abuse.
- > **Emergency Department Discharge Data:** The NC Hospital Emergency Surveillance System is a new North Carolina database of emergency department discharge data that offers administrative level data, including diagnosis codes, and nursing triage notes. The system includes the largest hospitals in the state. However, in two years, only 137 children were discharged with child abuse specific codes. In addition, evaluation of the data is labor intensive for a relatively small number of cases.
- > **Medicaid Claims:** An analysis of Medicaid claims data may provide information about the incidence of maltreatment among children, but this strategy needs to be explored more thoroughly. The challenge is that a group of experts would have to agree on a set of diagnosis and/or procedure codes that are likely to indicate maltreatment. The State Center for Health Statistics used a similar strategy recently to estimate the number of medically fragile children in the state.
- > **Independent Surveillance Activity:** North Carolina could choose to administer a population-based study modeled after CarolinaSAFE or the National Incidence Study.

## Consequences

- > **Youth Risk Behavior Surveillance System:** This survey is administered by the NC Department of Public Instruction and collects data through a biannual survey of middle and high school students. The focus of the survey is at-risk behavior including delinquent and violent behavior, substance abuse, and sexual activity. Given that we know many of these behaviors arise because of abuse and neglect, these behaviors could be measured as a marker for prior abuse and neglect. However, it is difficult to assess accurately which behaviors are a direct result of abuse and neglect, and which are attributable to other causes.
- > **Criminal Justice:** Criminal justice data includes information about violent and non-violent crimes as well as juvenile delinquency. Prior abuse and neglect is a risk factor for involvement with the criminal justice system. Again, these behaviors could be measured as a marker for prior abuse and neglect but would not show a direct cause and effect from abuse and neglect because other factors could have contributed to the delinquency.
- > **NC Department of Public Instruction:** The NC Department of Public Instruction maintains county level data on dropouts and college or trade school attendance for high school graduates. School failure is a known consequence of child maltreatment, but is again, subject to the same problems in interpreting the data as referred to above.
- > **Childhood Exit Interview:** This would be a novel monitoring strategy involving new data collection efforts. The methodology has been used by AddHealth (based at the University of North Carolina), an ongoing national longitudinal sample of adolescents. This involves interviewing young adults that have reached the age of eighteen about their prior personal experience of violence. This allows monitoring from the victim's perspective and eliminates ethical concerns involved in surveying minors. There is obviously a significant time lag from occurrence to monitoring (up to eighteen years) and potential for recall bias. Many incidents of abuse and neglect happen before the age of permanent memory development.

## Risk Factors

- > **Birth Certificates:** Birth certificates can provide information about Medicaid eligibility, adequate and timely prenatal care, and the number of children in a household.
- > **Pregnancy Risk Assessment Monitoring System:** This is a survey of pregnant and postpartum women that can provide information about postpartum depression, domestic violence, and the health of the child at well-child visits.
- > **Behavioral Risk Factor Surveillance System (BFRSS):** This is an ongoing, random survey of a representative sample of adults that asks respondents about a variety of topics including their experience of physical and sexual violence, socio-demographic characteristics, health concerns/issues, social/emotional support, use of health services, and presence of firearms in or around their home.
- > **Criminal Justice Data:** Criminal justice data can generate reports about how frequently certain violent crimes are occurring.
- > **Child Health Assessment and Monitoring Program Survey (CHAMP):** This is a new child health survey that the State Center for Health Statistics hopes to continue yearly. It is currently funded for two years. The survey is an add-on to the BFRSS and will survey 5,000 parents annually. CHAMP adds nine questions related to parenting behaviors and discipline to the BFRSS survey, in an effort to measure emotional abuse, positive/negative discipline, and supervision.
- > **Census:** Data from the US Census Bureau provides information on the economic workforce, demographic factors that affect families, counties, zip codes, and neighborhoods.

The Task Force on Child Abuse Prevention agrees that it is a critical priority to establish a data collection system that monitors, with a high degree of accuracy, the incidence of child maltreatment in the North Carolina. The Task Force on Child Abuse Prevention recommends:

- Rec. 5.1. The NC Division of Public Health's Injury and Violence Prevention Branch should develop a North Carolina data collection system for monitoring child abuse prevention through the analysis of the incidence of maltreatment as well as through indicators, including risk and protective factors, that are associated with child



maltreatment. A Technical Advisory Committee should be established by the Injury and Violence Prevention Branch and should include representatives from the NC Division of Social Services, the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the NC Division of Child Development, PCA North Carolina, the NC Division of Public Health - Women's and Children's Health Section, the NC State Center for Health Statistics, law enforcement agencies, organizations housing relevant databases from which child maltreatment data will be collected, and other researchers. This system will:

- A. Monitor the incidence of child maltreatment, including maltreatment perpetrated by family caregivers and non-family caregivers.
- B. Monitor the incidence of child fatalities due to neglect.
- C. Use multiple sources of data to provide a picture of child maltreatment in North Carolina.
- D. Identify science-based measures for collecting indicators of, and risk and protective factors associated with, child maltreatment.
- E. Collect, summarize, and report data at the state and county level on a yearly basis, to measure trends over time.
- F. The NC Division of Public Health should work with the Child Maltreatment Prevention Leadership Team to secure funding for the surveillance system..

The NC Division of Public Health's Injury and Violence Prevention Branch should report progress toward implementing this recommendation to the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

## CHAPTER 6

# Social Norms and Policies that Promote Effective Parenting and Community Responsibility for Child Well-Being

**E**ffective child maltreatment prevention efforts must focus not just on individual parent-child relationships, but also on the larger social environment in which children are raised. One of the greatest challenges in advancing child maltreatment prevention efforts in North Carolina is to identify ways to change community attitudes, social norms, and policies to more effectively support parenting and the healthy development of all children. The Task Force on Child Abuse Prevention identified distinct but interrelated strategies to accomplish this: child abuse prevention public awareness campaigns focused on individual and community support of positive parenting; and increased statewide support and coordination of grassroots, comprehensive violence prevention efforts.

### Strategy 1 - Child Abuse Prevention Public Awareness Campaigns

Child abuse prevention public awareness campaigns, including public service announcements, information kits, television shows, news stories, special events, and other educational and outreach campaigns, can play a key role in changing public attitudes and social norms. Typically, public awareness campaigns are used to educate the public about the issue, create momentum to change public policy, and influence individual attitudes and group behaviors. Public awareness activities have long played an important role in raising the awareness of child abuse and neglect, however, recent research on public opinion and media coverage of child abuse and neglect demonstrate that these campaigns have limited influence on family and community behaviors and in changing public policies to better promote child maltreatment prevention.<sup>80</sup>

Since the early 1970s child maltreatment prevention campaigns have been implemented across the country. In large part, they have been tremendously successful at making child abuse a social issue and bringing it to the forefront of the public's concerns. Studies show that the public is now knowledgeable about child maltreatment and considers it an important issue. Public awareness campaigns have effectively raised awareness of the existence of the problem from less than 10% to greater than 90% since the mid-1970s.<sup>81</sup> Nevertheless, such campaigns have not been able to garner significant public support of child maltreatment prevention efforts, nor have they been able to motivate positive behavior change at the individual level.

While the public is very aware of the issue of child maltreatment, they do not believe they can prevent it nor do they understand how to prevent it.<sup>82</sup>

To better understand this issue, Prevent Child Abuse America, with support from the Doris Duke Charitable Foundation, initiated a unique project to examine public opinion, communications research, and media coverage and to use that information to develop a more effective public awareness message to further child maltreatment prevention efforts. Collaborating with Frameworks Institute and Public Knowledge and Societal Logic, Prevent Child Abuse America undertook a strategic frame analysis of the issue of child abuse and neglect.<sup>83</sup> This research found that Americans see child abuse as a very serious problem. They believe implementing child abuse prevention activities is extremely important, however, the average American thinks that prevention means reporting suspected abuse. Americans cannot clearly define child maltreatment prevention, nor do they believe they can do anything to affect child maltreatment. This, in part, stems from an overwhelming imbalance between media coverage of the negative aspects of child abuse and neglect compared to its coverage of potential solutions to the problem. Much of the public's understanding of child maltreatment comes from the media, where child abuse is typically portrayed as a criminal atrocity and a failure of child protective services. The focus is on horrific cases of physical abuse, neglect, and sexual abuse. As a result, the average American will picture the worst case scenario when you ask them to describe child abuse and neglect. They believe child abuse is intentional, extreme, perpetual, and, not preventable.<sup>84</sup>

Findings from this research also suggest that current solutions to the issue of child maltreatment and “calls to action” result in frustration for the general public. The current campaign model has not been successful in finding non-stigmatizing ways to engage in child maltreatment dialogues with parents or communities, which are not considered to be an indictment of a parent or family, or an intrusion into family life. Societal values, including the belief in family privacy and the sanctity of one's home, influence American's apprehension to address the issue of maltreatment.

### **Reframing Prevention Messages**

Public awareness efforts for child maltreatment prevention are at a crossroads. The prevention community can either continue to raise awareness of the issue of child maltreatment with old messages, while the public continues to feel powerless to prevent maltreatment, or it can redesign prevention messages to focus on changing individual and community behaviors to better support nurturing parenting and families/communities. There is a growing consensus in the field that the prevention community needs to change the focus of its prevention message in order to accomplish the following goals:

- > To create a community climate in which children are valued and families are strengthened.
- > To create public will in support of policies benefiting parents and families.
- > To motivate and enable positive changes in individual behavior because ultimately, individual behavior is what makes a difference.<sup>85</sup>

To develop these new messages, Prevent Child Abuse America has focused on two communications strategies that have been used successfully in other social change efforts - strategic framing and social marketing.

### **Strategic Framing**

Framing is an approach to communications research and practice that pays attention to the public's deeply held worldviews and assumptions.<sup>86</sup> As individuals and society, we have preconceived notions, personal experiences, and societal modes and myths. The manner in which an individual and society processes new information is related to their worldviews and assumptions. These worldviews or “frames” reflect our association of specific issues with deeply held, durable societal values. Once evoked, the frames provide the context through which we process information and solve problems. People adapt new messages or new stories to frames that they already have set in their mind. In other words, they translate information to conform to a theory they already have in place. For example, with the issue of child abuse prevention,

- > Individuals may have the preconceived notion that people who abuse their children are bad people.
- > They may have had a personal experience in which they were spanked but feel that they “turned out fine.”
- > They may share a widely held societal belief that no one should be able to interfere with the way they parent their children.

Each of these frames will impact the way in which these individuals process information about parenting and perceive the role of the community in supporting parents. Effective communication of a prevention message means “framing” the issue of child maltreatment prevention differently. Framing means communicating issues using carefully selected words, phrases, and images to cue a certain response. The power of framing can be seen in Diagram 6.1, which demonstrates ways the following phrases position social issues.<sup>87</sup>

<b>Diagram 6.1</b>		
Female circumcision	or	Female genital mutilation
Learning disabilities	or	Learning differences
Pro-life	or	Pro-choice
Gun control	or	Constitutional rights

The way an issue is framed explains who is responsible and suggests potential solutions conveyed by images, stereotypes, messengers, and metaphors.<sup>88</sup> The way the story is told, including the choice of a narrator and the way the message is framed, determines if one views the story as a personal or community problem. For example, if a parent says that being a parent is hard and sometimes they lose control, we see it as a personal problem - “that person needs to get some help.” However, if a pediatrician says that it is hard for all parents to raise children, and that without support, the stress can lead parents to lose their temper, individuals are more inclined to see it as a community problem - “we need to help parents.” This is important in creating the public will to address the issue of child maltreatment. Changing the focus of child abuse prevention from focusing on individual bad choices and behaviors (episodic framing) to societal responsibility to support families (thematic framing) is a critical step in public awareness initiatives. Additionally, child abuse prevention messages must associate the problem with enduring societal values, communicate community responsibility, and connect the problem to solutions that appear relevant and feasible.

As the prevention field wrestles with the challenge of developing new messages, two hurdles must be overcome. First, the public’s lack of understanding of normal child development may lead people to believe that a young child is being intentionally disobedient, when in fact, the child may be overwhelmed or tired and not able to fully control his/her behavior. This may lead some people to believe that children must be disciplined in order for them to behave.<sup>89</sup> Societal focus is typically not on supporting a child’s cognitive and social/emotional development, but on ensuring that the child behaves. Second, our society’s value on family privacy significantly hinders effective support from the larger community. The “family bubble” reflects the public’s belief in not interfering in another family’s problems unless some damage has obviously been done to a child.<sup>90</sup> As a result, parents assume they should be able to parent without help from others and communities believe that parents should be left alone. These frames make it challenging for prevention messages calling for communities to support families to promote behavior change among individuals and communities.

**Social Marketing**

Social marketing is the use of commercial marketing techniques and strategies to promote the adoption of behaviors or values that will improve the health or well-being of the target audience or society as a whole. The social marketing approach differs from traditional health and human services approaches. In social marketing, you design messages/materials/programs from the targeted audience’s point of view.

There are three strategies used in social marketing to motivate behavior change.

- > By Convincing (Education) - This strategy proposes that if you give people enough information they will voluntarily adopt the desired behavior. Examples of campaigns employing this strategy that worked: breastfeeding, Back to Sleep, and the “truth” anti-smoking campaign.
- > By Enticing (Marketing) - This strategy says that if we give people enough motivation they will voluntarily adopt the behavior change. Examples of campaigns using this strategy include disposable diaper manufacturers sending out free coupons, free infant formula giveaways, condom giveaways to decrease incidence of HIV infection, and designated driver campaigns where designated drivers receive free sodas at bars.
- > By Law - With this strategy, people are given powerful incentives or fear of severe punishment in order to adopt the behavior change. Examples include tax deductions for charitable giving, insurance discounts for being a “safe” driver, and the “Click It or Ticket” seatbelt campaign.

One of the most important aspects of social marketing is defining a target audience. It is too easy to say that parents are your targeted audience. There are endless variations of parents today, all with different experiences, influences, and parenting beliefs. What appeals to a single, teenage mother is very different from what appeals to a forty-year-old married father. When targeting an audience, you must be as specific and distinct as possible, taking into consideration the age of the family’s children, level of education, geographic location, marital status, and other characteristics that define their perspectives and experiences.

Child abuse prevention public awareness efforts have been effective in raising knowledge of child abuse as a social problem, but should now move toward new messages that tell the public - clearly and in language that resonates with their own views and assumptions - how to prevent the problem from occurring in the first place. Recognizing the importance of a new public awareness campaign about parenting and community support of families, the Task Force on Child Abuse Prevention recommends:

**Rec. 6.1. PCA North Carolina, in partnership with the NC Division of Public Health, should take the lead in developing a public education and marketing campaign aimed at encouraging community members to support parents by promoting positive parenting behaviors and increasing public support for programs and resources aimed at strengthening positive family interaction. This initiative should use the latest research on public awareness efforts for child maltreatment prevention and should be coordinated with efforts of the Child Maltreatment Prevention Leadership Team to promote positive parenting behaviors, increase protective factors, and reduce risk factors. PCA North Carolina and the NC Division of Public Health should report on the progress towards implementing this recommendation to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.**

## Strategy 2 - Comprehensive Grassroots Violence Prevention Efforts

Over the last few decades, acts of violence have become increasingly pervasive in American life. There is a growing awareness that violence now constitutes one of the country’s most pressing public health problems and is more dangerous to children than most childhood diseases combined. The Centers for Disease Control and other national agencies are giving this issue increased attention, as is a grassroots movement comprised of parents, healthcare providers, and community members focused on the prevention of violence. Such efforts are critical to child maltreatment prevention because the larger societal context of violence creates an environment that places healthy parenting and healthy child development in jeopardy. Supporting and encouraging such anti-violence efforts in North Carolina is intricately linked to the ultimate success of our child maltreatment prevention initiatives.

### What is violence?

In broadest terms, violence can be defined as actions by people against other people to intentionally threaten, attempt, or inflict physical, emotional, or psychological harm.<sup>96</sup> Different types of violence include child maltreatment, juvenile aggression, sexual violence including sexual harassment, domestic violence, homicide, suicide, and elder abuse/neglect.<sup>97</sup> Many of these forms of violence are not discrete phenomena, but co-occur within families and communities.<sup>98</sup> For example, in 30%–60% of the homes where one type of family violence (domestic violence or child abuse) is present, the other is present as well.<sup>99</sup>

### Violence Permeates American Life

Deborah Prothrow-Stith and Howard Spivak, authors of *Murder is No Accident: Understanding and Preventing Youth Violence in America*, noted that the high rate of violence in the United States has evolved over decades from an imbalance of too many risk factors and too few protective factors. They emphasize the culture's admiration of violence, particularly violence in entertainment, and state, "Children learn to use violence from the media. Television is the most obvious conveyer of the value, success and reward attributed to super-heroic, violence responses to problems... Five decades of sound scientific research have documented this fact and demonstrated direct causality between the viewing of violence on TV and the displaying of violent behavior."<sup>102</sup> This violent culture creates an environment in which child maltreatment is more likely to occur.

### Engaging Communities in the Prevention of Violence

Communities can play an important role in the prevention of violence and child maltreatment. Violence must be viewed in a social context, which will require a change in social norms. This change is more likely to occur when the people affected by a problem are defining the problem and are engaged in solving it.

A key step in the public health approach is to engage the community in actively changing social norms around violence, both in terms of what is acceptable behavior and in attitudes toward violence. Engaging communities in grassroots efforts to change our culture's glamorization of violence and acceptance of violence must be a part of a comprehensive approach to the prevention of child maltreatment. Using community organizing strategies, mass media, and media advocacy to change organization and societal policies and to affect community norms will be critical strategies within this larger effort. As demonstrated through public health initiatives, such as anti-smoking campaigns, strategic use of the mass media in combination with community

**Table 6.2**

### U.S. Violence Statistics

- > In 2001, homicide claimed the lives of 20,308 Americans. Suicide was responsible for the deaths of 30,622 Americans.<sup>91</sup>
- > In 2002, more than 877,700 young people ages 10 to 24 were injured from violent acts. Approximately one in thirteen required hospitalization.<sup>92</sup>
- > Homicide is the second leading cause of death among young people ages ten to twenty-four overall. In this age group, it is the leading cause of death for African-Americans, the second leading cause of death for Hispanics, and the third leading cause of death for American Indians, Alaskan Natives, and Asian Pacific Islanders.<sup>93</sup>
- > Nearly 5.3 million intimate partner victimizations occur each year among U.S. women ages eighteen and older. This violence results in nearly two million injuries and nearly 1,300 deaths. There were 29,573 firearm-related deaths among the female population in 2001.<sup>94</sup>
- > According to the National Violence Against Women Survey, one in six women and one in thirty-three men in the United States have experienced an attempted or completed rape at some time in their lives.<sup>95</sup>

**Table 6.3**

### North Carolina Violence Statistics

- > Between January and June of 2004, the number of North Carolina deaths from violence was 803. Of these violent deaths, 485 (60.3%) were from suicide and 288 (35.8%) were from homicide.<sup>100</sup>
- > In North Carolina, 24% of women and 19.8% of men reported experiencing some type of physical and/or sexual violence during adulthood (since turning eighteen years of age).<sup>101</sup>

organizing can change social norms, motivate behavior change, and ultimately advance healthy public policies. The Task Force on Child Abuse Prevention believes that similar strategies can be utilized to create nurturing communities in which healthy parenting and healthy children can flourish.

In North Carolina, there are already a number of grassroots and state level activities focused on the prevention of violence. Recognizing the importance of violence prevention efforts to decreasing risk factors associated with child maltreatment, the Task Force on Child Abuse Prevention recommends that:

**Rec. 6.2. PCA North Carolina, in collaboration with the NC Division of Public Health, the NC Division of Social Services, the NC Coalition Against Domestic Violence, the NC Domestic Violence Commission, the NC Partnership for Children, the NC Department of Public Instruction, the NC Department of Juvenile Justice and Delinquency Prevention, and the Mediation Network of North Carolina should work with and support ongoing grassroots efforts (and establish new ones where necessary) to establish community norms that support families and healthy child development, and reduce social acceptance of violence as an appropriate response to interpersonal conflict. Issues such as the acceptance of corporal punishment in North Carolina schools, the glamorization of violence, and the presence of violence in the media should be examined in these efforts. PCA North Carolina, the NC Division of Public Health, and other appropriate agencies shall report on the progress towards implementing this recommendation to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.**

# Evidence-Based and Promising Programs to Prevent Child Maltreatment

**I**ncreasingly, policy makers, researchers and practitioners are focusing on the use of evidence-based and promising programs in community and state efforts to prevent maltreatment in order to ensure that public and private investments in child maltreatment prevention services are used effectively and strategically. Although the field of child maltreatment prevention is relatively new and an extensive body of scientifically proven programs does not yet exist, the need to incorporate research into practice is critical. By increasing the use of evidence-based and promising programs in child maltreatment prevention, North Carolina can take the first step in assuring that program interventions will produce the desired impact with children and families and ensure that resources are being used well.

## Program Evaluation Research

Evidence-based programs are those programs that have scientific evidence that the strategies they employ do cause changes within the child, family, or community that lead to a reduction of risk factors, an increase in protective factors, and ultimately the prevention of child maltreatment. Within outcome evaluation research, there are different levels of evidence. Experimental studies can confidently demonstrate a “cause-effect” relationship, quasi-experimental studies try to link intervention with comparison groups to evaluate the impact of specific interventions, and non-experimental studies may demonstrate changes in knowledge, skills, attitude, or behavior, but cannot demonstrate with certainty that these changes were caused by the program’s services or that they lead to the prevention of maltreatment.

Determining whether a program is evidence-based is a complicated endeavor that requires significant expertise in research methodology and practice. Challenges include:

- > Issues related to evaluation design and implementation (e.g. sampling strategy, attrition, data collection methods) that can affect an evaluation’s findings and strength, and that need to be considered when determining whether a specific program or practice meets the criteria of being a proven, evidence-based program.
- > Lack of rigorous evaluation studies on child maltreatment prevention programs that leaves practitioners and advocates with the challenge of trying to weigh the existing evidence as best they can.



**Table 7.1** Types of Evaluations

<b>Design</b>	<b>Description</b>
<b>Experimental studies</b>	Randomized controlled trials are the most rigorous for evaluating program effectiveness. These evaluations randomly assign a target population to an experimental group that receives an intervention and a control group that does not receive an intervention. Differences in outcomes for the two groups can be attributed to the intervention with a high degree of confidence if the evaluation is well-designed. However, the cost and expertise needed to conduct such an evaluation are prohibitive for most programs. In addition, ethical issues regarding the provision of services to families in the control group must be addressed. In child abuse prevention, there are some, but not many, programs that have undergone such rigorous evaluation.
<b>Quasi-experimental studies</b>	Quasi-experimental studies use a non-randomized, comparison group design in which the intervention and comparison groups are closely matched. Differences in outcomes for the intervention and comparison groups are seen as “possible evidence” of program effectiveness. However, causality cannot be established with a high level of confidence as differences in the groups that are not easily observable (level of motivation in the intervention group, etc.) may account for differences in outcomes. Quasi-experimental studies are less costly and easier to conduct than randomized, controlled trials, and are more common in evaluating child abuse prevention programs. Nevertheless, quasi-experimental studies still require significant resources and expertise in implementation.
<b>Non-experimental studies</b>	Non-experimental designs do not compare the intervention group to another group, either a randomized control group or a comparison group. So, they cannot determine with a high degree of confidence that changes in program participants are caused by the program intervention or by other factors. Non-experimental designs include pre/post testing with no control group, focus groups, case studies, and ethnographic approaches. Many child abuse prevention programs utilize non-experimental designs in evaluating their programs because of constraints in funding and staff expertise.

- > Lack of consensus in the research community on what are sufficient measures of child maltreatment. For instance, there are multiple potential ways to measure whether a family maltreats or is likely to maltreat a child - Central Registry reports, observation of parent/child interaction, surveys of parent knowledge or attitude, etc. - but none is perfect.
- > Questions about model fidelity, particularly as programs move from implementation in a controlled academic environment to implementation in real-world circumstances -efficacy versus effectiveness.

The Task Force on Child Abuse Prevention created a Program Subcommittee to examine the current body of research on child maltreatment prevention efforts to determine which programs appeared to be most promising in reducing child maltreatment. With the assistance of the Program Subcommittee, the Task Force on Child Abuse Prevention identified the major service models used in child maltreatment prevention, summarized the research literature for each of these models, and identified several programs that had strong bodies of evidence with regard to program effectiveness.

The field of child maltreatment prevention is relatively new, so few interventions have been subject to thorough evaluation. In addition, program evaluation research with children and families can be very complex. Ethical issues related to withholding interventions and carrying out experimental studies with children may prohibit the use of some of the most rigorous research evaluations on this population. Maintaining model fidelity can be challenging because program effectiveness may be limited if aspects of the program's services are not tailored to the specific needs of different populations. For these reasons, and others, replicating findings is a complicated endeavor and these challenges should be kept in mind as one considers the program evaluation research available for maltreatment programs.

It is important for the state to keep abreast of new findings, in order to provide direction to state and local agencies and organizations, and state philanthropies about evidence-based and promising programs that are effective in helping to reduce child maltreatment. Recognizing the importance of this issue, the Task Force on Child Abuse Prevention recommends that:

- Rec. 7.1. PCA North Carolina, through its involvement with the Child Maltreatment Prevention Leadership Team, should continue the work begun by the Task Force on Child Abuse Prevention Program Subcommittee on evidence-based child maltreatment prevention practice by convening an Expert Work Group on Evidence-Based Practice.**
- A. The Expert Work Group on Evidence-Based Practice should include members of the Child Maltreatment Prevention Leadership Team, researchers, practitioners, and other experts.**
  - B. The responsibilities of the Expert Work Group on Evidence-Based Practice should include the following:**
    - i. Review prevention research literature and keep abreast of ongoing studies and current findings.**
    - ii. Identify evidence-based and promising programs for child maltreatment prevention and family strengthening.**
    - iii. Identify strategies to disseminate this information to state and local policy-makers, funders, and practitioners/community-based programs.**
    - iv. Identify ways to financially and programmatically support the use of evidence-based programs in North Carolina.**
    - v. Identify strategies and funding to further evaluate promising practices that merit more scientifically rigorous evaluation.**

**A report on the progress towards implementing this recommendation should be provided to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.**

## Major Service Models for Child Maltreatment Prevention

The Task Force on Child Abuse Prevention Program Subcommittee identified eight service models for child maltreatment prevention including home-based services/home visitation; parent education/parent training; mutual support/social support; early childhood education initiatives; primary healthcare initiatives; respite care; child sexual assault prevention (school-based); and family resource centers. There is significant overlap between these models and often it is difficult to view them as discrete interventions. For example, programs may combine different models into one programmatic efforts, such as home-visiting programs may use parent education curricula/activities and coordinate social support groups and respite care for parents receiving home visits. Nevertheless, there is benefit in looking at these different models to better understand their purpose, primary activities, and effectiveness in preventing maltreatment. The following section provides background information on each type of service model including intervention activities, outcomes, target population, and a brief summary of the evaluation literature on that model. More detailed information about these programs is available in the Appendix.

## **Home-Based Services/Home Visitation**

Home visiting has been identified as one of the most promising strategies for the prevention of child maltreatment, as well as a program that is effective in promoting school readiness, improving maternal and child health, decreasing welfare dependence, and a host of other outcomes.<sup>103</sup> Home visiting programs typically involve the delivery of voluntary services in a family's home for an extended period of time, often for two to three years, and on a regular basis, often weekly or bi-weekly. Home visitors may be professionals (ex. nurses, social workers, mental health professionals) or paraprofessionals (ex. staff that are from the neighborhoods they are serving, volunteers with experience in raising children) depending on the model used. They typically provide services to pregnant women and new parents, or other families who may demonstrate risk factors for maltreatment.

Home visitors use a number of strategies to increase parental competence, improve parent-child interaction, decrease parental stress, and increase family use of community resources. Home visitors provide information to parents about appropriate child development and positive parenting; they ensure children are receiving their well-child visits and immunizations on-time; they offer social support; and they connect families with community resources such as health insurance, housing, financial aid, domestic violence programs, and substance abuse treatment services.

There is strong evidence that early intervention can have a significant and lasting impact on parenting behavior and child health.<sup>104</sup> A large number of empirical studies on home-based services and home visiting programs during the perinatal and early childhood period suggest these strategies are promising for producing a number of positive outcomes including improved maternal health, child health and development, school readiness, child abuse prevention, and economic self-sufficiency.<sup>105</sup> Nevertheless, positive outcomes are not consistent across all models or populations, pointing to the need to attend to both the specifics of the model and match between the model and the targeted population.<sup>106</sup>

Many different models of home visitation and home-based services focus on child maltreatment prevention as one of their outcomes. For example, the Nurse Family Partnership, Healthy Families, Project 12-Ways/Project SafeCare, Parents as Teachers, Parent Aide Program, and Family Connections were reviewed by the Program Subcommittee.

## **Parent Education and Parent Training**

Parent education and parent training are group-based or parent-child interventions that focus on strengthening the parent/child relationship by enhancing parental knowledge, attitude, skills and behavior, and parent/child communication and interactions.<sup>107</sup> Parent education and parent training programs are the most common services offered to prevent maltreatment and improve child outcomes in North Carolina. There are hundreds of parent education programs that serve diverse populations - first-time parents, divorced parents, single parents, Hispanic parents, court-ordered parents, etc. - to achieve a range of outcomes -child maltreatment prevention, substance abuse prevention, juvenile delinquency prevention, school readiness, improved maternal/child health, etc. Parent education programs are typically information-based while parent training programs are skills-based interventions.

The parent education programs reviewed by the Program Subcommittee include Parent-Child Interaction Therapy, Nurturing Program, Circle of Security, The Incredible Years, Triple P (Positive Parenting Program), Strengthening Families, and Parenting Wisely. While there is an abundance of literature discussing parent education, few programs have been rigorously evaluated specifically for child maltreatment prevention. Existing research does suggest that efforts to educate abusive or neglectful families with established patterns of maltreatment and with significant personal and environmental challenges have limited success.<sup>108</sup> However, there is promise in efforts to support and work with new parents or high-risk parents whose behavior is not yet well-established.<sup>109</sup> A number of parent training programs developed for treating and preventing child behavioral problems have been rigorously tested and hold promise for child abuse prevention, particularly for physically abusive parents.<sup>110</sup> Research on these family strengthening programs indicates that successful programs are interactive and skills-based, match the intensity of the intervention with family need, are

developmentally focused, target parental behavior and cognitions that specifically contribute to child maltreatment, and often involve both the parents and the children.<sup>111</sup> Additionally, there is increasing recognition that all parents need support and information throughout the developmental life of their child and that different types of parent education and training (from basic information on diapering a baby to more intensive interventions for families experiencing significant difficulties) need to be easily accessible throughout a community.<sup>112</sup>

### **Mutual Support/Social Support**

Mutual Support/Social Support programs provide opportunities for parents to find social support, share experiences, learn about resources that support healthy family development and positive parenting, and develop confidence and leadership skills that increase their sense of self-efficacy.<sup>113</sup> These programs can use a group-based, self-help format or they may offer a one-to-one mentoring relationship between parents. Mutual support groups can be found throughout North Carolina communities in programs such as neighborhood parenting groups, programs linking parents of children with special needs, and therapeutic groups led by clinicians. Key aspects of these programs are that they are voluntary, readily available for parents to use when they feel they need support, and the format and content of the programs are driven by the parents themselves rather than by professionals.<sup>114</sup> Outcomes include increased social support, parental knowledge, appropriate expectations of children, linkages to community resources, parental empowerment, and leadership development.<sup>115</sup>

The Program Subcommittee examined different self-help/social support models, including Circle of Parents, Parents Anonymous, and Parent to Parent. Self-help/social support interventions have a strong theoretical foundation, although most program models directed toward child maltreatment prevention lack rigorous evaluation. There is some evidence on mutual support groups with regard to child maltreatment prevention that suggests this strategy improves parent/child relationships, improves parenting skills, decreases parental stress, and enhances social support and access to community resources.<sup>116</sup>

### **Respite Care**

Respite care provides temporary childcare, support, and referral services for families who are experiencing stress and are having difficulty juggling the demands of caretaking with other responsibilities. Families receiving respite care services may have children with special needs, children with behavioral issues, or may have various other risk factors for maltreatment. There are two types of respite care: preplanned or crisis/emergency oriented (often called crisis nurseries). Respite care may be a separate, distinct program or it may be a service component in a comprehensive and multi-faceted intervention. Much of the research on respite care has focused on families of children with special needs. This research and other studies focused on at-risk families demonstrate promise in reducing parental stress, situations of neglect, and out-of-home placements.<sup>117</sup> While there are numerous programs operating in North Carolina, no single model was identified during the literature review.

### **Early Childhood Initiatives**

Early childhood education programs foster the physical, cognitive, social, and emotional development of young children so that each child is prepared for success in school and later in life.<sup>118</sup> There is strong evidence that quality early childhood programs positively impact children and result in better academic performance, lower drop-out rates, fewer juvenile delinquency and behavior problems, and more employment and economic earnings later in life.<sup>119</sup> Quality early childhood education programs partner with parents in fostering children's growth and development, and focus on developing strong parent-child relationships. They offer an opportunity to increase protective factors that may reduce the risk of child maltreatment. In fact, there is growing interest nationally to enhance the capacity of early childhood education programs to strengthen parent/child relationships, nurture families, and prevent maltreatment.<sup>120</sup>

The Program Subcommittee examined data around the Chicago Child-Parent Centers and Early Head Start. Although there is not an extensive body of evidence that focuses specifically on the prevention of child maltreatment through early childhood education programs, there is some indication that it is a promising strategy for improving parent/child

relationships, improving parenting skills, and fostering parental participation in a child's education.<sup>121</sup> Evaluations of the Chicago Child-Parent Centers in particular show evidence of preventing child maltreatment among the children who attended the Centers.

### **Primary Healthcare Initiatives**

Primary healthcare providers can play a key role in preventing maltreatment.<sup>122</sup> Parents often look to their child's health providers for information and support, which provides primary healthcare providers opportunities to promote healthy parenting, support child social/cognitive/physical development, and link families with needed resources all in a non-stigmatizing environment. Initiatives such as Triple P (Positive Parenting Program) and Healthy Steps for Young Children have provided parent education and parent support in primary healthcare settings and these efforts have been successful in increasing parent knowledge and skills.<sup>123</sup>

The Program Subcommittee reviewed the Healthy Steps for Young Children program closely. This initiative was funded by the Commonwealth Foundation to improve delivery of developmental and behavioral services to young children through pediatric practices. The program added nurses, nurse practitioners, early childhood educators, or social workers to the staffs of fifteen pediatric offices in fourteen states. Healthy Steps specialists met with physicians and parents during office visits, made home visits, staffed call-in child development phone lines, performed developmental assessments, provided developmental materials to parents, organized parent support groups, and made community referrals. A trial of several thousand families found that compared to mothers in the control group, parents in the Healthy Steps program were less likely to use severe physical discipline, more likely to receive developmentally oriented care for their child, and more likely to discuss feelings of sadness and depression with someone in the pediatric office. Additionally, children had better continuity of care and a decreased likelihood of having an emergency department visit in the past year for injury-related causes.<sup>124</sup>

The difficulty in funding additional staff in pediatric offices hinders the extensive replication of this program. However, in North Carolina several of the program's activities, such as developmental screenings, community referrals, and anticipatory guidance for child development, are being performed through the Assuring Better Child Health and Development (ABCD) Project. Spearheaded through the Medicaid Program, the ABCD Project is a comprehensive effort to improve the delivery and financing of child developmental services. Through the ABCD Project, community health providers administer validated screening tools at well child visits to identify children experiencing developmental issues, refer them to appropriate services, and provide parent and family support.

### **Child Sexual Assault Prevention**

Child sexual assault prevention programs are typically school-based programs designed to educate and empower young children to protect them from sexual victimization. They do this by teaching concepts and skills that are believed to help them recognize, resist, and report sexual abuse. There are numerous child sexual abuse prevention programs but most focus on a set of core goals:

- > Improving a child's ability to identify and avoid situations in which child sexual abuse could potentially occur.
- > Providing a child with self-protection skills to respond to threatening situations.
- > Creating an environment in which children are encouraged to disclose previous or ongoing abuse so that they can receive the help they need.<sup>125</sup>

There are a number of studies that have evaluated the effectiveness of school-based child sexual abuse prevention programs.<sup>126</sup> Overall, empirical evidence suggests that children do obtain knowledge and skills from certain programs. However, the gains are slight, they decrease over time, and they have a weak primary preventive effect.<sup>127</sup> The literature suggests that child sexual abuse prevention programs may not be effective as a universal or selective strategy for the prevention of sexual abuse, but that they can be effective in increasing disclosures among children who have already been victimized and who need intervention.<sup>128</sup>

An alternative strategy is to focus efforts on adults. An increasing number of agencies are employing public health strategies to focus on the responsibilities of adults to protect children from child sexual abuse. One such initiative, STOP IT NOW!, looks at preventing child sexual abuse by:

- > Increasing the public's knowledge of the perpetration of sexual abuse through mass media campaigns.
- > Teaching adults the skills to recognize signs of abusive behavior and to intervene before abuse occurs.
- > Encouraging abusers and potential abusers to seek help.
- > Challenging family members and friends of suspected abusers to confront them and encourage them to get help.<sup>129</sup>

Several states - including Vermont, Minnesota, Georgia, and Massachusetts - are either implementing STOP IT NOW! or are employing other promising public health approaches to the issue. The Centers for Disease Control and Prevention is evaluating a number of these initiatives. Other initiatives, including Darkness to Light in South Carolina, are also focusing on the responsibility of adults to protect children from sexual abuse.

The Program Subcommittee did not examine any specific models because the emerging public health approach to child sexual abuse prevention is still very new. Instead, members decided to wait and review evaluative data from the Centers for Disease Control and Prevention when they become available.

### **Family Resource Centers**

In the 1990s, family resource centers were identified as a major strategy to prevent child maltreatment. Family resource centers are a way to organize and deliver services to a geographically defined community using a strengths-based approach that fosters parental and community involvement. They may be located in schools, churches, housing complexes, hospitals, or independent facilities. These centers involve community members in planning, implementing, and evaluating services that are designed to meet the needs of the surrounding community. Family resource centers strive to improve family well-being by providing services such as afterschool programming, parent support groups, respite care, literacy training, parent skills training, employment assistance, housing, and financial issues. Family resource centers also strive to develop a sense of community cohesion and efficacy by becoming a place where community members know one another, feel empowered, and develop bonds that create strong communities and neighborhoods.<sup>130</sup> States have taken varying approaches to developing networks of family resource centers with some focusing on the development of school-based family resource centers and others focusing on community-based networks that support pregnant women and parents of young children.

Despite the prevalence of and support for family resource centers, there has been little empirical evaluation of these centers particularly with regard to child maltreatment. In part, this stems from the difficulties involved with evaluating this type of service and the desire of programs to avoid labeling families as abusive. Nevertheless, there is a growing body of evidence that demonstrates that family resource centers can contribute to child and family well-being. For example, in a comprehensive review of family resource centers, the UCLA Center for Healthier Children, Families, and Communities cites several studies that indicate that some family resource centers may be effective in improving children's educational performance.<sup>131</sup> Additionally, the Carnegie Corporation of New York's Starting Points Initiative included the development of family resource centers as a core strategy to improve care for children birth to three years of age. The Initiative reports that preliminary evaluation data show strong participation by low-income families; improvements in child health insurance coverage, immunization rates and parenting skills; and increased use of nutrition and other community services.<sup>132</sup> While more empirical studies of family resource centers are needed, they demonstrate promise as a strategy to strengthen families.

## **Implementation of Prevention Programs with a Strong Body of Evidence**

The Task Force on Child Abuse Prevention supports the implementation of child maltreatment prevention programs with strong evidence of effectiveness. In the implementation process of all evidence-based and promising programs, the Task Force on Child Abuse Prevention recognizes the importance of providing sufficient resources for training, professional staff compensation, and quality assurance (for model fidelity), along with the need to establish guidelines and provide technical

assistance in program evaluation. To promote the implementation of these programs, the Task Force on Child Abuse Prevention encourages both public and private funders of family support, family strengthening, and child maltreatment prevention programs to shift funding priorities toward those programs that have evidence of effectiveness. The Task Force on Child Abuse Prevention recommends:

**Rec. 7.2. Public and private funders should place priority on funding evidence-based and promising child maltreatment prevention and family strengthening programs. When those programs are not available for a specific population, public and private funders should give funding priority to those programs that are theory-based and incorporate elements identified in the research literature as critical elements of effective programs. A report on the progress on this recommendation should be provided to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.**

### **Nurse Family Partnership**

Of all the child maltreatment prevention programs described previously, the Nurse Family Partnership remains the model that has the strongest research demonstrating positive outcomes in preventing maltreatment. The Nurse Family Partnership is a nationally recognized, cost-effective model that has been scientifically proven to reduce child maltreatment, delay second pregnancies, improve child and maternal health, decrease juvenile delinquency, and increase family economic self-sufficiency in high risk populations.<sup>133</sup> Home visits by trained, experienced nurses are conducted with first-time, low-income mothers and their families over a period of two years. The program has amassed considerable evidence of reducing child maltreatment through three large-scale randomized controlled trials in which participants were followed over time. Currently, one Nurse Family Partnership program exists in North Carolina and the Task Force on Child Abuse Prevention believes that expansion of this effective program to additional sites is critical to the state's child maltreatment prevention efforts.

The Task Force on Child Abuse Prevention recommends two strategies to expand the Nurse Family Partnership:

- > Target use of the program with first-time adolescent mothers.
- > Implement the program within a Community Care of NC Provider Network.

With regard to the first strategy, the Nurse Family Partnership has demonstrated excellent results in reducing child maltreatment among adolescent parents and in delaying second pregnancies.<sup>134</sup> One strategy may be for North Carolina to use the Nurse Family Partnership program as a model child maltreatment prevention/adolescent parenting program with first-time adolescent parents.

With regard to the second strategy, the Community Care of NC (CCNC) program is a program organized around local networks of healthcare providers that help to manage the care of Medicaid recipients. There were fourteen regional networks covering sixty-nine counties in January 2005. The program is expected to be statewide by December 2005. These networks include primary healthcare providers, hospitals, health departments, and social services agencies. Primary healthcare providers along with care managers help coordinate prevention, treatment, referral, and institutional services for certain Medicaid recipients who have high-cost or complex health problems. Currently, each of the networks are responsible for providing care management to people with asthma, diabetes, congestive heart failure, and other high-cost cases. Primary healthcare providers in CCNC are also responsible for screening children for developmental and social/emotional risks, as part of the Assuring Better Child Health and Development initiative. Local networks can also develop other initiatives to improve quality of care and health status of Medicaid recipients. The Task Force on Child Abuse Prevention believes that exploring implementation of a Nurse Family Partnership within a CCNC network to improve maternal and child health outcomes, reduce maltreatment, and produce cost savings is an important step in expanding the Nurse Family Partnership in North Carolina. The Task Force on Child Abuse Prevention recommends that:

- Rec. 7.3. PCA North Carolina should work with the NC Division of Medical Assistance, the NC Division of Public Health, and Community Care of North Carolina to implement the Nurse Family Partnership Program in two to three additional sites in North Carolina. In implementing this program, these organizations should:
- A. Target at least one of the Nurse Family Partnership programs toward the first-time adolescent mother population;
  - B. Attach at least one of the Nurse Family Partnership programs to a Community Care of North Carolina provider network and conduct a cost-benefit analysis to assess savings to the Medicaid Program; and
- A report on progress towards implementing this recommendation to the Child Maltreatment Prevention Leadership Team should be made by January 2006 and annually thereafter.

### **Home Visiting Programs - Other Models**

North Carolina has several other home visiting programs that have a growing body of evidence and have been identified as promising programs. For example, North Carolina has eleven Healthy Families programs, over sixty Parents As Teachers programs, and nine Parent Aide programs that serve hundreds of families annually. The Task Force on Child Abuse Prevention recognized the importance of using this foundation of existing home visiting resources in enhancing North Carolina's child abuse prevention efforts and also recognized that the Nurse Family Partnership would not be able to serve all high-risk families due to eligibility requirements and program implementation issues. For example, counties must have at least 200 births annually to support a Nurse Family Partnership program, women must be enrolled in the program during pregnancy, and participants must be first-time mothers. The Task Force on Child Abuse Prevention felt that there is a need for an intensive model of home-based services for high-risk families that builds on the existing infrastructure for home visiting in North Carolina to serve those families who may not be best served by the Nurse Family Partnership. Consequently, the Task Force on Child Abuse Prevention recommends that:

- Rec. 7.4. PCA North Carolina and the NC Division of Public Health should work with the Education Begins at Home Alliance to develop a model of home visitation for families at high risk of maltreatment, based on the most current research of perinatal and early childhood home visitation programs and from an assessment of the current resources and infrastructure for home visiting programs in North Carolina. This collaborative effort should:
- A. Integrate this model within a larger continuum of perinatal and early childhood home visitation programs;
  - B. Identify strategies to rigorously evaluate this model of home visitation;
  - C. Develop a system for quality assurance and long-term funding;
- Report on progress of the development of the home visitation model to the Child Maltreatment Prevention Leadership Team should be made in January 2006 and annually thereafter.

### **Other Programs with Strong Evidence**

The Task Force on Child Abuse Prevention also identified several promising programs that had very strong bodies of research demonstrating their effectiveness in preventing child maltreatment or in improving parent/child interactions.

- > **Parent-Child Interaction Therapy (PCIT)** is a parent training program originally designed to treat children with conduct behavior problems. It is now being used to treat and prevent maltreatment with physically-abusive families with children ages four to twelve. Trained therapists coach parents in child management techniques through the use of a "bug-in-the-ear" microphone/listening device while parents are interacting with their children in a safe environment. Training focuses on helping parents learn how to praise appropriate behavior; ignore undesirable behavior; give clear, age-appropriate instructions; and implement time-outs effectively. A strong body of evidence supporting the efficacy of PCIT as a treatment program for children with behavior problems exists. A recent randomized trial with physically abusive parents found that parents who completed the PCIT program had a 60 % lower re-report rate for physical abuse (19%)



compared to those who completed a standard community-based parent education group (49%).<sup>135</sup>

- > **Strengthening Families Program** is a family skills training program for elementary school children (ages six to twelve years) and their families. The program is designed to improve family relationships, parenting skills, and the youth's social and life skills to reduce problem behaviors in children, improve school performance, and reduce alcohol/drug use in adolescents. Although originally designed to prevent behavioral problems in children of alcohol or drug abusers, the program is now being offered to parents with children in the child protection system, as well as other at-risk groups. Numerous randomized controlled evaluations have proven the program to be efficacious with a variety of populations. It has also shown positive effects on parental depression; parental alcohol and drug use; decreases in family conflict and stress; increases in parenting confidence, efficacy, and knowledge; and positive parenting skills.<sup>136</sup> While the program has not specifically measured child maltreatment, the effects demonstrated so far show great promise in this area.
  
- > **Chicago Child-Parent Center** is a federally funded (Title 1), center-based early childhood program for low-income children in preschool through third grade (ages three to nine years). It was designed to improve children's school readiness through four features: early intervention, parent involvement, a structured language-based instructional model, and program continuity between preschool and early school-age years. The Centers use a multi-faceted program that includes a parent resource room staffed by a Head Start teacher, parental involvement in the classroom, and home visits focused on increasing parental involvement in their child's education. A quasi-experimental study of 1,539 low-income mostly African American children, with a fifteen-year follow-up, demonstrated that children who participated in the Child Parent Center preschool were 52% less likely to be victims of maltreatment (as measured through court and CPS reports). Additionally, children who participated in one-two years of the Child Parent Center preschool had higher reading and math achievement scores, lower rates of grade retention and special education placement, were more likely to complete high school, had fewer violent and nonviolent arrests, and fewer drop-outs than the comparison group.<sup>137</sup> The longer the children participated in the Child Parent Center, the greater the results.

The Task Force on Child Abuse Prevention believed that these programs were worthy of preliminary public and private investment in North Carolina. Therefore, the Task Force on Child Abuse Prevention recommends that:

**Rec. 7.5. The Child Maltreatment Prevention Leadership Team should work with members to pilot or replicate promising child abuse prevention programs and to evaluate their effectiveness with a North Carolina population including, but not limited to:**

- A. Parent-Child Interaction Therapy for families with children ages four to twelve years who are at risk for and who are already experiencing physical abuse.
- B. The Strengthening Families Program as a selective prevention strategy for families with children ages six to twelve years.
- C. The Chicago Child-Parent Center model for low-income children in preschool through third grade (ages three to nine years) and their families.

A report on the progress of this recommendation should be provided to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

## Using Research to Strengthen Current Programs and Initiatives

North Carolina has a number of existing programs and initiatives targeted at strengthening families and preventing maltreatment. Such initiatives would benefit from integrating timely research on program effectiveness into program development and refinement activities.

For example, both the NC Division of Social Services and the NC Partnership for Children fund family resource centers. These family resource centers are extremely diverse and offer a variety of services including literacy training, GED classes,

employment counseling, afterschool programming, respite care, and parent education classes. With an increased federal focus on linking the activities and outcomes of family resource centers to the prevention of child maltreatment, it is important for these programs to focus on either offering or linking to evidence-based and promising child maltreatment prevention and family strengthening programs.

Similarly, agencies that fund or sponsor parent education and parent training programs should be required to fund programs that have some evidence of effectiveness with the targeted population. This is particularly true for programs that are working with families at risk of maltreatment or who are maltreating. Additionally, agencies that fund child sexual abuse prevention programs should take into careful consideration the research conducted on school-based child sexual abuse prevention programs when making decisions about future efforts to prevent child sexual abuse. As discussed previously, there is little empirical evidence that children who participate in these programs are actually able to use the information they receive to avoid victimization.

Finally, there is a need for numerous agencies that are funding and sponsoring family strengthening and child maltreatment prevention programs to jointly identify a shared set of programmatic outcomes and indicators that will help them monitor and assess program effectiveness across multiple programs. As a result of these issues, the Task Force on Child Abuse Prevention recommends:

**Rec. 7.6. The Child Maltreatment Prevention Leadership Team should work with:**

- A. The NC Division of Social Services and the NC Partnership for Children to ensure that community-based family resource centers offer or link to evidence-based and promising prevention programs, and to develop a model family resource center that uses evidence-based and promising prevention programming to address risk factors associated with child maltreatment and school readiness.
- B. The NC Division of Social Services, the NC Partnership for Children, and the NC Children's Trust Fund should require use of social support and parent education programs that have been evaluated and show evidence of or promise in preventing maltreatment (e.g. the Nurturing Program) or in strengthening family functioning (e.g. The Incredible Years), and/or that incorporate critical components identified in the research literature.
- C. The NC Division of Public Health, the NC Children's Trust Fund, and other funding entities for child sexual abuse prevention programs to re-target funding for school-based child sexual abuse prevention programs to other more promising models of prevention, as recommended by the Expert Work Group on Evidence-Based Practice.
- D. The Expert Work Group on Evidence-Based Practice, the NC Partnership for Children, the NC Division of Social Services, the NC Children's Trust Fund, and other agencies as appropriate, in developing a shared set of research-based intermediate indicators of child maltreatment, nurturing parent-child interaction, and healthy child development to evaluate family support and child maltreatment prevention programs. This group should collaborate with the Technical Advisory Group on Surveillance to ensure that the intermediate indicators developed are consistent with the measures developed as part of the prevention measurement system, to the extent practicable.

A report on the progress of this recommendation should be provided to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

## Implementation of Treatment Programs with a Strong Body of Evidence

Although not a specific focus of the Task Force on Child Abuse Prevention, treatment for children who have been maltreated is a critical piece of preventing the re-occurrence of maltreatment and preventing children from becoming abusive or neglectful parents themselves later in life. The Kauffman Best Practice Project to Help Children Heal from the

Effects of Child Abuse - funded by the Ewing Marion Kauffman Foundation in Kansas City and led by the Chadwick Center at Children's Hospital in San Diego - reviewed the literature on treatment for child victims and identified three evidence-based and effective treatment protocols: Parent-Child Interaction Therapy and Abuse-Focused-Cognitive Behavioral Therapy for physically abused children and Trauma Focused-Cognitive Behavioral Therapy for sexually abused children. The Appendix of this report includes more details about these programs. These scientifically proven programs should be used across North Carolina in treatment programs for this population. The Task Force on Child Abuse Prevention recommends:

**Rec. 7.7** The Child Maltreatment Prevention Leadership Team should work with the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and other agencies and private providers that provide oversight or treatment for children who have experienced abuse or neglect to encourage the use evidence-based models (i.e., Parent-Child Interaction Therapy; Trauma-Focused-Cognitive Behavioral Therapy; Abuse Focused-Cognitive Behavioral Therapy) identified by the Kaufmann Best Practice Initiative, the Substance Abuse, Mental Health Services Administration, and the Centers of Excellence. A report on the progress on this recommendation should be provided to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

# Systems Changes to Strengthen Families and Prevent Child Maltreatment

**P**ublic and private agencies/programs that serve families and children can help prevent child maltreatment by strengthening parent/child relationships, enhancing parental knowledge and skills, and decreasing environmental stressors that increase risk of maltreatment. Chapter Three of this report describes the critical principles of a child maltreatment prevention system. These principles outline a coordinated and integrated system of agencies and programs that promote efforts to foster healthy parenting among all families (not only the at-risk families), and utilize a developmental framework for providing services. Such a system primarily focuses prevention efforts during the critical period of pregnancy and the early years of life, and then adds services as children grow older and the parent/child relationship evolves. While there are strong examples of communities in North Carolina that integrate these principles into their efforts, the services in most communities are “crisis” oriented, they are designed to help the most at risk families who need considerable services to become stable again. Aligning agency resources and efforts with the prevention principles outlined in this plan will help support families before they are in need of crisis services. This chapter outlines some opportunities within existing agencies and programs to align services toward prevention.

## Strengthening Families

### **Focus on Pregnancy and the Early Years of Childhood**

Pregnancy and the first years of life (birth to five years) are critical periods in creating healthy and nurturing parent/child relationships. An effective family strengthening system should begin during this developmental period because it offers an opportunity to ensure that every pregnant woman and new family has the support and resources needed to guide their children toward success in school and later in life. While state, county, and local organizations offer many services for parents and children during this time period, these services are not always well coordinated. The Early Childhood Comprehensive System Initiative (ECCS) is a new endeavor to align the different systems of support for children and families during pregnancy and early childhood.

The ECCS grant was a two-year (July 2003 - June 2005) planning grant from the Maternal and Child Health Bureau of the US Department of Health and Human Services that is now moving into its implementation phase. The main goal of

the project was to develop a plan for an integrated, comprehensive early childhood service system that supports school readiness. The goals and recommendations of the ECCS Initiative overlap and complement many of the goals and recommendations of the Task Force on Child Abuse Prevention. For example, the ECCS Initiative includes recommendations to establish medical homes for young children; foster young children's social-emotional development; enhance parent education and family support services for families with young children; and ensure quality early childhood education for all young children. Due to the complementary nature of the two initiatives, the Task Force on Child Abuse Prevention recommends:

**Rec. 8.1** The Child Maltreatment Prevention Leadership Team should work closely with the Early Childhood Comprehensive System Initiative in the development of an integrated and comprehensive early childhood system that promotes the health and well-being of young children from birth through age five. Specifically, stakeholders from both initiatives should identify common outcomes, common areas of focus, and integrate efforts whenever possible to maximize resources and prevent duplication. Leadership from both initiatives shall make a report back on their collaborative efforts to the full membership of the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

### **Home Visiting Services**

Home visiting programs play a central role in child maltreatment prevention service delivery systems. North Carolina has a number of home visiting programs that target an array of outcomes including improved maternal health, improved infant health, school readiness, improved family functioning, and child maltreatment prevention. While many of these programs share a coordinated approach at the local level, there needs to be a common statewide vision for a system of prenatal and early childhood home visitation programs that provides some level of services to every expectant family and new parent.

The Education Begins at Home Alliance is a recently established group of representatives from multiple home visiting programs that have begun working together in anticipation of federal funding for early childhood home visitation programs. The formation of this group provides an opportunity to develop a vision for universal home visiting services in North Carolina. To ensure better coordination and improve the effectiveness of home visiting programs, the Task Force on Child Abuse Prevention recommends:

**Rec. 8.2** The NC Division of Medical Assistance, the NC Division of Public Health's Women's and Children's Health Section, PCA North Carolina, and other appropriate partners should work with the Education Begins at Home Alliance to ensure there is a coordinated and effective system of prenatal and early childhood home visitation programs across North Carolina that are voluntary and that services appropriately match families' risks and needs. This collaborative effort should:

- A. Determine the most strategic ways to align existing home visitation services and programs including but not limited to Maternity Care Coordination, Child Service Coordination, Parents as Teachers, the Parent Aide Program, Healthy Families, the Nurse Family Partnership, and Early Head Start to promote the outcomes of child safety, healthy child development, secure parent-child relationships, and school-readiness.
- B. Assess the need for and potential benefits of a universal postpartum home visiting program in preventing maltreatment in North Carolina.

The NC Division of Medical Assistance, the NC Division of Public Health, and PCA North Carolina should report their progress in implementing this recommendation to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

Additionally, the Task Force on Child Abuse Prevention recognized that higher rates of child maltreatment, child abuse fatalities, and domestic violence in communities with military installations indicates a significant need for additional

support among these families. Efforts to strengthen the array of home visiting programs in North Carolina should also assess the benefits of expanding these programs in military communities.

### **Maternal and Child Health Services**

The NC Division of Public Health has a number of services that focus on maternal and child health promotion, many of which reduce risk factors associated with child maltreatment. The Maternity Care Coordination program promotes healthy pregnancies and positive birth outcomes with Medicaid eligible women during pregnancy and sixty days postpartum. The Child Service Coordination programs serve children birth through age three years who are at risk for or are diagnosed with developmental delay or disability, chronic illness, or social/emotional disorders through case management services. Both programs have significant potential to help prevent maltreatment by refining the assessment, training, and intervention processes to better encompass issues of parent-child interaction and attachment, and risk factors associated with maltreatment. For example, the Maternity Care Coordination Program has refined its screening, assessment, and intervention protocols (pathways) to enhance pregnancy outcomes. The NC Division of Public Health could build on these tools to strengthen child maltreatment prevention efforts by including additional risk factors during screening, such as violence within home of origin, and using specific tools to assess attachment and bonding. Enhancement of interventions within these programs will require review of Medicaid funding for these programs. To support the continuation and expansion of such work, the Task Force on Child Abuse Prevention recommends:

- Rec. 8.3** The NC Division of Public Health and the NC Division of Medical Assistance should request that child maltreatment prevention be included as a major goal for the Maternity Care Coordination and Child Service Coordination programs. Furthermore, these programs should be strengthened with regard to child maltreatment prevention by:
- A. Developing and implementing standardized intervention models for identified risk factors such as the Maternity Care Coordination Pathways process that is currently being piloted.
  - B. Requiring that Maternity Care Coordination and Child Service Coordination workers have regularly scheduled training in identifying risk factors and implementing appropriate interventions or referral processes.

The NC Division of Public Health and the NC Division of Medical Assistance shall report their progress in implementing this recommendation to the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

### **Early Intervention Services**

North Carolina's comprehensive, interagency Early Intervention System, Together We Grow, serves children birth through five years, who are identified as having or being at-risk for developmental issues. The Early Intervention System includes two components: Part C of the Federal Individuals with Disabilities Education Act (IDEA) that serves children birth to age three years, and Part B of IDEA that serves children ages three through five years. Part C is administered through the NC Division of Public Health and Part B is administered through the NC Department of Public Instruction. These two programs provide children with services that promote and stimulate their development, including occupational, physical, and speech therapy. They also provide parents with information, skills, and support to help their children achieve their full developmental potential.

Children who experience maltreatment are at a significantly higher risk for developing problems such as speech impairments, cognitive delays, and social/emotional difficulties. The same is true for children who live in high-risk households characterized by instability, violence, or neglectful parenting practices. The services provided through the Early Intervention System not only help children overcome the effects of maltreatment so that they may succeed later in life, but they also help prevent maltreatment by engaging parents in supporting their children's cognitive, emotional, and social development.

North Carolina has a broad definition of children birth through age three years who are eligible for early intervention services. Currently, the system serves not only children who are demonstrating developmental delays but also those who are at-risk of developing such issues. This is extremely important from a child maltreatment prevention perspective. Such broad definitions of eligibility provide the Early Intervention System with the ability to provide risk-reduction services for children and families at high-risk for maltreatment even if the child does not yet demonstrate developmental delays. However, the system's capacity to actually provide these prevention services is significantly limited. Currently, the Early Intervention System is experiencing an influx of children from the child welfare system. New federal requirements, part of the reauthorization of the Child Abuse Prevention and Treatment Act, require that the NC Division of Social Services refer every young child age birth to three years who has been substantiated for child maltreatment to the Early Intervention System. The resulting influx of new children is significantly taxing the system. Without additional resources, the system will be unable to adequately serve all the children and families who are in need of services and there is concern among prevention practitioners that narrowing the eligibility criteria may be considered as a way to contain program costs.

Maintaining the current eligibility criteria for at-risk children and providing additional prevention training to better serve families at risk for maltreatment are critical strategies to ensure that child maltreatment prevention is adequately addressed in the Early Intervention System. In addition, strengthening the connections between the Children's Developmental Services Agencies and local Family Support Network programs can also serve as a strategy to decrease families' risk for maltreatment. The Task Force on Child Abuse Prevention recommends:

**Rec. 8.4** The NC Division of Public Health and the NC Division of Medical Assistance should support the Children's Developmental Services Agencies to serve families who are maltreating or who are at high risk of maltreating their children by:

- A. Ensuring that Children's Developmental Services Agencies continue to serve at-risk children birth to three years of age.
- B. Providing additional funding, training, and support to the Early Intervention System to ensure that families in the child abuse high risk category, and families who enter the Early Intervention System through Child Protective Services can receive timely and appropriate services.
- C. Exploring the possibility of broadening the community-based rehabilitative services definition to include work with caregivers around safety and health issues.
- D. Providing additional training to community-based rehabilitative service providers and early intervention coordinators in healthy parent/child interaction and attachment.
- E. Strengthening connections between Family Support Network Programs and Children's Developmental Services Agencies.

The NC Division of Medical Assistance and the NC Division of Public Health should report on the progress of this recommendation to the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

### **Primary Healthcare Providers**

Primary healthcare providers have a strong role to play in the primary prevention of child maltreatment. There is a growing recognition in the medical field that child maltreatment significantly contributes to health and mental health problems including chronic illness, addiction, and social/emotional disorders, both in childhood and later in adulthood. In addition, preventing maltreatment is as important to a child's health and development as preventing diabetes or other illnesses.<sup>138</sup> Additionally, primary healthcare providers are in an excellent position to offer parents support and guidance on child development and behavioral issues because most parents view their child's pediatrician or family practice physician as a reliable resource for information, support, and guidance about child development. There are currently two efforts underway that can better utilize primary healthcare providers in the effort to help reduce child maltreatment: North Carolina's Medical Home Initiative and the Assuring Better Child Health and Development Project.

All children should have a medical home with a primary healthcare provider. A medical home ensures that a child receives accessible, family centered, comprehensive, continuous, coordinated, compassionate, and culturally competent healthcare services. The concept of a primary healthcare medical home is based on recognized standards of child and adolescent healthcare and documented in policies and best practice guidelines by professional organizations such as the American Academy of Pediatrics and the American Academy of Family Physicians. The NC Pediatric Society, the NC Academy of Family Physicians, and the NC Department of Public Health's Women's and Children's Health Section are currently promoting this concept across the state. By providing such care to families who are experiencing multiple stressors, including child health and behavioral issues, primary healthcare providers can help decrease risk for maltreatment and offer supportive guidance to strengthen parents' interactions with their children. The medical home concept is being implemented by the Medicaid program through the Community Care of North Carolina Program (CCNC). CCNC, or its precursor, Carolina Access, covers 90% of children on Medicaid, and reaches a large group of children at higher risk for maltreatment. CCNC is a primary healthcare case management program for Medicaid recipients. Its early iteration, called Carolina Access, helped link Medicaid recipients (including children) to primary healthcare providers, to establish a medical home. The expanded program, CCNC, builds on this medical home concept. CCNC also provides care management and disease management to children and adults with certain complex or chronic health problems. Carolina Access already operates statewide. CCNC is expected to be statewide by December 2005.

The second healthcare initiative pertinent to child maltreatment prevention is the Assuring Better Child Health and Development (ABCD) Project. Spearheaded through the CCNC program, the ABCD Project is a comprehensive and coordinated system to improve the delivery and financing of child developmental services. In this program, community health providers administer validated screening tools at well child visits to identify those children who are experiencing developmental problems. Through collaboration with community partners and the family, the provider refers children to appropriate early intervention services. The project began with Medicaid eligible children in several pilot counties, and is going statewide in July 2005.

The ABCD project has significant potential to prevent the maltreatment of children. By identifying those children who are experiencing developmental delays or who are at risk of developing problems, primary healthcare providers can link families to needed community resources, provide social support, and help parents promote their children's developmental potential. All of these activities help decrease a family's risk for maltreatment. Primary healthcare practices that participate in the ABCD Project develop a network of community services and referrals for their pediatric patients and their families. They have the potential to serve as a critical resource for parents who need additional support and references.

**Rec. 8.5 The NC Division of Medical Assistance, the NC Office of Research, Demonstrations, and Rural Health Development, and the NC Division of Public Health should work together to explore ways to enhance the role of primary healthcare providers in child maltreatment prevention. Specifically:**

- A. The Task Force on Child Abuse Prevention supports the efforts of the NC Division of Medical Assistance to expand Community Care of North Carolina to ensure all children on Medicaid have access to medical homes, and the efforts of the NC Division of Public Health to promote public awareness efforts to educate families about the importance of establishing a medical home for all children.**
- B. The NC Division of Medical Assistance should support the Assuring Better Child Development Project to enhance the capacity of primary healthcare providers to reduce child maltreatment by:**
  - i. Adopting child maltreatment prevention as a major goal of the program.**
  - ii. Exploring ways in which it can further support community networks of prevention, early intervention, and family support services that help prevent developmental delays and child maltreatment.**



The NC Division of Medical Assistance, the NC Office of Research, Demonstrations, and Rural Health Development, and the NC Division of Public Health should report on their progress in implementing this recommendation to the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

### **Early Childhood Mental Health Services and Practices**

Helping parents and families promote the social and emotional development of their children is an important child maltreatment prevention strategy. Children's healthy social and emotional development is a result of a complex interplay of children's genetic traits and the environment in which they grow. Through responsive and nurturing caregiving, parents and families can help promote children's social and emotional well-being, providing them with a critical foundation for success in school and life.<sup>139</sup> Universal prevention strategies to promote social/emotional well-being assist all parents in providing responsive care for their children. For example, universal prevention efforts help parents understand the normal range of social and emotional child development, identify and respond to their child's emotional cues, and appropriately address the typical challenges that arise during various stages of childhood development. More intensive universal prevention strategies address specific risks and challenges within the parent-child relationship, help parents support a child with developmental and/or mental health issues, or help parents address their own mental health issues that are impeding their ability to form strong relationships with their children.

Policy makers at state and national levels are increasingly recognizing the importance of children's social and emotional well-being to school readiness and success, development of appropriate peer relationships, and the ability to function effectively later in life. Florida, Indiana, Ohio, Illinois, and Vermont are all engaged in innovative approaches to enhance and finance early childhood mental health services including the development of state strategic plans, creation of a statewide grant program to promote early childhood mental health consultation, and initiatives to blend and maximize funding streams.<sup>140</sup> North Carolina developed a child mental health plan in July of 2002 (and amended it in 2003) as a part of the mental health system reform. The plan recognizes that family supports are needed to promote child and family mental health. Some of these supports are currently available through state and regional agencies (including the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the NC Division of Public Health, the NC Partnership for Children, the NC Interagency Coordinating Council, the NC Department of Public Instruction) and community-based organizations. However, there is a need for additional resources and workforce development to ensure the statewide availability of evidence-based and promising practices that promote children's social and emotional well-being. This need has been identified in several previous initiatives including the NC Institute of Medicine Comprehensive Child Health Plan (2000) and is reinforced in North Carolina's Child Mental Health Plan. The Task Force on Child Abuse Prevention recommends:

**Rec. 8.6** The Child Maltreatment Prevention Leadership Team and the Early Childhood Comprehensive System Initiative should work together to identify the needs of families and other caregivers in promoting young children's social-emotional health, develop effective strategies to meet these needs, and enhance the capacity of the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, as well as other provider systems (e.g., Early Intervention, Public Schools, Head Start, private practitioners) in coordinating and delivering services to those caregivers and children. The NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and all other agencies working with the Early Childhood Comprehensive System Initiative shall report on their progress in implementing this recommendation to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

### **Early Childhood Education**

There are a number of emerging efforts that build on early childhood education as a means to prevent child maltreatment.

For example, the Strengthening Families Initiative of the Center for the Study of Social Policy,<sup>141</sup> is a national effort funded by the Doris Duke Foundation to increase the capacity of early childhood education centers to prevent maltreatment by developing partnerships with parents, implementing family support activities, providing tangible services to families in times of crisis, and promoting the involvement of fathers with their children. Other early childhood programs, such as Early Head Start, are also examining their effectiveness in promoting parental competence and involvement, improving parent/child interaction, and increasing positive parenting skills with a goal of reducing child maltreatment.

In North Carolina, approximately 28% of young children are in some form of regulated childcare.<sup>142</sup> Early childhood educators who interact with the parents of these young children have the opportunity to provide information on child development and community resources, teach skills to manage child behavior, and provide emotional support by introducing parents to one another. Early childhood education centers that embrace family support principles recognize that promoting children's cognitive and social/emotional development means reaching out to parents and families and working with them to focus on fulfilling each child's developmental potential. In doing so, early childhood educators can help reduce the risk of child maltreatment in the families of children they teach.

Increasing provider skills in working collaboratively with parents to support healthy parenting and healthy child development is a critical first step for North Carolina's early childhood education system in preventing child maltreatment. The Task Force on Child Abuse Prevention recommends:

**Rec. 8.7** The NC Division of Child Development, the NC Department of Public Instruction, the Office of School Readiness in the Office of the Governor, and the NC Partnership for Children should work with the Early Childhood Professional Development Institute to develop a plan for increasing the training of childcare providers to better understand and to assist parents in understanding stages of child development and age appropriate child behavior, and to promote infant/child mental health and social/emotional development. The NC Division of Child Development, the NC Department of Public Instruction, and the NC Partnership for Children should report on their progress in implementing this recommendation to the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

## Build Services Developmentally According to Family Need

A key assumption of the prevention principles outlined in this Task Force on Child Abuse Prevention Plan is that all parents need support in raising their children. Parents will continue to need help after pregnancy and the early years of childhood, as children get older and families face new developmental challenges through adolescence and early adulthood. Consequently, other support services for families with children of all ages should be available through public and community-based agencies. The Task Force on Child Abuse Prevention identified the following services as critical components in our child maltreatment prevention system.

### Parent Support Services

Parent support services are those supports and activities that assist parents in learning new skills, managing stress, obtaining social and emotional support, and finding resources to help them overcome certain parenting challenges or environmental stressors. Parent support services is a broad term that encompasses many activities including parent education, parent training, respite care, and social support/mutual support groups.

Multiple state agencies, non-profits, faith communities, and informal resources provide parent support services in North Carolina. For example, the NC Cooperative Extension, Exchange SCAN (Stop Child Abuse Now) Family Centers, Partnerships for Children, family service agencies, and family resource centers are just a few of the organizations that offer

parent education and parent training classes. PCA North Carolina is currently working with a growing network of fourteen Circle of Parents sites. The Family Support Network has fifteen Parent to Parent programs and five developing ones, which cover all 100 counties in North Carolina. This program helps link new parents of children who have special needs with veteran parents who have been through similar experiences and provides workshops, information, and education for family members. Respite care funding is provided to local communities by the NC Division of Social Services and the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. Many of these parent support programs are low-cost and relatively easy to implement at the community level. They build on family strengths and promote parental involvement and leadership. These programs can also be easily incorporated into existing interventions, such as intensive home visitation programs, to focus specifically on social support and parental stress risk factors. Increasing the availability of such programs in all North Carolina communities is a key step in ensuring that parents have supports available at the community level to help them address the challenges of child rearing. The Task Force on Child Abuse Prevention recommends:

**Rec. 8.8** PCA North Carolina should work with family support agencies, such as the Family Support Network and the NC Cooperative Extension, to increase the availability of respite care, parent support groups, including the Circle of Parents or Parents Anonymous, and parent support strategies such as Parent to Parent, and to ensure that families in need of support are able to access services within their communities. PCA North Carolina should report on their progress in implementing this recommendation to the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

The NC Department of Health and Human Services offers multiple programs to serve vulnerable families with children, such as:

- > Work First Program - To help families achieve economic self-sufficiency.
- > Child Protection Services - To ensure that children are safe.
- > Early Intervention Services - To ensure that children with or at risk of developmental delays receive appropriate services to reach their full potential.
- > Adolescent Parenting Programs - To help adolescent parents delay second pregnancies and finish school.
- > Mental Health Services - To help families who have members suffering from mental illness or addictions.

Although these programs have diverse goals and objectives, each serves families who are facing significant stressors and are at some risk of maltreating their children. Some programs, such as Adolescent Parenting Programs, may utilize elements of a research-based parenting approach. However, there is no systematic integration of evidence-based or research-based strategies for parent enhancement across all NC Department of Health and Human Services programs. Systematically integrating parenting activities focused on enhancing parenting knowledge and skills, strengthening the parent/child attachment, and increasing parental social support could significantly reduce the stressors that increase parents' risks of maltreating their children. The Task Force on Child Abuse Prevention recommends:

**Rec. 8.9** The NC Department of Health and Human Services should ensure that a research-based strengthening parenting component is included across departmental programs that serve families, to include culturally appropriate programmatic strategies that will support and strengthen parent-child relationships, especially during pregnancy and the first two years of the child's life. These parenting components should include, but not be limited to skills designed to enhance parent-child communication, problem-solving skills, positive discipline behaviors, and social support. The NC Department of Health and Human Services should report progress on this recommendation to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

## Services Through Public Schools

Public schools serve many children who are living in difficult, and sometimes unsafe, home environments. What these children experience outside of school - domestic violence, substance abusing caretakers, and abusive or neglectful parenting - often impairs their ability to perform in school, to develop appropriate social relationships, and to master skills such as impulse control and emotional regulation. Assisting these children and their families in developing a supportive, nurturing, and stable home environment is as critical to these children's academic success as is learning the core curricula in language, math, and science.

While many public school systems recognize the importance of assisting children and families with family life issues, the resources needed to adequately address them are limited. Professionals providing services in North Carolina schools include school health nurses, school social workers, and school counselors.

School nurses identify and respond to untreated illnesses, ensure that children have access to acquired immunizations, provide case management for children with special health problems, and help families access community resources to ensure healthy child development. While North Carolina is working toward a statewide school nurse to student ratio of 1:750, there are many school systems that do not yet meet that standard.

School social workers also offer support services to students and their families by assessing student/family needs, linking families with community resources, promoting home/school communication, assisting teachers in addressing student needs, and providing crisis intervention. Currently, North Carolina has a statewide school social worker to student ratio of 1:2500, but a number of counties still have no social workers in their school systems. Advocates are seeking a 1:800 ratio in every county so that school social workers have enough time and resources to adequately address child and family issues that contribute to poor school performance, high drop-out rates, and school violence.

School counselors also provide many direct services that help children in need, including individual and group counseling, educational planning, and career/vocational development. National standards call for a school counselor to student ratio of 1:250, but North Carolina only requires a ratio of 1:400. There is growing concern that counselors are spending less time addressing child and family needs because of increased responsibilities related to testing. While each of these professionals has a role to play in preventing maltreatment and strengthening families, there are significant resource challenges that prevent them from fully addressing the wide range of child and family needs.

In addition to the traditional roles played by the professionals above, Governor Easley has proposed the development of School-Based Child and Family Support Teams that would include social worker/nurse teams to assess, refer, and coordinate the care of students who may be experiencing issues at home, such as substance abuse, domestic violence, or depression. Additionally, children who may be suffering from mental health issues or emotional/behavioral problems could benefit from this new school-based support system. These teams would coordinate mental health services with Care Coordinators at Local Management Entities and Child and Family Team Facilitators in county departments of social services. These professionals would ensure that children are provided with effective treatment services.

There are also multiple opportunities to enhance child maltreatment prevention strategies through the NC Department of Public Instruction within Title I, Pre-K, and Exceptional Children's Services programs. Each of these programs addresses target populations for child maltreatment prevention. The Task Force on Child Abuse Prevention recommends:

**Rec. 8.10** The North Carolina State Board of Education and the NC Department of Public Instruction should identify strategies to increase support for children at risk of maltreatment and their families to ensure that the children are able to fulfill their academic potential in traditional schools, alternative schools, or other educational settings. This includes, but is not limited to:

- A. Expanding the availability of school health nurses, Child and Family Support Teams, school counselors, and school social workers.
- B. Ensuring that school counselors and school social workers have adequate resources and time, based on national professional standards, within their positions to provide needed services for high-risk children and their families.
- C. Identifying and encouraging schools to offer or link to evidence-based and promising child abuse prevention and family strengthening programs.
- D. Ensuring that the Title I, Pre-K, and Exceptional Children's Services programs work with the Child Maltreatment Prevention Leadership Team and PCA North Carolina to strengthen their capacity to prevent child maltreatment.

The NC Department of Public Instruction should report on its progress in implementing these recommendations to the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

### **Services Through Social Service Providers**

Social service agencies have traditionally provided a safety net for children and families who have exhausted their own resources and are in crisis. Their engagement in universal and selective maltreatment prevention efforts has historically been limited by legislative mandate and funding issues. Nevertheless, two programs offer opportunities to focus more on the primary prevention of maltreatment - the Multiple Response System and the Work First program.

The Multiple Response System is an effort to make child welfare services in North Carolina more family-centered, consistent, and effective through implementation of seven key strategies:

- > A structured intake process that focuses on family strengths.
- > A differential response to reports of child maltreatment that includes both a traditional investigative assessment for child physical and sexual abuse and a strengths-based family assessment for neglect.
- > Coordination between law enforcement agencies and child protective services for the investigative assessment approach.
- > Redesign of in-home family services.
- > Child and family team meetings to promote family and shared community responsibility for helping families.
- > Shared parenting meetings between biological parents and foster parents.
- > Collaboration between Work First and child welfare programs to ensure that family well-being encompasses both family economic self-sufficiency and child safety in a coordinated approach.

The Multiple Response System offers an opportunity to expand prevention efforts within the Child Protection System. In particular, the differential response allows social workers to use a family-centered approach building on family strengths to ensure child health and safety when families come to the attention of child protective services. This is a departure from the traditional "investigative" approach that tends to place the social worker and parent in an antagonistic relationship by focusing more on substantiating whether an incident actually happened than on building parent and family strengths to protect the child. Social services' move toward a family-centered approach is a welcome change that will encourage families and communities to see local departments of social services as a source of support for families in need rather than an agency that removes children and places them in foster care. The Multiple Response System now operates in fifty-two counties and the NC General Assembly is currently considering expansion of the system statewide.

Another program that holds opportunity for child maltreatment prevention is North Carolina's Temporary Assistance for Needy Families or Work First program. Through Work First, parents can receive short-term training and other services to assist them in finding employment with the goal of becoming self-sufficient. Between 30% and 40% of parents/caretakers in the Work First population have had a report for child maltreatment either before or after they entered the program.<sup>143</sup> That makes them a logical target population for prevention efforts. Engaging Work First families in job training,

employment counseling, GED programs, and other services to help them stabilize and strengthen their families financially, will help reduce their risk factors for child maltreatment. It also makes sense to engage this population in parent education, parent training, and other risk-reduction activities such as substance abuse treatment and social support programs. Further exploration of this issue is warranted and the Task Force on Child Abuse Prevention recommends:

**Rec. 8.11** The NC Division of Social Services, the NC Association of County Directors of Social Services, and the Children's Services Advisory Committee should explore ways to strengthen universal and selective child maltreatment prevention efforts by:

- A. Expanding prevention services through the Multiple Response System for all children;
- B. Developing family strengthening and child maltreatment prevention strategies for the Work First population.

The NC Division of Social Services should report on their progress on this recommendation to the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

## Reducing Risk Factors Including Unwanted or Closely Spaced Pregnancies, Substance Abuse, Depression, and Domestic Violence

A number of family and environmental stressors increase a family's risk for child maltreatment. To reduce risk factors associated with child maltreatment, the Task Force on Child Abuse Prevention recommends a specific statewide focus on the following issues.

### **Unwanted or Closely Spaced Pregnancies**

Research indicates that unwanted and/or closely spaced pregnancies increase a family's risk for child maltreatment.<sup>144</sup> Families who have either unwanted children or multiple children within a short time frame are more likely to lack the emotional and financial resources and support needed to provide nurturing, responsive care for infants and toddlers. In North Carolina, research indicates about 45% of all pregnancies that resulted in births were unplanned (1997-2000).<sup>145</sup>

Family planning services play an important role in helping families reduce unwanted pregnancies and plan appropriately spaced pregnancies. Family planning services include well woman check-ups, preconception counseling, access to low cost contraceptive services, and screening and identification of medical conditions, such as sexually transmittable infections. Ideally, all persons who need family planning services - adults and adolescents, women and men - would be able to access and receive appropriate family planning services. In North Carolina, the NC Division of Public Health and local health departments offer family planning services to low-income persons through the Medicaid program. Currently, Medicaid pays for family planning services for pregnant women with incomes up to 185% of the federal poverty guidelines for 60 days postpartum, and to other low-income adults with dependent children who have incomes up to approximately 40% of the federal poverty guidelines. States must obtain waivers to continue Medicaid coverage of family planning services for women who would otherwise lose Medicaid coverage postpartum, and/or to other adults (men or women) with incomes too high to normally qualify for Medicaid. North Carolina's Medicaid waiver allows health departments to provide family planning services to adults (men and women) up to 185% of the poverty level, including to women who exceeded their 60-day postpartum Medicaid coverage. A national evaluation of Medicaid family planning waiver programs demonstrated that these programs are cost-effective resulting in often substantial net savings of public dollars, increased access to services, and in some states, measurably reduced pregnancy rates among the total population of women eligible for services.<sup>146</sup> By reducing unwanted pregnancies and helping families better plan for pregnancy and birth, North Carolina's family planning waiver can help reduce risk factors for child maltreatment.

The Task Force on Child Abuse Prevention not only supports the federal Medicaid family planning waiver, but it recommends pursuing a more rapid rollout of the waiver so that more families can be served. Pursuing a more rapid rollout will save the state money over the long-term, but would require additional resources in the short-term. The Task Force on

Child Abuse Prevention recommends:

**Rec. 8.12** The NC Division of Public Health and the NC Division of Medical Assistance should pursue a more rapid roll-out of the federal Medicaid family planning waiver. The NC Division of Public Health shall report progress on implementing this recommendation to the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

### **Preventing Adolescent Pregnancy**

Preventing pregnancies within the adolescent population is an important child maltreatment prevention strategy. Adolescent parents often lack the emotional maturity, psychological resources, family support, and financial stability to provide a safe, nurturing, and responsive environment for their children. All adolescents should be taught in the public school system how to prevent unwanted pregnancies. Education programs used should be accurate, and evidence-based. Adolescents who are at higher risk for becoming pregnant should also have access to teen pregnancy prevention programs.

In North Carolina, a 2003 Youth Risk Behavior Survey revealed that 52.3% of high school students and 73.5% of seniors had experienced sexual intercourse and 10% of the state's high school students had sex before the age of thirteen.<sup>147</sup> Despite a decline in the state's teen pregnancy rate of more than 39% since 1990, North Carolina still has the fourteenth highest teen pregnancy rate for fifteen to nineteen year olds in the nation. Minority adolescents continue to be at higher risk for unintended pregnancies than non-minority students are.

The North Carolina Healthful Living Standard Course of Study has sexuality education objectives for the seventh and eighth grade and high school that focused on abstinence before marriage. There is significant concern among healthcare providers, public health experts, and adolescent pregnancy prevention practitioners that these objectives are not providing students with the medically accurate information they need to protect themselves from unwanted pregnancies and sexually transmitted diseases.<sup>148</sup> The current curriculum also contradicts the preferences of the majority of North Carolina parents. According to the 2003 North Carolina Parent Opinion Survey, 90.5% of all parents surveyed thought sexuality education should be taught in North Carolina public schools. The vast majority of parents believe time should be devoted to sexuality topics such as how to talk with a girlfriend, boyfriend, or partner about birth control and sexually transmitted diseases; how to use birth control or condoms; and sexual behaviors and risks.<sup>149</sup>

In addition to receiving accurate and research-based sex education information in schools, adolescents who are at higher risk for pregnancy should have the opportunity to participate in adolescent pregnancy prevention programs. Research has shown that the most effective programs are comprehensive ones that include a focus on delaying sexual behavior and providing information on how sexually active young people can protect themselves. North Carolina currently provides \$2.3 million in funding for adolescent pregnancy prevention programs across the state through the NC Department of Public Instruction's Teen Pregnancy Initiative which provides funding to local community programs. Programs are carried out through local public health departments and focus on reproductive responsibility, as well as academics, sports, arts, recreation, and cultural/civic education. Programs are strongly encouraged to use models that have been scientifically evaluated and shown to be effective. Due to limited funding, these adolescent pregnancy prevention programs serve only a portion of the adolescents who are in need of services. Additional resources are needed to ensure that all adolescents who are at high risk of having unwanted pregnancies are able to participate in a pregnancy prevention program. To ensure that these programs are readily available, the Task Force on Child Abuse Prevention recommends:

**Rec. 8.13** The NC General Assembly should:

- A.** Appropriate additional, stable funding to the NC Division of Public Health to expand the Teen Pregnancy Prevention Initiative with particular attention to minority populations, which continue to have higher rates of teen pregnancies than non-minorities.

- B. **Revise G.S. 115C-81 (e3-8) to ensure that students are receiving medically accurate information and that schools are using evidence-based approaches to prevent unwanted pregnancies and the transmission of STD/HIV.**

**The NC Division of Public Health and the NC Department of Public Instruction shall report the status of these recommendations to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.**

For those adolescents who do have children, a second child only further increases their risk for maltreatment. Delaying second pregnancies with adolescent parents is another priority strategy for preventing maltreatment in this population. Currently there are thirty-two Adolescent Parenting Programs in North Carolina that focus on helping adolescent parents delay second pregnancies, learn appropriate parenting techniques, and complete their education. These programs serve only a portion of the total adolescent parent population. Given the level of risk for maltreatment associated with adolescent parents, and given the effectiveness of interventions with this population, North Carolina should consider this population a priority to target for prevention services. The Task Force on Child Abuse Prevention recommends:

**Rec. 8.14 The NC Division of Public Health should assess the potential costs and benefits to the state of providing some level of service to all pregnant adolescents and adolescent parents by reviewing evaluation data from programs serving these populations across the country. The NC Division of Public Health shall report progress on implementing this recommendation to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.**

### **Substance Abuse**

Parental substance abuse is strongly associated with child maltreatment. Children whose parents abuse drugs and alcohol are almost three times as likely to be physically or sexually assaulted and more than four times more likely to be neglected than children of parents who are not substance abusers.<sup>150</sup> National studies have found that substance abuse is a factor in one-third to two-thirds of all child maltreatment reports and in 90% of reports for families whose children are in foster care.<sup>151</sup> Anecdotal evidence from North Carolina child protection agencies point to substance abuse as one of the top reasons children are reported for maltreatment.

A 1995 RTI Household Survey revealed that 7.2% of the North Carolina population uses illicit drugs.<sup>152</sup> A 1999 national survey found that 16.6% of all North Carolinians (age twelve and older) indulged in binge drinking during the thirty days prior to the survey.<sup>153</sup> Additionally, North Carolina had the sixth highest reported percentage of illicit drug use in the twenty-six or older age group in the country and the state had one of the highest percentages of reported illicit drug use in the eighteen to twenty-five age group.<sup>154</sup>

Given the high risk for maltreatment among parents who are abusing alcohol or drugs, parents who need substance abuse treatment should be able to access effective, affordable treatment options. Under the state's new mental health plan, pregnant women, women with children, and parents who are involved with the NC Division of Social Services are included in the state's target population for state-funded mental health services. Three state programs that address part of the need for substance abuse treatment services for parents at-risk for child maltreatment include the Child Protection/Work First Substance Abuse Initiative; CASAWORKS; and the Perinatal and Maternal Substance Abuse Treatment Initiative.

- > The Child Protection/Work First Substance Abuse Initiative seeks to identify families served by Work First and Child Protective Services with substance abuse problems. This program provides screening, assessment, and case management services to support recovery and improved parenting.



- > The CASAWORKS for Residential Families Initiative targets Work First mothers with substance abuse or dependency diagnoses who have a child younger than eleven years of age. This nationally replicated family residential collaborative program between Work First, Child Protective Services, and the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services is a twelve month apartment-based substance abuse program followed with six months of aftercare. Components include case management, counseling for employability and sobriety, parenting skills, childcare, job development, job retention and support, and child mental health intervention.
- > Finally, the Perinatal and Maternal Substance Abuse Treatment Initiative targets substance abusing pregnant women and mothers and their children by providing gender specific substance abuse services that include, but are not limited to, screening, assessment, case management, out-patient services, parenting skills, residential care, referrals for primary and preventive healthcare, and referrals for appropriate interventions for the children.

Despite the existence of the programs above, there is still a significant need in the state for substance abuse treatment services for all adults and adolescents with addiction problems. The 1995 RTI Household Survey found that 6% of North Carolina adults were in need of comprehensive substance abuse treatment, yet of that group, only 10% had a history of receiving substance abuse treatment.<sup>155</sup> Given the high risk of maltreatment for pregnant women and parents who are abusing alcohol or drugs, effective treatment services should be a priority for this population. The Task Force on Child Abuse Prevention recommends:

**Rec. 8.15** The Child Maltreatment Prevention Leadership Team should work with the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and other non-profit substance abuse treatment organizations to increase the number of substance abuse treatment programs, with a particular focus on gender specific programs for pregnant women and women with children, and increase outreach to identify women in need of these services. The NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall report progress on implementing this recommendation to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

### **Postpartum and Maternal Depression**

Numerous research studies have found that serious depression and postpartum depression are strongly associated with maltreating behavior in mothers.<sup>156</sup> For example, one study found 60% of neglectful mothers have clinically significant depression as opposed to only 33% in the comparison group.<sup>157</sup> Depressed mothers are more likely than non-depressed mothers to be unable to provide adequate developmental stimulation for their children. Postpartum and maternal depression can also adversely affect a woman's ability to provide affectionate, consistent, and safe care for her child. For many women who seek regular healthcare, depression goes undiagnosed and untreated. Screening and treatment for depression is available and effective. Early identification and treatment are essential to improving outcomes for women and their children.

Currently in North Carolina, there is little information about the prevalence of maternal depression. Multiple providers including private obstetricians/gynecologists, public health clinics, family practitioners, and midwives all have opportunities to identify and refer women for treatment and support. For example, some health departments - specifically those that participate in the Baby Love Plus program that focuses on infant mortality reduction - regularly screen for depression, but this protocol is not required statewide. Ideally, all mothers would be screened for depression using a validated screening instrument at routine prenatal and postpartum exams. Once identified, women should be able to access services and supports to treat the depression. However, there are currently challenges in helping women access services for their depression. These challenges include lack of insurance coverage for mental health benefits, inability to access enhanced public mental health benefits due to not meeting medical necessity guidelines, lack of respite care and other family

supports, and stigma attached to seeking mental health services.

Although it is generally recognized that maternal depression affects child developmental outcomes and is a high risk factor for child maltreatment, there is little information about its prevalence among North Carolina mothers or about the treatment services that they need and are receiving. Developing a more thorough and in-depth understanding of maternal depression in North Carolina and of the service system available for treatment will help target services to more effectively treat this population and lower the risks of child maltreatment. The Task Force on Child Abuse Prevention recommends:

**Rec. 8.16** The NC Division of Public Health should work with the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the NC Division of Social Services, the NC Division of Medical Assistance, professional associations including the NC Pediatric Society, the NC Academy of Family Physicians, and the NC College of Obstetricians/Gynecologists, Area Health Education Centers program, and appropriate health professional training schools to jointly develop a strategy to assess the prevalence of maternal and postpartum depression for North Carolina women and examine the issues regarding screening, access to, and availability of services for this condition. The NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the NC Division of Social Services should report on their progress in implementing this recommendation to the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

### **Domestic Violence**

Research has now demonstrated that domestic violence is a significant risk factor for child maltreatment. In 30% to 60% of cases where one form of violence is present, the other is present as well.<sup>158</sup> In the past few years, North Carolina has made considerable progress in developing a more systematic, coordinated, and effective response to incidents of domestic violence, particularly when children are involved. A 2002 statewide Task Force on Child Well-Being and Domestic Violence produced a number of recommendations that were focused on improving the response of social services, law enforcement, the court system, and domestic violence agencies for victims and their children. Many of these recommendations have been implemented. For example, the NC Division of Social Services adopted a comprehensive policy on domestic violence for Child Protective Services in October 2004 and completed the training on that policy for all 100 counties on June 30, 2005. In addition, the NC General Assembly enacted new legislation criminalizing assault on an intimate partner in the presence of a minor and the state adopted the North Carolina Violent Death Reporting System, which will provide meaningful information regarding a myriad of factors present when adults or children die violent deaths in North Carolina.

The Task Force on Child Abuse Prevention recognizes the work of the Domestic Violence/Child Well-Being Task Force as critically important and supports the continued implementation of its recommendations. However, it recognizes that the majority of these recommendations were not primarily focused on preventing family violence from occurring in the first place. Developing a research-based public health approach to the prevention of family violence is the state's next challenge. There are numerous efforts occurring both nationally and in North Carolina that are beginning to lay the foundation for such an effort. For example, the Centers for Disease Control has funded pilot prevention programs coordinated by domestic violence coalitions in fourteen states, including North Carolina. The Domestic Violence Prevention Enhancement and Leadership Through Alliances project funds three community-based projects in North Carolina - in Chatham County, Elizabeth City, and Wilmington - to pilot strategies for preventing domestic violence. Additionally, the Centers for Disease Control has funded a new \$3.68 million training program at the Injury Prevention Research Center at UNC-Chapel Hill. The PREVENT program brings together professionals who deal with various forms of violence - including domestic violence, child maltreatment, and juvenile violence - to learn about, implement, and share strategies for violence prevention. Given these resources, as well as other burgeoning grassroots efforts to prevent violence, North Carolina is poised to take the next step in preventing domestic violence. The Task Force on Child Abuse Prevention recommends:

**Rec. 8.17** The Child Maltreatment Prevention Leadership Team should work with the NC Coalition Against Domestic Violence and other domestic violence advocates, PCA North Carolina, the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and the NC Division of Public Health's Injury and Violence Prevention Branch to identify and pilot evidence-based or primary prevention strategies for domestic violence and child maltreatment. The Child Maltreatment Prevention Leadership Team should report on its progress in implementing this recommendation by January 2006 and annually thereafter.

### **Children with Disabilities**

Research indicates that children with disabilities are at increased risk for child maltreatment. One study found that children with disabilities were 3.4 times more likely to be maltreated and 3.8 times more likely to be physically abused than children without disabilities.<sup>159</sup> These children place additional caretaking demands and stressors on their parents who may lack the social support, parenting skills, or resources to cope effectively. Additionally, children who have communication disorders (deaf, hard of hearing, etc.) are at increased risk of being abused.<sup>160</sup>

In North Carolina, the Office of Education Services serves as the central office for schools and programs in the state that serve the blind/visually impaired, deaf/hard of hearing, and deaf-blind. These include the Governor Morehead School and Preschool for the Blind, North Carolina School for the Deaf, Early Intervention Programs for Children who are Deaf or Hard of Hearing, and Resource Support Program for the Deaf and Hard of Hearing. The mission of the Office of Education Services is to provide quality, comprehensive developmental and educational opportunities for eligible students ages birth to 21 years and their families so that students can develop the skills necessary to lead productive lives, vocationally, socially, and personally. The Office of Education Services should enhance existing supports for parents and families to ensure the incorporation of child maltreatment prevention information and approaches. It would also be valuable to provide information about the Central Directory of Resources, which is mandated under the Individuals with Disabilities Education Act to provide information about disability-related issues and resources to callers. The Task Force on Child Abuse Prevention recommends:

**Rec. 8.18** The Office of Education Services should work with PCA North Carolina to strengthen early intervention services with regard to parent/child interaction and child maltreatment prevention for families of children with special needs enrolled in their services. The Office of Education Services shall report on its progress in implementing this recommendation to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

### **Unavailable, Inadequate Childcare**

One of the major stressors for families in our modern society is finding quality, affordable childcare. The 2000 Census indicates that the majority of children in North Carolina live in households where all parents are in the labor force. In dual-parent households, 56% of young children and 66% of school age children have both parents in the workforce. The vast majority of children living with single parents have their parent in the workforce: 73% of young children living with single mothers and 83% of young children living with single fathers.<sup>161</sup> The growing number of working families has significantly increased the need for childcare, however, the availability of quality, affordable childcare slots has not kept pace with this need. For example, North Carolina provided over \$387 million in childcare subsidies for over 160,000 children and their families in state fiscal year 2003-2004. However, the need is much greater than current funding can address. The childcare subsidies are only provided to approximately 30% of the families who are in need of subsidies to pay for childcare. As of March 2005, there were 14,864 children on the childcare subsidy waiting list.

Inadequate, unavailable childcare is a risk factor for child maltreatment for two reasons. First, lack of childcare is a tremendous stress for parents who are already juggling multiple work and family responsibilities. Second, many parents

must make difficult decisions about leaving their children in poor quality childcare settings or leaving them alone (and risk being reported for neglect) because they cannot afford to miss work for fear of losing their jobs.

The need for quality, affordable childcare is not going to go away in the future. While this is an important issue for all families, it has particular significance for families already dealing with multiple family, financial, and environmental stressors who are in desperate need of care for their children. The Task Force on Child Abuse Prevention recommends:

- Rec. 8.19** The Child Maltreatment Prevention Leadership Team should work with the Early Childhood Comprehensive System Initiative, the NC Partnership for Children, PCA North Carolina, the NC Division of Child Development, and other appropriate organizations to identify strategies to increase the availability of affordable, quality childcare. The Child Maltreatment Prevention Leadership Team should immediately:
- A. Request that the NC General Assembly increase funding for childcare subsidies to county department of social services to ensure that 1% of additional families needing childcare subsidies are served each year until at least 50% of eligible families are being served.
  - B. A report on the progress towards implementing this recommendation should be provided to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

### **Natural Disasters**

North Carolina has experienced several natural disasters, most notably hurricanes and the flooding that can occur after such events. The stress experienced by individuals living in an area struck by a natural disaster can be significant. Loss of housing, treasured belongings, basic amenities, employment, and the experience of extreme financial stress, can place families at risk for maltreatment. Research indicates children in areas affected by Hurricane Floyd in 1999 were five times more likely to experience an inflicted traumatic brain injury, commonly known as Shaken Baby Syndrome, in the months following the hurricane than children living in other areas of North Carolina. These children remained at increased risk for six months following the disaster.<sup>162</sup> While the state has excelled in developing its disaster response teams and infrastructure, additional focus is needed to address the increased risk of inflicted traumatic brain injury and other types of maltreatment in communities that experience these events. The Task Force on Child Abuse Prevention recommends:

- Rec. 8.20** The Child Maltreatment Prevention Leadership Team should work with the State Emergency Management Services, NC disaster response professionals, and rapid response professionals (Critical Incidence teams, FEMA, etc.) to raise awareness of increased risk for child maltreatment in young children, particularly Shaken-Baby Syndrome, immediately after and up to six months following a natural disaster, and to ensure that appropriate parent support services are in place for those families at highest risk. The Child Maltreatment Leadership Team should report on its progress toward implementing this goal by January 2006 and annually thereafter.

### **Military Communities**

The military community has several factors that may put children at greater risk of maltreatment. Military families tend to be young parents, they experience increased life event stress, and they are often disconnected from traditional supports. The transient nature of military life removes families from natural supports like extended family, churches, and a neighborhood community. These risk factors, combined with the stigma of asking for help and fear of repercussions, combine to make detection and prevention of maltreatment difficult.

North Carolina has six military installations. The counties with the two largest military populations (Cumberland and Onslow) have the highest rates of child abuse homicides. The average rate of child abuse homicide for North Carolina was 2.2 per 100,000 children over an 18 year period (1985-2002). During that same period, Cumberland County had a rate of 4.6 per 100,000 and Onslow County's rate was 4.3 per 100,000. Other studies suggest that children with a parent in the

military are almost five times more likely to experience an inflicted traumatic brain injury.<sup>163</sup>

Leadership to address these issues should be developed within the communities where such military installations exist to promote child maltreatment prevention. The Task Force on Child Abuse Prevention recognizes the existence of multiple community-based efforts to strengthen prevention efforts in military communities exist, and that strategies differ across counties. Information about these efforts must be compiled and should inform any state level efforts to reduce maltreatment among military communities. Additionally, state and local level efforts should be coordinated and build upon one another. The Task Force on Child Abuse Prevention recommends:

**Rec. 8.21** The Child Maltreatment Prevention Leadership Team should work with state and local non-profit organizations to increase the capacity of local communities to identify and implement research-based strategies focused on the primary prevention of child maltreatment among military families and communities. The Child Maltreatment Prevention Leadership Team should report on its progress toward implementing this goal by July 2006 and annually thereafter.

### **Incarcerated Parents**

Over seven million children in the United States have a parent under some form of correctional supervision. Approximately 75% of incarcerated women are mothers and two-thirds have children under age 18. Of incarcerated men, 55% are fathers. More than half of each group reports never having had visits with their children while in prison.<sup>164</sup> In North Carolina, there are over 2,600 women who are incarcerated.<sup>165</sup>

Some research indicates that parental incarceration increases a child's risk for child maltreatment.<sup>166</sup> A parent's history previous to incarceration may be indicative of family problems that hinder their ability to provide appropriate care. While incarcerated, parents may need to leave their children with caregivers who are inappropriate or who are unable to provide care. For those incarcerated parents re-entering the community, reuniting with the family can be extremely stressful. Attachment between the parent and child has been disrupted making it difficult to reestablish trust, affection, and effective child management approaches with the child. The parent will also face a number of social and economic challenges that will influence their ability to provide appropriate care, such as finding employment, housing, and social support. Finally, the child may exhibit a host of negative reactions to the transition. Each of these stressors can increase the family's risk for maltreatment. The Task Force on Child Abuse Prevention recommends:

**Rec. 8.22** The Child Maltreatment Prevention Leadership Team should work with the NC Department of Corrections to examine whether incarcerated parents have a higher risk of future child maltreatment, and if so, develop recommendations to address this issue. The Child Maltreatment Prevention Leadership Team should report on its progress toward implementing this goal by July 2006 and annually thereafter.

## CHAPTER 9

# Funding

**E**ffective statewide efforts to prevent child maltreatment must be adequately funded and should include resources for program implementation, training, quality assurance, and evaluation to ensure the success of such efforts. New resources are often very limited. The Task Force on Child Abuse Prevention wanted to assess existing funds to determine the extent to which existing resources are or could be used to prevent child maltreatment. The Task Force on Child Abuse Prevention chose on the major state and federal funding sources that could be used to support child maltreatment prevention efforts.

Information about these sources of funding was collected from the following agencies: NC Department of Public Instruction, the NC Department of Health and Human Services, the NC Department of Juvenile Justice and Delinquency Prevention, and the NC Department of Crime Control and Public Safety. In addition, information was collected from the NC Partnership for Children. More detailed information about how this data was collected can be found in the Appendix of this report.

### NC Department of Public Instruction (DPI)

**NC Children's Trust Fund:** DPI houses the NC Children's Trust Fund (NCCTF), the only source of funding in North Carolina that is dedicated explicitly to the purpose of preventing child maltreatment. The NCCTF was established in 1983 by the NC General Assembly (G.S. §110-147) to provide funds for programs and services to prevent child abuse and neglect. The fund is supported by a part-time staff person who has sole administrative duties. The NCCTF provides small grants (approximately \$15,000) to public and non-profit organizations across the state to conduct education and broad family support activities. Some state-level organizations receive larger grants. Activities funded are diverse in nature and include parent education and parent support programs, child safety programs, parent leadership training, and home visiting programs.

Funding for the NCCTF is comprised of an annual state appropriation of \$250,000; fees from marriage licenses that total approximately \$300,000 annually; and fees from specialized "Kids First" license plates, which totaled \$21,135 in revenue from mid-2002 until June 2004 (approximately 1,400 plates sold). The state appropriation and marriage license fees have provided an average of \$652,402 in revenue annually since 1996. In two instances, fund transfers were made from the NCCTF to help balance the state's budget: \$1.7 million in 2000 and \$50,000 in 2001. These transfers undermined the NCCTF efforts to fund a large-scale child maltreatment prevention initiative of home visiting programs.

The Task Force on Child Abuse Prevention recognized the importance of the NCCTF in supporting child maltreatment prevention efforts in North Carolina. It also recognized that multiple opportunities exist to strengthen the capacity of the NCCTF. A previous analysis of the NCCTF outlined such opportunities and highlighted strategies used by other states to strengthen their Children's Trust Funds.<sup>167</sup> One strategy would be to ensure that a full-time position leads and promotes the goals of NCCTF, to enhance its capacity to serve as a leadership organization in the state's maltreatment prevention efforts. The Task Force on Child Abuse Prevention recommends:

**Rec. 9.1** The NC Department of Public Instruction should ensure that funds from the NC Children's Trust Fund are used to support a full-time administrator for the NC Children's Trust Fund whose responsibilities are solely dedicated to child maltreatment prevention efforts. These efforts should be associated with managing, promoting, and increasing resources for the NC Children's Trust Fund and with serving in a leadership role for maltreatment prevention in the state. The NC Department of Public Instruction should report back its progress in implementing this recommendation to the Child Maltreatment Prevention Leadership Team by January 2006 and annually thereafter.

**Safe and Drug Free Schools and Communities Program:** The federal "No Child Left Behind" act includes the Safe and Drug-Free Schools and Communities program as Title IV-Part A. North Carolina received \$9.9 million in Safe and Drug Free School funds last year. The purpose of this program is to support activities that prevent violence in and around schools and to prevent the illegal use of alcohol, tobacco, and drugs. Activities are to be coordinated with other school and community-based programs, and are to include performance measures. A wide range of programs in NC are funded through Safe and Drug Free Schools resources including life skills programs, safety fairs, school resource officers, anti-bullying programs, public speakers, parent involvement activities, and individual/group counseling. Some programs, such as social skills programs for children and their parents and parent education programs, may contribute to the prevention of child maltreatment.

## NC Department of Health and Human Services

The NC Department of Health and Human Services has many divisions and agencies that provide child maltreatment prevention services. Some efforts focus on primary prevention, while others focus more heavily on tertiary prevention. In addition, existing funds are used to strengthen family and community protective factors, and to reduce risk factors that put families at greater risk of abuse and neglect. The divisions most heavily involved in funding these programs at the state or local level include the NC Division of Social Services, the NC Division of Public Health, and the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

**NC Division of Social Services (DSS):** DSS has several funding sources that allow for and/or require the support of child abuse prevention. These include federal Title IV-B,1 and IV-B,2 funds, Child Abuse Prevention Treatment Act/Basic State Grants, Child Abuse Prevention Treatment Act Community-Based Child Abuse Prevention Program, and the Temporary Assistance for Needy Families and Social Services Block Grant programs. In addition, the NC General Assembly has allocated funds for family resource centers.

> *Title IV-B,1 Child Welfare Services:* Federal child welfare services funds can be used for a wide range of activities spanning the entire scope of the child welfare system, including prevention, case management services, placement of children in adoptive homes, and reunification services. Funds for foster care maintenance, childcare, and adoption assistance are limited. The state must provide a 25% match to draw down these federal funds. North Carolina received \$8.2 million in federal Title VI-B,1 funds for state fiscal year 2003-2004. These funds are currently used to fund county departments of social services (permanency planning funding), statewide adoption recruitment efforts (NC KIDS), state maternity homes, child welfare attorneys, training, LINKS (program to assist youth in foster care transition into adulthood

successfully), interpretation services, and a State Bureau of Investigation contract (fingerprinting for foster/adoptive families). The funding is not used for primary child maltreatment prevention efforts.

- > *Title IV-B,2 Promoting Safe and Stable Families (PSSF)*: PSSF funds are used to prevent maltreatment, assure children's safety in the home and preserve families when possible, support reunification, and support/promote adoption services. North Carolina received \$9.7 million during state fiscal year 2003-2004 in PSSF funds. Federal law mandates a 25% state match, and that at least 20% of the funds are spent on each of the following four activities: family support, family preservation, family reunification, and adoption support and promotion. The remaining 20% may be spent on administration and evaluation. In North Carolina, these funds are combined with the Child Abuse Prevention Act/Community-Based Child Abuse Prevention funding and additional state funds into one funding pool for family support programs/family resource centers, which is distributed to local communities through a request for proposals process.
- > *Child Abuse Prevention and Treatment Act (CAPTA)/Basic State Grant*: The CAPTA/Basic State Grant funds are used to improve child protection systems, including developing, strengthening, and supporting child abuse and neglect prevention, treatment, and research programs in the public and private sectors. North Carolina received approximately \$553,000 during fiscal year 2004-2005. North Carolina primarily uses the CAPTA/Basic State Grants funds for child protective services training, the child medical evaluation program, funding contracts for public awareness and child abuse prevention, and newly created domestic violence trainer positions.
- > *CAPTA/Community-Based Child Abuse Prevention (CBCAP)*: These funds are used to support community-based services and networks of coordinated resources to reduce the likelihood of abuse and neglect within families. North Carolina received \$550,000 in state fiscal year 2004-2005 in CAPTA/CBCAP funds. The amount of funding available is based on the number of children under age eighteen in the state and the amount of money that the lead agency can provide as a match. The governor of each state appoints the lead agency for the CBCAP program and these agencies vary across the country. In North Carolina, these funds are administered through the NC Division of Social Services and are combined with other funds into a request for proposals for local communities.
- > *State Appropriations for Family Resource Centers*: The NC General Assembly annually appropriates \$900,000 for the development and implementation of family resource centers as an essential long-term crime prevention strategy. The NC General Assembly began this program in 1994 (G.S. §143B-152.10). The intent of the legislation was to create programs in communities and neighborhoods that have "disproportionately high levels of children who would be less likely to attain educational or social success; families with low-incomes; and crime and juvenile delinquency" (G.S. §143.152.10). The goals of the program focus on school success, family economic self-sufficiency, and the mobilization of public/private community resources to help children and families. These funds are combined with other funds into one request for proposals for local communities.
- > *Combination of Funds to Support a Request for Proposals for Local Communities*: Currently, the NC Division of Social Services combines the funding from Title IV-B,2, CAPTA/CBCAP, and state funds for family resource centers into one request for proposals that provides funds to local communities. The funds have been used to support Family Support Services/Family Resource Centers (\$2.9 million),<sup>168</sup> Non-Intensive and Intensive Family Preservation Services (\$450,000 non-intensive; \$2.7 million intensive), Respite Care Services (\$240,000), Time-Limited Family Reunification Services (\$1.95 million), and Adoption Promotion and Support Services (\$1.05 million). Local agencies eligible to apply include any tribal government, community-based public or private nonprofit, or governmental organization with capacity to plan and provide services in a multi-county area.



> *TANF Block Grant*: TANF is a block grant created by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. The TANF block grant replaced the Aid to Families with Dependent Children program, which had provided cash welfare to poor families with children since 1935. Under the TANF structure, the federal government provides a block grant to each state, which uses the funds to operate its own programs. States can use TANF dollars in ways designed to meet any of the four purposes set out in federal law, which are to: “provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives; end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage; prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and encourage the formation and maintenance of two-parent families.”<sup>169</sup>

North Carolina received \$369,77,414 in TANF Block Grant funds for state fiscal year 2004–2005. Of those funds \$119.8 million was used for Work First Cash Assistance; \$94 million for Work First Block Grants; and \$115 million for childcare subsidies. These allocations represent almost 90% of the total TANF funds. Other programs and efforts funded by TANF include afterschool programming; mentoring programs for children; funding for children’s services, child welfare training, special children’s adoption fund, and childcare institutions; domestic violence services for Work First families; teen pregnancy prevention; Boys and Girls Clubs; and NC Fast Implementation. A few of these initiatives, such as the Teen Pregnancy Prevention programs, could be seen as contributing to the primary prevention of child maltreatment.

> *Social Services Block Grant (SSBG)*: The purpose of the SSBG is to enable states to provide services directed toward the goals of economic self-support; personal self-sufficiency; preventing or remedying neglect, abuse, or exploitation of children and vulnerable adults and support for families; preventing or reducing inappropriate institutional care; and securing appropriate institutional care.

SSBG funds support thirteen mandatory services that are available statewide, including: adjustment services for the blind and visually impaired; adoption services; adult placement services; childcare services; family planning services; foster care services for adults; foster care services for children; health support services; individual and family adjustment services; in-home aide services; in-home aide services for the blind; protective services for adults; and protective services for children. A number of other services are considered optional.

For state fiscal year 2004–2005, North Carolina has approximately \$57 million in SSBG funds. Of those funds, almost \$29 million was allocated to counties to support the thirteen mandatory services outlined above. The other efforts funded through SSBG are varied but range from the Commission on Indian Affairs - In Home Services for the Elderly to childcare subsidies to services for the blind and mental health services for adults and children. Several of these efforts can be linked to risk factors associated with child maltreatment.

**NC Division of Public Health:** The NC Division of Public Health has several funding streams that can be used in an effort to prevent violence in the home and/or to reduce risk factors. These include the Rape Prevention and Education Grant and the Maternal and Child Health Block Grant.

> *Rape Prevention and Education Grant*: The Violence Against Women Act authorizes rape prevention and education funds that are administered by the Center for Disease Control National Center for Injury Prevention and Control. These funds are designed to help prevent sexual violence by supporting increased awareness, education, and training for all age groups. These efforts are carried out by local rape crisis centers, state sexual assault coalitions, and other public and private non-profit entities. North Carolina received \$1.2 million in state fiscal year 2005 in rape prevention and education funds. The funds are administered in North Carolina by the NC Division of Public Health’s Injury and Violence Prevention Branch. The Branch is currently overseeing a strategic planning process (which is also being

conducted at the federal level) for use of the Rape Prevention and Education Grant funding, and there is discussion of utilizing the funding to more effectively support primary prevention.

- > *Maternal and Child Health Block Grant (MCH)*: The MCH Block grant (Title V) is used to improve the health of mothers and children by reducing infant mortality and the incidence of handicapping conditions among children; increasing the number of children appropriately immunized against disease; increasing the number of children in low-income households who receive assessments and follow-up diagnostic and treatment services; providing and ensuring access to comprehensive perinatal care for women, preventive and childcare services, comprehensive care (including long-term care services) for children with special healthcare needs, and rehabilitation services for blind and disabled children under sixteen years of age who are eligible for Supplemental Security Income; and facilitating the development of comprehensive, family-centered, community-based, culturally competent, coordinated systems of care for children with special healthcare needs.

In state fiscal year 2004–2005, North Carolina received \$25,296,768 in Maternal and Child Health Block Grant funds. Of this, \$9.5 million was block granted to local health departments, \$6 million was targeted toward the School Health Nurse Initiative, \$4.2 million funded services for children with special healthcare needs, and \$2.2 million was used for a variety of services including high-risk maternity clinic services, perinatal education and training, childhood injury prevention, and public information and education. Several of these efforts are closely linked with child maltreatment prevention.

**NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS):**

DMH/DD/SAS receives state and federal funds that are used for prevention and treatment of mental health, developmental disabilities, and substance abuse problems. While not directly tied to child maltreatment prevention, these funds are used to reduce some of the risk factors associated with child maltreatment. For example, DMH/DD/SAS receives:

- > *Mental Health Block Grant (MHBG)*: The Mental Health Block Grant provides federal financial assistance to states for the provision of community-based services for people with mental illness. Services provided through the use of the block grant must be those described in the state's plan in accordance with Federal P.L. 102-321. These services include outpatient, day treatment, psychosocial rehabilitation, emergency services, and residential services for adults and children. The funds may also be used for evaluating programs and services carried out under the plan and planning, administration, and educational activities related to providing services under the State Plan.

The State must maintain the level of state funds expenditures for mental health services at no less than the average of the preceding two-year period and must expend an amount equal to the amount expended by the state in fiscal year 1994 for a system of services for children.

The state MHBG plan for state fiscal year 2003–2004 allocated a total of \$9,892,319 to three areas: the Adult Mental Health Plan, Child Mental Health Plan, and Comprehensive Treatment Services Program. Of that allocation, the Child Mental Health Plan received \$2,665,018 as a continuation of Child Mental Health services in accordance with the NC Community Mental Health Services Plan and Block Grant. Applications of this plan include services/programs for children who are sexually aggressive, deaf or have multiple needs, family preservation programs, group homes, specialized foster care, therapeutic homes, professional parenting programs, mental health services in schools, respite services, suicide prevention, training, and initiatives to develop systems of care for serving children with serious emotional disturbance and their families.

## NC Partnership for Children

The NC Partnership for Children, or “Smart Start,” currently receives \$190 million in state and other funds that are distributed to local partnerships throughout the state. Local partnerships are required to spend 70% of all funds to improve the quality of childcare, and the remaining 30% may be used for additional quality childcare services and for children’s health and family support services. Each local partnership determines its funding priorities based on identified needs in the community.

Between \$16.5 and \$17 million in NC Partnership for Children funding is used annually for family support services to ensure that children are ready for school, and a large portion of this funding focuses on risk reduction activities to prevent child maltreatment. This makes the NC Partnership for Children one of the state’s largest supporters of child maltreatment prevention. For example, in 2003 the NC Partnership for Children funded 221 family support programs throughout the state, including seven home visiting programs, eighteen parenting skills training programs, fourteen teen parent/child programs, and fifty-one parent education programs.

## NC Department of Crime Control and Public Safety

**NC Governor’s Crime Commission:** The NC Governor’s Crime Commission administers approximately \$30 million in federal block grant money in four areas drug control and system improvement, juvenile justice and delinquency prevention, information systems and technology, and victims services. Funding from the juvenile justice and delinquency prevention and victims services could be used to support child maltreatment prevention efforts. The NC Governor’s Crime Commission received \$1.6 million in federal funds for delinquency prevention programs in state fiscal year 2004, which are targeted services for youth at risk of involvement in the juvenile justice system. Some of these funds have been used in the past to support adolescent parenting initiatives and parent education. Federal Juvenile Justice and Delinquency Prevention formula grant funds have also been used to support nurse home visiting programs (Nurse Family Partnership), which have been shown to be effective in longitudinal studies in reducing juvenile delinquency and also in reducing child maltreatment. Currently, 10% of the funds for victims’ services (approximately \$1.9 million in state fiscal year 2005) were used to support programs addressing abuse and neglect. Most of these funds have been distributed to child advocacy centers.

## NC Department of Juvenile Justice and Delinquency Prevention

Funding resources within the NC Department of Juvenile Justice and Delinquency Prevention are primarily targeted at juveniles who are at risk of delinquency or who have been adjudicated undisciplined or delinquent. Examination of this funding did not identify clear opportunities to fund primary prevention of child maltreatment. However, Juvenile Crime Prevention Councils (JCPC), located in each county, are allocated funds and can make data-based decisions to determine the need for prevention programs from the actual indicators of risk factors in each county and from juvenile justice data. Local officials who comprise the JCPCs would decide upon the funding of any child maltreatment prevention initiatives.

## Opportunities for Funding the Task Force on Child Abuse Prevention Plan

The Task Force on Child Abuse Prevention has identified several broad strategies to increase funding for child maltreatment prevention efforts in North Carolina.

**Strategy 1. Raise additional revenue for the NC Children’s Trust Fund.** The NC Children’s Trust Fund is the state’s only source of revenue specifically dedicated for child maltreatment prevention. However, current funding is limited. Other states have developed strategies to increase funding to their children’s trust funds; initiatives that North Carolina could duplicate. Two approaches to increasing revenues in the Trust Fund are raising fees on specific legal documents, such as

birth certificates, marriage licenses, or divorce decrees and having those funds allotted to the NC Children's Trust Fund and strengthening marketing efforts to result in increased sales of specialty KIDS FIRST license plates.

**Strategy 2. Shift current funding from federal funding streams, block grants, and state appropriations to support priority recommendations of the Task Force on Child Abuse Prevention.** There are a number of funding streams that are being used or could be used to fund child maltreatment prevention activities or activities to reduce specific high-impact risk factors. The Child Maltreatment Prevention Leadership Team should take responsibility for identifying and analyzing these opportunities.

**Strategy 3. Require current programs to adopt research-based/evidence-based practices as their core programming strategy when available.** There is a growing body of research regarding effective child maltreatment prevention efforts. State agencies and other funders should provide assistance to local organizations to help them implement these proven models. Funding should be targeted to evidence-based programs.

**Strategy 4. Seek new funding through federal, state, and non-governmental resources.** The Child Maltreatment Prevention Leadership Team should explore opportunities for new funding. This includes maximizing federal funding, seeking additional state revenue for specific programmatic efforts, and pursuing non-governmental funding for pilot programs.

Recognizing the importance of each of these strategies in funding child maltreatment prevention efforts in North Carolina, the Task Force on Child Abuse Prevention recommends:

- Rec. 9.2 The NC General Assembly should make necessary funds available to implement the recommendations of the Task Force on Child Abuse Prevention with a specific focus on the support of child maltreatment prevention programs identified by the Task Force on Child Abuse Prevention as evidence-based and promising. Specifically, the Task Force on Child Abuse Prevention recommends that the NC General Assembly:
- A. Impose an additional fee of \$10 on all birth certificates and allocate funds to the NC Children's Trust Fund.
  - B. Increase the existing fee on all marriage licenses from \$5 to \$10 and allocate funds to the NC Children's Trust Fund.
  - C. Impose an additional fee of \$10 to all applications for divorce decrees and allocate funds to the NC Children's Trust Fund.
  - D. Provide a check-off on income taxes of \$5 to be used for child abuse prevention programs. Funding from this check-off should be allocated to the NC Children's Trust Fund.
  - E. Appropriate funds for replication of the following programs identified by the Task Force on Child Abuse Prevention as evidence-based and/or promising in preventing maltreatment and strengthening families:
    - i. Parent-Child Interaction Therapy - \$50,000 for providing training to three sites involving three or four providers with follow up for model fidelity and skill mastery.
    - ii. Strengthening Families Program - \$1.57 million to fund three additional programs for three years.
- A report on the progress on this recommendation should be provided to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

- Rec. 9.3 The Child Maltreatment Prevention Leadership Team should work to increase funds available to implement the recommendations of the Task Force on Child Abuse Prevention, with a specific focus on the support of evidence-based and promising child maltreatment prevention programs. Specifically, the Task Force on Child Abuse Prevention recommends that the Child Maltreatment Prevention Leadership Team:
- A. Work with all NC Department of Health and Human Services divisions to ensure that the Task Force on Child Abuse Prevention recommendations are viewed as funding priorities within existing funding streams for child maltreatment prevention and within the following block grants to the NC Department of Health and Human Services: Temporary Assistance for Needy Families, Social Services, Mental Health, Substance Abuse, Maternal and Child Health.
  - B. Explore with the NC Division of Medical Assistance various strategies to reduce long-term health costs associated with child maltreatment trauma. Strategies should focus on reimbursement changes within the Maternity Care Coordination programs, Child Service Coordination programs, postpartum home visit efforts, and other home visiting programs.
  - C. Prioritize the following funding proposals that would help decrease risk factors that significantly contribute to child maltreatment, including funding to:
    - i. Shorten the rollout timeframe of the Medicaid family planning waiver to decrease the number of unplanned and unwanted pregnancies in North Carolina.
    - ii. Expand the number of programs funded by the Teen Pregnancy Prevention Initiative to decrease the number of adolescent pregnancies.
    - iii. Expand the number of perinatal and maternal substance abuse treatment programs to decrease the number of mothers with substance abuse problems.
    - iv. Increase the capacity of the Children's Developmental Services Agencies to ensure that children at-risk of or experiencing developmental delays are receiving timely assessments and services.
    - v. Increase the number of School-Based Child and Family Support Teams, school nurses, school social workers, and school counselors to ensure that high-risk children and their families receive appropriate services to reduce risk and increase protective factors.
    - vi. Increase the availability of childcare subsidies to reduce the number of children without access to quality, affordable childcare.
  - D. Work with the NC Children's Trust Fund to support its efforts to increase the sale of the KIDS FIRST license plate.
  - E. Identify funding from non-governmental sources to pilot and evaluate new initiatives.
  - F. Work with local communities and governmental organizations and partner with private foundations and funders to promote funding for evidence-based and promising programs as identified in the Task Force on Child Abuse Prevention plan and by Child Maltreatment Prevention Leadership Team, and to ensure that program evaluation activities are provided through the grant-making process.
- A report on the progress on this recommendation should be provided to the Child Maltreatment Prevention Leadership Team by July 2006 and annually thereafter.

## CHAPTER 10

# Conclusion

**I**n North Carolina, a child is mistreated every fifteen minutes by a parent or caretaker. Every two weeks a child dies from abuse. Campaigns against child maltreatment have been successful in informing the general population about recognizing and reporting child maltreatment. Unfortunately, many people continue to view the issue as one that does not affect them and one that they cannot prevent. However, child maltreatment has broad societal consequences for the entire population, both human and financial.

Financially, child maltreatment costs taxpayers in North Carolina an estimated \$3 billion each year. These estimates include increases in expenditures for healthcare, child welfare, education and special education, law enforcement, the judicial system, and juvenile detention and incarceration. Maltreatment can also cause long-term consequences for the child, including negative changes in neurobiological development, adverse impacts on a child's cognitive abilities and emotional well-being, difficulty or inability to form positive relationships with other people, higher rates of juvenile delinquency, higher rates of criminal behavior, and transmission of intergenerational child maltreatment.

Historically, North Carolina has concentrated on reporting and substantiating cases of child maltreatment, rather than on prevention. Prevention efforts that do exist in North Carolina are fragmented across multiple state and local agencies. To date, there has been no state leadership to help coordinate prevention activities across systems, or to target resources towards programs and activities that have been demonstrated to be effective in strengthening families, reducing risk factors, or otherwise preventing child maltreatment. The Task Force on Child Abuse Prevention recommends a new statewide framework so that agencies, organizations, and individuals understand their roles in a unified prevention effort. The new system will help protect children and strengthen families and communities by creating a culture based on the following features:

- > Every child is nurtured, supported, and protected within a safe and stable home and community environment.
- > Families recognize the rewards and responsibilities of raising children and have access to support within their own communities for meeting those responsibilities.
- > Families are able to ask for and receive timely assistance, without fear of being punished or blamed.
- > Communities are supported in their efforts to meet the diverse needs of families in raising their children.

At the core of these recommendations is the development of a Child Maltreatment Prevention Legislative Oversight Council, a Child Maltreatment Prevention Leadership Team, and a statewide child maltreatment monitoring system. The Child Maltreatment Prevention Legislative Oversight Council will be responsible for implementing the Task Force on Child Abuse Prevention plan and drawing statewide attention to the issues of child maltreatment prevention. The Child Maltreatment Prevention Leadership Team will provide expertise and assistance to support the work of the Child Maltreatment Prevention Legislative Oversight Council by coordinating prevention efforts, developing funding strategies for maltreatment prevention programs, and promoting evidence-based practices throughout the state. Finally, to measure achievements in reducing the incidence of child maltreatment in the state, the NC Department of Public Health - Injury and Violence Prevention Branch will guide the development of a statewide monitoring system.

The new child maltreatment prevention system will be based on evidence-based child maltreatment prevention efforts and other promising practices so that limited resources can be targeted to those programs and activities that have the greatest potential of strengthening families and reducing risks that can lead to maltreatment. By increasing the use of evidence-based and promising programs in child maltreatment prevention, the state can help assure that program interventions will produce the desired impact with children and families, and that resources are being well used.

Preventing child maltreatment is an issue that affects agencies and organizations serving children and families at all levels across the state. This strategic plan outlines a collaborative, systematic approach to the issue that will benefit the state by saving costs over the long-term and strengthening families and communities.

The Task Force on Child Abuse Prevention spent nine months examining child abuse prevention and developed thirty-seven recommendations that are the foundation of a strategic plan outlining a collaborative, systematic approach to this issue. These recommendations call for legislative action by the NC General Assembly, policy changes within the NC Department of Health and Human Services, collaboration and action from maltreatment prevention organizations and state agencies, and targeted grant-making and evaluation by funders. Thirteen of the thirty-seven recommendations are considered top priority and, if implemented, would have a significant impact on the prevention of child maltreatment throughout the state. These recommendations are summarized below. The priority recommendations are highlighted in the following table.

## Recommendations

*Priority recommendations are highlighted in blue.*

### Chapter 4: Leadership

Rec. 4.1 The General Assembly should establish a standing Child Maltreatment Prevention Legislative Oversight Council that has a diverse membership representation and strong leadership from state and local agencies and community providers.

✓

Rec. 4.2 The NC Department of Health and Human Services - NC Division of Public Health should develop a Child Maltreatment Prevention Leadership Team to assist in supporting the work of the Child Maltreatment Prevention Legislative Oversight Council.

✓

✓

✓

✓  
Domestic  
Violence  
Agencies;  
Other  
Appropriate  
Agencies

### Chapter 5: Monitoring Child Maltreatment Prevention

Rec. 5.1 The NC Division of Public Health's Injury and Violence Prevention Branch should work with a Technical Advisory Committee to develop a North Carolina data collection system for monitoring child abuse prevention.

✓

✓

✓  
Law  
enforcement,  
Center for  
Health  
Statistics

### Chapter 6: Social Norms and Policies that Promote Effective Parenting and Community Responsibility for Child Well-Being

Rec. 6.1 PCA North Carolina, in partnership with the NC Division of Public Health, should take the lead in developing a public education and marketing campaign aimed at encouraging community members to support parents by promoting positive parenting behaviors and increasing public support for programs and resources aimed at strengthening positive family interaction.

✓

✓

Rec. 6.2 PCA North Carolina, in collaboration with the NC Division of Public Health, the NC Division of Social Services, the NC Coalition Against Domestic Violence, the NC Domestic Violence Commission, the NC Partnership for Children, the NC Department of Public Instruction, and the NC Department of Juvenile Justice and Delinquency Prevention, should work with and support ongoing grassroots efforts to establish community norms that support families and healthy child development, and reduce social acceptance of violence as an appropriate response to interpersonal conflict.

✓

✓

✓

✓  
NC  
Department  
of Juvenile  
Justice and  
Juvenile  
Delinquency  
Prevention;  
Domestic  
Violence  
Agencies



General Assembly	DHHS	DPI/NC Children's Trust Fund	PCA North Carolina	Other
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## Recommendations

### Chapter 7: Evidence-Based and Promising Programs to Prevent Child Maltreatment

Rec. 7.1 PCA North Carolina, through its involvement with the Child Maltreatment Prevention Leadership Team, should convene an Expert Work Group on Evidence-Based Practice to identify, support, and disseminate information about evidence-based and promising programs in the field of child maltreatment prevention and family strengthening.				✓	
Rec. 7.2 Public and private funders should place priority on funding evidence-based and promising child maltreatment prevention and family strengthening programs. When those programs are not available for a specific population, public and private funders should give funding priority to those programs that are theory-based and incorporate elements identified in the research literature as critical elements of effective programs.					✓ Public and private funders
Rec. 7.3 PCA North Carolina should work with the NC Division of Medical Assistance, the NC Division of Public Health, and Community Care of North Carolina to implement the Nurse Family Partnership Program in two to three additional sites in North Carolina.		✓		✓	✓ Community Care of North Carolina
Rec. 7.4 PCA North Carolina and the NC Division of Public Health should work with the Education Begins at Home Alliance to develop a model of home visitation for families at high risk of maltreatment, based on the most current research of perinatal and early childhood home visitation programs, and from an assessment of the current resources and infrastructure for home visiting programs in North Carolina.		✓		✓	✓ Education Begins at Home Alliance
Rec. 7.5 The Child Maltreatment Prevention Leadership Team should work to pilot or replicate promising child maltreatment prevention programs such as Parent-Child Interaction Therapy, the Strengthening Families Program, and the Chicago Child-Parent Centers and to evaluate their effectiveness with a North Carolina population.					✓ Child Maltreatment Prevention Leadership Team to designate collaborators

## Recommendations

	General Assembly	DHHS	DPI/NC Children's Trust Fund	PCA North Carolina	Other
<p>Rec. 7.6 The Child Maltreatment Prevention Team should work to ensure community-based family resource centers offer or link to evidence-based and promising prevention programs; require use of social support and parent education programs that have been evaluated and show evidence/promise in preventing maltreatment; re-target funding for school-based child sexual abuse prevention programs to promising models; and develop an evaluation process for family support and child maltreatment prevention programs using a shared set of research-based intermediate indicators for child maltreatment, nurturing parent-child interaction, and healthy child development.</p>		✓	✓	✓	✓ NC Partnership for Children; Expert Workgroup; Other CSA Programming Funders; Other Agencies
<p>Rec. 7.7 The Child Maltreatment Prevention Leadership Team should work with the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and other agencies and private providers providing oversight or treatment for children who have experienced abuse or neglect to encourage the use evidence-based models identified by the Kaufmann Best Practice Initiative, Substance Abuse Mental Health Services Administration, and the Centers of Excellence.</p>		✓			✓ Agencies/ Providers of Mental Health Treatment
<p><b>Chapter 8: Systems Changes to Strengthen Families and Prevent Child Maltreatment</b></p>					
<p>Rec. 8.1 The Child Maltreatment Prevention Leadership Team should work closely with the Early Childhood Comprehensive System Initiative in the development of an integrated and comprehensive early childhood system that promotes the health and well-being of young children birth through age five. Specifically, stakeholders from both initiatives should identify common outcomes and common areas of focus, and integrate efforts whenever possible to maximize resources and prevent duplication.</p>		✓		✓	✓ Stakeholders from Child Maltreatment Prevention Leadership Team; ECCS
<p>Rec. 8.2 The NC Division of Medical Assistance, the NC Division of Public Health's Women's and Children's Health Section, PCA North Carolina, and other appropriate partners should work with the Education Begins at Home Alliance to ensure a coordinated and effective system of prenatal and early childhood home visitation programs across North Carolina, which are voluntary and appropriately match services to families' risk and needs.</p>		✓		✓	✓ Other Appropriate Partners
<p>Rec. 8.3 The NC Division of Public Health and the NC Division of Medical Assistance should strengthen the Maternity Care Coordination and Child Service Coordination programs with regard to child maltreatment prevention by requesting that prevention is included as a major goal of the programs, strengthening intervention models, and increasing training on the issue.</p>		✓			

## Recommendations

	General Assembly	DHHS	DPI/NC Children's Trust Fund	PCA North Carolina	Other
Rec. 8.4 The NC Division of Public Health and the NC Division of Medical Assistance should support the Children's Developmental Services Agencies to serve families who are maltreating and who are at high risk of maltreating their children continue to be served.		✓			
Rec. 8.5 The NC Division of Medical Assistance, the NC Office of Research, Demonstrations, and Rural Health Development, and the NC Division of Public Health should work together to explore ways to enhance the role of primary care providers in child maltreatment prevention through the NC Medical Home Initiative and the Assuring Better Child Health and Development Project.		✓			
Rec. 8.6 The Child Maltreatment Prevention Leadership Team and the Early Childhood Comprehensive System Initiative should work together in identifying the needs of families and other caregivers in promoting young children's social/emotional health, identifying effective strategies to meet these needs, and enhancing the capacity of multiple provider systems to coordinate and deliver services to those caregivers and children.		✓	✓	✓	✓ ECCS; Child Maltreatment Prevention Leadership Team
Rec. 8.7 The NC Division of Child Development, the NC Department of Public Instruction, and the NC Partnership for Children should work with the Early Childhood Professional Development Institute to develop a plan for increasing the training of childcare providers to better understand and to assist parents in understanding stages of child development and age appropriate child behavior, and to promote infant/child mental health and social/emotional development.		✓	✓	✓	✓ Early Childhood Professional Development Institute
Rec. 8.8 PCA North Carolina should work with family support organizations to increase the availability of respite care, parent support groups, , and parent support strategies, and to ensure that families in need of support are able to access services within their communities.				✓	✓ Family Support Network; Cooperative Ext; Others
Rec. 8.9 The NC Department of Health and Human Services should ensure that a strengthening parenting component is included across state programs that serve families, including culturally appropriate programmatic strategies that will support and strengthen parent-child relationships, especially during pregnancy and the first two years of the child's life.		✓			

## Recommendations

	General Assembly	DHHS	DPI/NC Children's Trust Fund	PCA North Carolina	Other
Rec. 8.10 The North Carolina State Board of Education and the NC Department of Public Instruction should identify strategies to increase support for children at risk of maltreatment and their families to ensure that children are able to fulfill their academic potential in traditional schools, alternative schools, or other educational settings.			✓		✓ State Board of Education
Rec. 8.11 The NC Division of Social Services, the NC Association of County Directors of Social Services, and the Children's Services Advisory Committee, in conjunction with community providers, should explore ways to strengthen universal/selective child maltreatment prevention efforts by expanding prevention services through the Multiple Response System for all children and developing family strengthening/child maltreatment prevention strategies for the Work First population.		✓			✓ NCACDSS
Rec. 8.12 The NC Division of Public Health and the NC Division of Medical Assistance should pursue a more rapid rollout of the federal Medicaid family planning waiver.		✓			
Rec. 8.13 The NC General Assembly should appropriate additional stable funding to the NC Division of Public Health to expand the Teen Pregnancy Prevention Initiative and revise G.S. 115C-81 (e3-8) to ensure that students are receiving medically accurate information and that schools are using evidence-based approaches to prevent unwanted pregnancies and the transmission of STD/HIV.	✓				
Rec. 8.14 The NC Division of Public Health should assess the potential costs and benefits to the state of providing some level of service to all pregnant adolescents and adolescent parents by reviewing evaluation data from programs serving these populations across the country.		✓			
Rec. 8.15 The Child Maltreatment Prevention Leadership Team should work with the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and other substance abuse treatment organizations to increase the number of substance abuse treatment programs with a particular focus on gender specific programs for pregnant women and women with children, and increase outreach to identify women in need of these services.		✓			✓ Child Maltreatment Prevention Leadership Team; Other Nonprofits

## Recommendations

	General Assembly	DHHS	DPI/NC Children's Trust Fund	PCA North Carolina	Other
<p>Rec. 8.16 The NC Division of Public Health should work with the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the NC Division of Social Services, the NC Division of Medical Assistance, professional associations, and appropriate health professional training schools to jointly develop a strategy to assess the prevalence of maternal and postpartum depression for North Carolina women, and examine the issues regarding screening for, access to, and availability of services for this condition.</p>		✓			<p>✓</p> <p>NC Pediatric Society; NC Academy of Family Physicians; NC College of OB/GYN; AHEC; Others</p>
<p>Rec. 8.17 The Child Maltreatment Prevention Leadership Team should work with the NC Coalition Against Domestic Violence and other domestic violence advocates, PCA North Carolina, the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and the NC Division of Public Health's Injury and Violence Prevention Branch to identify and pilot evidence-based or primary prevention strategies for domestic violence and child maltreatment.</p>		✓		✓	<p>✓</p> <p>Domestic Violence Agencies</p>
<p>Rec. 8.18 The NC Office of Education Services should work with PCA North Carolina to strengthen early intervention services with regard to parent-child interaction and child maltreatment prevention for families of children with special needs enrolled in their services.</p>				✓	<p>✓</p> <p>Office of Education Services</p>
<p>Rec. 8.19 The Child Maltreatment Prevention Leadership Team should work with the Early Childhood Comprehensive System Initiative, the NC Partnership for Children, the NC Division of Child Development, and other appropriate organizations to identify strategies to increase the availability of affordable, quality childcare and request that the NC General Assembly increase funding for childcare subsidies to county departments of social services offices to ensure that 1% of additional families needing childcare subsidies are served each year until at least 50% of eligible families are being served.</p>		✓	✓		<p>✓</p> <p>ECCS; Other Organizations</p>
<p>Rec. 8.20 The Child Maltreatment Prevention Leadership Team should work with the State Emergency Management Team and other NC disaster response professionals and rapid response professionals to increase awareness of increased risk for child maltreatment in young children, particularly inflicted traumatic brain injury, occurring immediately after and up to six months following a natural disaster, and to ensure that appropriate parent support services are in place for those families at highest risk.</p>		✓			<p>✓</p> <p>Child Maltreatment Prevention Leadership Team</p>

## Recommendations

	General Assembly	DHHS	DPI/NC Children's Trust Fund	PCA North Carolina	Other
Rec. 8.21 The Child Maltreatment Prevention Leadership Team should work with state and local nonprofit organizations to increase the capacity of local communities to identify and implement research-based strategies focused on the primary prevention of child maltreatment among military families and communities.					✓ Child Maltreatment Prevention Leadership Team
Rec. 8.22 The Child Maltreatment Prevention Leadership Team should work with the NC Department of Corrections to examine whether incarcerated parents have a higher risk of future child maltreatment, and if so, develop recommendations to address this issue.					✓ Child Maltreatment Prevention Leadership Team; NC Department of Corrections
<b>Chapter 9: Funding for Child Maltreatment Prevention Efforts</b>					
Rec. 9.1 The NC Department of Public Instruction should ensure that funds from the NC Children's Trust Fund are used to support a full-time administrator for the NC Children's Trust Fund whose responsibilities are solely dedicated to child maltreatment prevention efforts.			✓		
Rec. 9.2 The NC General Assembly should make necessary funds available to implement the recommendations of the Task Force on Child Abuse Prevention through the implementation of an additional fee on birth certificates, marriage licenses, and divorce decrees, or through a check-off on income taxes for the NC Children's Trust Fund, and to appropriate funds to replicate specific programs identified as evidence-based or promising in preventing child maltreatment or strengthening families.	✓				
Rec. 9.3 The Child Maltreatment Prevention Leadership Team should work to increase funds available to implement the recommendations of Task Force on Child Abuse Prevention with a specific focus on the support of evidence-based and promising child maltreatment prevention programs.		✓	✓		✓ Child Maltreatment Prevention Leadership Team

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# PCA North Carolina Program Advisory Series

The PCA North Carolina Program Advisory series consists of full-color research reports on issues relating to effective child maltreatment prevention. Copies of the reports are available for purchase by calling 919-829-8009 or visiting [www.preventchildabusenc.org](http://www.preventchildabusenc.org).

**Advice to Professionals on Child Sexual Abuse Prevention Programs for Preschoolers and Elementary-Aged Children** provides a summary of current research and program guidance on child sexual abuse prevention. Included are discussions on key elements of such programs, their effectiveness, and suggestions for future planning. This report also provides a thorough background understanding of child sexual abuse.

**Circle of Parents: Advice to Communities on Supporting Today's Parents** provides a summary of current research on mutual self-help support groups and their potential to prevent child maltreatment. The Circle of Parents program is discussed in detail as well as parent leadership. Topics include how Circle of Parents groups work and the benefits participants receive.

**Understanding Child Maltreatment: An Introduction to Definitions, Incidence, and Risk/Protective Factors** provides an overview of definitions, incidence, and impacts of child maltreatment. It also summarizes the current research and theory including key risk and protective factors that play a role in child maltreatment or in child protection. It identifies key issues for practitioners and advocates to address as they plan prevention programming in their community.

**Reframing the Issue: Advice to Professionals on Child Abuse Public Awareness Campaigns** provides a history of child abuse prevention public awareness and a crucial summary of research on public opinion and media activities. This publication also offers information on social marketing and strategic framing, and includes a wide variety of recommendations for future public awareness campaigns.

**Child Maltreatment Prevention: An Introduction to Definitions, Principles, and Evidence-Based/Promising Programs** provides a foundation for understanding child maltreatment prevention including definitions, history, and principles. It summarizes the need for evidenced-based programs and promising programs. It also offers a thorough examination of more than thirty current prevention programs.

PCA North Carolina also has two white papers available by request. *Child Maltreatment In NC* offers a detailed view of risk and protective factors affecting North Carolina's families. It also includes a thorough discussion of the use of an ecological model in child abuse prevention and incidence of maltreatment in North Carolina. *Child Maltreatment Birth to Age Three: An Approach to Primary Prevention* offers a closer look at services for pregnant women and families with very young children. It identifies strengths and challenges in North Carolina's continuum of services and offers recommendations on serving this population more effectively.

# Programs That Prevent Child Maltreatment

This handout was originally presented to the Task Force on Child Abuse Prevention in November 2004. PCA North Carolina's *Understanding Prevention: An Introduction to Definitions, Principles, and Evidence-Based/Promising Programs* contains further information and updated evaluations of the following programs.

## Home Visiting Programs/Home Based Services

**Nurse Family Partnership** - SELECTIVE - Prenatal and early childhood home visitation program designed to improve maternal and child health and well-being. Home visits conducted by experienced, well-trained and supervised nurses who work intensively with first-time, low-income mothers and their families over a period of two years. Goals for the program include improving maternal and fetal health by helping pregnant women improve their health-related behaviors; improving infant and child health and development by enhancing parental caregiving skills; and improving the families' economic self-sufficiency.

*Evaluation Summary: The Nurse Family Partnership has amassed considerable evidence of reducing child maltreatment through three large-scale randomized controlled trials in which participants were followed over time. Studies found significant reductions in state-verified reports for child maltreatment among all mothers in the treatment group (but particularly for poor unmarried teens) and fewer emergency room visits than controls; significant reductions in subsequent pregnancies; increased rate for labor force participation; significant reduction in low-income mother's behavioral problems due to alcohol/drug abuse. Outcomes for children included fewer arrests, sexual partners and alcohol/substance use at fifteen year follow-up. Although the Nurse Family Partnership is probably the best supported model of perinatal home visiting, recent evaluations have pointed out that outcomes are not as strong when substance abuse and domestic violence are present, and efforts are now underway to address these issues.*

**Project 12 Ways/Project SafeCare** - SELECTIVE/INDICATED - Home-based set of skills-based parent training interventions designed to treat or prevent child maltreatment, with a focus on child neglect. Project 12 Ways consists of a set of twelve protocols focused on building parent skills in the areas of parent-child interaction, health and safety training, stress reduction, self control training for parents, money management, and others. Project SafeCare refined protocols to three: bonding/parent-child interaction training; infant and child health care, and home safety and cleanliness. Originally designed for families involved with child welfare, protocols can be used in prevention programs.

*Evaluation Summary: Over sixty published studies support the efficacy of Project 12-Ways/SafeCare model, including quasi-experimental recidivism studies, and single-case designs. In several studies child maltreatment recidivism was found to be significantly lower than comparison groups (for example, 10% in Project 12-Ways versus 21% in comparison cases). In addition, families improve in their use of a number of activities/skills related to child neglect including appropriate interaction skills, use of planned activities, identification of child illness and injury symptoms; and reducing hazards in home. Currently, Project SafeCare is being implemented statewide in Oklahoma and tested in a randomized trial to determine whether a statewide replication can reproduce the positive effects seen in earlier trials.*

**Healthy Families** - SELECTIVE - Early childhood home visitation program designed to prevent maltreatment, improve maternal/child health and child development, and improve maternal life course outcomes. Home visits begin prenatally or within the first few weeks after birth and can continue up to age five, are targeted toward high-risk mothers, and are conducted by paraprofessionals or professionals.

*Evaluation Summary: Evaluations of Healthy Families programs have produced mixed results. Findings from randomized, controlled trials of Healthy Families programs have not produced significant effects with regard to maltreatment reduction, although there is a large body of quasi-experimental and single group studies that has shown promise in producing positive child health*

outcomes and reducing child maltreatment. Overall, additional experimental evaluation is needed to discern which program elements need to be re-tooled to produce more significant effects (for example, incorporating a cognitive change component), and programs need to more effectively address risk-clusters such as domestic violence, substance abuse, maternal depression and delay of second pregnancy. Currently, discussion is being held among North Carolina stakeholders to determine if a North Carolina model that addresses the issues above should be developed.

**Parents As Teachers** - UNIVERSAL/SELECTIVE - Early childhood education and family support program designed to enhance child development and school achievement through home visits, parent group meetings, periodic developmental screenings, and referrals to community services. Prevention of child maltreatment is one of the program's goals. Home visits conducted by certified parent educators to families with children prenatal through five years old. Standardized curriculum teaches parents about the importance of learning in a child's early years, provides information about child development, teaches parents strategies to foster their child's intellectual/social development, and focuses on enhancing parent-child interaction. The model is committed to a universal approach, but some programs target high-risk groups (low income, adolescent parents) and there are increasing number of programs serving high-risk families who use the Parents As Teachers curriculum (e.g. Healthy Families).

*Evaluation Summary: There have been thirteen outcome evaluations of the Parents as Teachers model; the majority has been quasi-experimental studies although five involved randomized trials of programs that targeted primarily at-risk families (low income, adolescent parent). Findings from studies have been primarily focused on school readiness outcomes and parent involvement in activities that promote learning (e.g. reading books to children). Although studies have examined outcomes related to parenting beliefs and practices (e.g., parent knowledge, attitude, parent child interaction, parental sense of competence), findings in the randomized trials have been inconsistent. A recent report of an ad hoc Scientific Advisory Committee on Parents as Teachers noted that few studies have examined the outcome of child abuse prevention directly, although there is some evidence that Parents as Teachers may reduce maltreatment among adolescent parents. The Committee concluded that additional research is needed using a rigorous design and examining parenting indicators that are specifically associated with maltreatment such as positive parenting practices and parent-child interaction.*

**Parent Aide Program** - SELECTIVE/INDICATED - Developed in the 1970s as one of the earliest home visitation programs designed to strengthen families and prevent maltreatment by using members of a community (volunteer or paid) to work with a family in areas of child safety, problem-solving skills, parenting skills, and social support. The program serves families with children across developmental stages and provides a minimum of four visits a month until families achieve success in all four areas of their treatment plan and maintain those successes for three months.

*Evaluation Summary: No randomized controlled trials with significant sample size have been conducted, although several quasi-experimental (with small sample sizes) and descriptive studies have pointed to positive outcomes for families served by the Parent Aide Program including reductions in recidivism, and improvements in parenting attitudes and skills. Several large retrospective studies have shown significant decrease in parental stress, increases in problem-solving and social support as well a significant reduction in risk for child abuse (in one fifteen year study of 200 families 88% were not resubstantiated). Additional experimental research is needed to assess program efficacy. Currently, a randomized controlled trial (funded through the Office of Child Abuse and Neglect) is being conducted with the Exchange SCAN Parent Aide Program in Winston-Salem, North Carolina. Dr. Neil Guterman is serving as the principal evaluator.*

**Family Connections** - SELECTIVE - Multi-faceted, community-based service program that works with families with children between ages of five and eleven who have no current Child Protective Services involvement and who exhibit risk for neglect. Core components include emergency assistance; home-based family intervention (family assessment, outcome driven service plans, individual and family counseling); service coordination with referrals targeted toward risk (e.g., substance abuse treatment) and protective factors (e.g. mentoring program); multi-family supportive recreational activities.

Services are offered in three month increments for up to nine months and include individual, conjoint and family and group counseling; service facilitation and advocacy.

*Evaluation Summary: An on-going randomized, controlled trial which compares short (three month) versus longer-term (nine month) doses of services has demonstrated significant improvements in parenting attitudes, parenting competence, social support, parental depressive symptoms, physical and psychological care of children. Services in this model were originally provided by social work graduate students and the model is currently undergoing effectiveness trials in several sites across the United States Services with support from the Children's Bureau.*

## Parent Education/Parent Training Programs

**Parent Child Interaction Therapy** - INDICATED - Parent training program originally designed to treat children (age two to eight) with conduct problem behavior and now being used for treatment with physically-abusive families. Designed to help parents improve parenting skills; help parents build a warm and responsive relationship with their child; and decrease child behavior problems in fourteen weekly, one hour sessions. Trained therapists “coach” parents (use of a one way mirror in which therapist uses a microphone device from another room) in child management techniques (e.g. how to praise appropriate behavior, ignore undesirable behavior, give clear, age-appropriate instructions, how to implement “time-outs”) while parents are interacting with their children in a safe environment.

*Evaluation Summary: There is a strong body of evidence supporting the efficacy of Parent-Child Interaction Therapy (PCIT) as a treatment program for children with externalizing behavior problems (age two to eight). There is a growing body of evidence that supports use of PCIT with physically abusive parents. One recent randomized trial (Chaffin et al. 2004) found that 19% of parents assigned to PCIT had a re-report for physical abuse compared to 49% assigned to standard community-based parenting group (parent education). PCIT has been cited as an evidence-based practice by the Kauffman Best Practices Project to Help Children Heal from Child Abuse.*

**Nurturing Program** - SELECTIVE/INDICATED - Home and group-based parent education sessions designed to treat child maltreatment, prevent its recurrence, and build nurturing parenting skills in at-risk families. Fifteen separate curriculums exist based on age of child and family needs (substance abusing families; foster families) and include activities for both parents and children. Number of sessions range from nine to forty-eight and focus on discipline, empathy, developmentally appropriate expectations, stress and anger management, and substance abuse among others. Content delivered through activity manuals, parent handbooks, instructional video, group discussion, and games.

*Evaluation Summary: Numerous evaluations have been conducted on the Nurturing Program using a pre-post test, non-experimental design; several with longitudinal follow up. The initial trial was a pre-post design (no control group) with abusive families. Using a battery of standardized inventories, parents significantly improved attitudes about parenting practices (including developmental expectations, corporal punishment, parent-child role reversal); demonstrated increases in abstract reasoning, enthusiasm, social boldness, self-assuredness and reductions in anxiety and tough demeanor; and increased their knowledge about behavior management concepts and techniques. Families demonstrated increased cohesion and expressiveness and reduced family conflict. Numerous subsequent evaluations using pre-post design have replicated these results.*

**Circle of Security** - SELECTIVE/INDICATED - A twenty-week, group-based parent intervention program designed to enhance “attachment-caregiving relationships” between parents and their children. Based on attachment theory and current research on early relationships, the intervention uses edited videotapes of interactions between the parent participants and their children to help parents increase their sensitivity and responsiveness to their children’s needs in an effort to promote secure attachment between caregiver and child. Can be implemented in a group format or individually with parents.



*Evaluation Summary: Currently corresponding with the Principal Investigator to discuss evaluation design and results. A 2002 article noted that preliminary results from evaluation of seventy-five parent-child pairs looks promising in strengthening attachment relationship.*

## Additional Programs

Following are several parent education/parent training programs that have strong evidence with regard to preventing and treating emotional/behavioral disorders in children, and other negative outcomes. They target parental knowledge, skills, attitudes and behavior and target risk factors closely associated with child maltreatment such as harsh physical discipline, coercive parent/child relationships, verbal aggression, negative attributions of child behavior, family communication and family cohesion. Although these programs have not been tested, or tested extensively with regard to child maltreatment prevention, they hold promise and should be considered by prevention practitioners.

**The Incredible Years** - UNIVERSAL/SELECTIVE/INDICATED - Comprehensive, developmentally-based intervention with components for parents, teachers and children (age two to twelve years) designed to prevent and treat emotional/behavioral problems in young children by promoting children's social, emotional and academic competence; strengthening parental competence and family relationships; promoting teacher competence in managing classroom behavior and strengthening school-home connections. Interventions use a group format and deliver content through multiple methods including video, discussion, activities, role playing, and home assignments.

*Evaluation Summary: All three components have been extensively evaluated using randomized control group studies and have shown consistently positive results. One study of the program used as a universal program for preventing conduct problems in Head Start Children found that mothers in the treatment group were significantly less likely to verbally attack or criticize their children or to use physical punishment such as hitting or spanking. They used less harsh discipline; were more nurturing, reinforcing, and competent in parenting; used more consistent discipline, and more appropriate limit-setting techniques. Children in the treatment group demonstrated fewer negative behavior and conduct problems, less noncompliance and more pro-social behaviors. Although the Incredible Years has not measured child maltreatment reduction specifically, it holds promise for reducing negative parenting behaviors that may contribute to abuse.*

**Triple P (Positive Parenting Program)** - UNIVERSAL/SELECTIVE/INDICATED - Multi-level set of parenting interventions that primarily targets the treatment/prevention of emotional/behavioral disorders in children, but also focuses on the prevention of other negative outcomes such as child maltreatment and juvenile delinquency. Interventions range from the provision of brief information resources such as tip sheets and videos at Level One, to brief targeted interventions (for specific behavior problems) offered by primary care practitioners at Levels Two and Three, to more intensive parent training programs at Level Four and Level Five targeting broader family issues such as relationship conflict and parental depression and stress. Triple P targets five developmental periods from infancy through adolescence and aims to help parents create a safe, engaging and positive learning environment for their children, use assertive discipline, have realistic expectations, and take care of oneself as a parent.

*Evaluation Summary: Numerous randomized controlled trials have been conducted to evaluate different levels of the program with regard to reducing children's oppositional behavior and have produced favorable results. At least one study has focused on parents recruited from child protection who were experiencing significant difficulties in managing their anger and interactions with their children aged two to seven years. Parents were randomly assigned to the Enhanced Triple P (Level Five) or the standard Triple P (Level Four). Both groups had lower reported and observed disruptive child behavior, lower reported parental distress, relationship conflict, parental anger, blame, negative attributions, unrealistic expectations, and potential for child maltreatment. Only one family was reported for child abuse in the six month follow up period. Currently, the model is being replicated and tested in South Carolina (through support from the Centers for Disease Control) for the prevention of maltreatment.*

**Strengthening Families** - SELECTIVE/INDICATED - Family skills training program for elementary school children (ages six to twelve years) and their families, designed to improve family relationships, parenting skills, and youth's social and life skills to reduce problem behaviors in children, improve school performance and reduce alcohol/drug use in adolescents. Although originally designed for children of alcohol or drug abusers to prevent behavioral problems, the program is now being offered to parents with children in the child protection system, as well as other at-risk groups. Program implemented in fourteen, two-hour family training sessions in which parents and children meet separately for the first hour to focus on skills development (parents - child behavior management; children - social and problem-solving skills) and then meet together for a structured parent-child interaction activities in which they can practice their skills. A second program has been developed that target youth ten to fourteen years of age and their parents.

*Evaluation Summary: Strengthening Families has amassed considerable evidence through numerous randomized controlled evaluations and has been shown to be efficacious with a variety of populations (African-American families, Hispanic families, families living in urban, suburban, and rural communities). Outcomes related to child maltreatment prevention include significant differences in parents' depression, parent' alcohol and drug use, decreases in family conflict and stress, increase in parenting confidence and efficacy, parenting knowledge and positive parenting behavior skills. For children outcomes include improved social and communication skills, and pro-social support among peers.*

**Parenting Wisely** - SELECTIVE/INDICATED - a brief, interactive, self-administered, computer-based program that teaches parents and their children (nine to eighteen years of age) skills to prevent delinquent or substance abusing behavior. Parents and children watch video clips showing families in nine common problem situations (e.g. children not doing chores) and then parents choose from among three problem solution methods presented. Feedback about positive and negative consequences of the choice is given and parents receive additional instruction through a workbook with solutions and critiques, review questions, and detailed skill practice exercises. Program provides instruction in effective parenting skills through use of demonstration, quizzing, repetition, rehearsal, recognition and feedback from correct and incorrect answers. The program is being implemented in numerous locations including community mental health agencies, substance abuse treatment programs, and child protection agencies.

*Evaluation Summary: Thirteen evaluations of Parenting Wisely have been conducted, of which five involved the random assignment (small sample sizes) of parents to treatment and control groups. Overall, the studies suggest that parents participating in the program demonstrate increased knowledge and use of good parenting skills; improved problem-solving; increased ability to set clear expectations; and reduced spousal violence and violence toward their children. Additional experimental studies using larger sample sizes are needed but the program is currently listed as a Model Program and is seen as a cost-effective intervention.*

## Self-Help/Social Support

**Parent Anonymous** - UNIVERSAL/SELECTIVE - Founded in 1969, Parents Anonymous is one of the oldest child abuse prevention programs in the country. A mutual, self-help parent support group program open to all parents that focuses on shared parent leadership, effective mutual support, and long-term personal growth for parents and children. Weekly group meetings are co-facilitated by parents and professionally trained facilitators, and are open to parents free of charge. Free childcare or children's programs are usually offered. The model focuses on reduction of risk factors such as unrealistic expectations, ineffective coping and social isolation and increasing protective factors such as social support, problem-solving strategies and self-esteem.

*Evaluation: Research on this model has been limited, but findings have been consistently positive. An initial study using a pre-post design (no control/comparison group) found that participants who had been in the group at least one year reported reductions in abusive behavior, and increase in self-esteem, frequency of social contacts, and knowledge about child behavior. A second study*

suggested that Parents Anonymous might be a key element in service delivery plans for at-risk and maltreating parents, finding that families who were involved in Parents Anonymous services were more likely, regardless of other services provided, to improve on measures of parental stress, appropriate behavior toward child, and parental knowledge. Currently, the Office of Juvenile Justice and Delinquency Prevention is funding a national outcome evaluation of Parents Anonymous. The evaluation is a longitudinal research design that compares groups with low Parents Anonymous model implementation to groups with high model implementation, and which will follow participants for six months regardless of their continued participation in the program.

**Circle of Parents** - UNIVERSAL/SELECTIVE - Mutual, self-help parent support group - very similar in theory and design to Parents Anonymous - in which parents who are experiencing difficulties in their parenting roles can exchange ideas, support, information and resources. The group is co-led by a parent and a professional, is open to all parents/caregivers with children of all ages (although some Circle of Parents groups target specific population such as single mothers, or parents of children with special needs/disabilities), is free of charge, and typically meets once a week. Programs provide a children's program or quality childcare. Circle of Parents programs focus on reducing parent isolation, increasing positive parenting practice, strengthening parent communication skills and problem-solving, and promoting parent leadership.

*Evaluation: Circle of Parents draws from the theoretical foundation and research of Parents Anonymous, and because it is a relatively new program, has very limited research to date. Nevertheless, two studies have been conducted in Minnesota and Florida that employed one-time surveys that asked participants to rate their parenting expectations and activities before their participation in the program and after their participation. Questions fell into four domains that included self-management skills; quality of parent/child relationship; parenting skills or parenting practices; and use of formal and informal support systems. Additional questions about group participation, empowerment and leadership were also included. Both studies reported statistically significant improvement in all four domains for program participants, and longer participation was positively correlated with increased improvement for participants. PCA North Carolina is currently investigating potential outcome evaluation designs for North Carolina's Circle of Parents programs.*

**Parent To Parent** - SELECTIVE - Matches trained veteran parents of children with special needs with newly referred parents who are experiencing similar issues with their own children. Parents are able to share common experiences, obtain social support, and learn about resources for their children within the community.

*Evaluation: Still working to identify all evaluation studies. At least one evaluation in which parents were randomly assigned to a veteran parent or to an eight week "wait list" group found that parents in the Parent to Parent program helped parents gain acceptance of their child's special needs; helped some parents cope better and increased their feelings of being able to problem-solve.*

## Early Childhood Initiatives

**Chicago Child-Parent Centers** - SELECTIVE - A federally funded (Chapter 1), center-based early childhood program for low-income children in preschool through third grade (ages three to nine years). Designed to improve children's school readiness through four features: early intervention, parent involvement, a structured language-based instructional model, and program continuity between the preschool and early school-age years. The Centers utilize a multi-faceted parent program that includes a parent resource room staffed by a Head Teacher, parental involvement in the classroom, and home visits focused on increasing parental involvement in their child's education. Comprehensive health and nutrition services (health screenings, nursing services, free breakfasts and lunches), community outreach (school-community representative, family recruitment, resource mobilization, home visitation), low teacher/student ratios, and a comprehensive school age .

*Evaluation: Most of the support for the Chicago Child-Parent Centers (CPC) is from the Chicago Longitudinal Study - a quasi-experimental study of 1,539 low-income, mostly African American children (1,150 in twenty CPC preschool and kindergartens;*

389 from six randomly selected schools with kindergarten programs for low income children). These children and families were followed longitudinally for fifteen years. Overall, children who participated in one to two years of CPC had higher reading and math achievement test scores and lower rates of grade retention and special education placement, were more likely to complete high school, had fewer violent and nonviolent arrests, and fewer drop-outs than control group. The longer the children participated in the CPC program, the greater the effects. Children who participated in CPC preschool were 52% less likely to be victims of maltreatment (measured through court and CPS reports) at fifteen year follow-up. Again, the more participation in CPC programming (continuing through second or third grade), the lower the rates of maltreatment.

**Early Head Start** - SELECTIVE - A federally funded community-based program for low-income, pregnant women and families with infants and toddlers up to age three. Goals are to promote healthy prenatal outcomes for pregnant women, enhance the development of children ages 0-3, and support healthy family functioning through either center-based, home-based or a combination of center and home-based services. Services include early childhood education, parent education, home visitation, comprehensive health and mental health services for children and parents; adult literacy, education and job skills training, assistance in obtaining safe housing, income assistance, and transportation.

*Evaluation:* A large-scale, experimental study of Early Head Start involved 3000 families across seventeen sites that provided a center-based, home-based and a mix of center and home-based services. Overall impacts were modest and positive, with mixed services (home and center-based) having the greatest effects and some sub-populations (African American families) demonstrating larger effects. Low-risk and high risk families did not seem to benefit from services as much as moderately-high risk families. Although maltreatment was not measured specifically, Early Head Start parents were observed to be more emotionally supportive, less likely than control-group parents to engage in negative behaviors (spanking) less detached, and reported a greater repertoire of discipline strategies, including milder and fewer punitive strategies.

## Primary Health Care Initiatives

**Healthy Steps for Young Children Program** - UNIVERSAL - Initiative to improve delivery of developmental and behavioral services to young children through pediatric practices. Program added two nurses, nurse practitioners, early childhood educators, or social workers (all with training and experience in child development and each carrying a caseload of approximately 100 families) to the staffs of fifteen pediatric practices in fourteen states. Healthy Steps specialists met with physicians and parents during office visits, made home visits, staffed call-in child development phone lines, performed developmental assessments, provided developmental materials to parents, organized parent support groups, and made community referrals.

*Evaluation Summary:* A trial of several thousand families found that parents in the Healthy Steps program had reduced likelihood of slapping their child in the face or spanking with an object and an increased likelihood of using negotiation and timeouts for discipline compared to control group; parents were four to twenty times more likely to receive developmentally oriented care; children had better continuity of care and decreased likelihood of having an emergency department visit in the past year for injury-related causes. In addition, mothers in Healthy Steps were twice as likely to discuss feelings of sadness and depression with someone in the pediatric office as mothers in the control group.

## Respite Care

No specific model of respite care was identified in this review. Respite care is discussed below as a general strategy for child abuse prevention.

UNIVERSAL/SELECTIVE/INDICATED - Respite care provides a range of services including temporary childcare, support, and referral services for families in order to reduce stress, support family stability, prevent child maltreatment and

minimize the need for out-of-home placement. Respite may be pre-planned and scheduled, or it may be crisis or emergency oriented. It may be center-based, or it can take place in the home of the caregiver or the child. It is often part of a more comprehensive early intervention strategy provided to children with developmental delays, disabilities, and other special needs (low birth-weight infants); to children who have a chronic or terminal illness (HIV/AIDS); to children with emotional and behavioral problems; and to those children at risk for or with a history of child maltreatment.

*Evaluation: The evaluation research examining respite care (particularly with regard to child abuse prevention) has been limited. No randomized controlled trials were identified in this review. Some studies have shown short-term positive effects on reductions of parental stress. A more recent study examined the impact of respite care on families with children experiencing emotional and behavioral problems. Compared to a wait-list comparison group, participating families had fewer incidents of out of home placement, greater optimism about caring for the child at home, and reductions in some areas of caregiving stress. The more hours of services the family used, the better the outcomes.*

## Child Sexual Assault Prevention Education

Child assault prevention education programs are typically school-based programs designed to educate and empower young children to protect themselves from sexual victimization by teaching concepts and skills that are believed to help them recognize, resist, and report sexual abuse. After a comprehensive review of the literature in 2002, PCA North Carolina concluded that although child assault prevention programs have produced gains in children's knowledge of abuse, there was no empirical evidence that children were able to transfer that knowledge into real life situations. In fact, researchers found that participation in a comprehensive child sexual assault prevention program was not associated with a reduced rate of sexual abuse incidence or victimization. PCA North Carolina does not recommend child sexual abuse prevention programs as a universal or selective strategy for prevention, but does believe that it can be effectively used to increase disclosures among children who have already been victimized and who need intervention. We do not currently recommend any specific program but have identified a set of critical elements that should be used in programs.

**UNIVERSAL** - An increasing number of agencies are focusing on the responsibilities of adults to protect children from child sexual abuse and they are employing public health strategies in their efforts. One such initiative, STOP IT NOW!, looks at preventing child sexual abuse by increasing the public's knowledge of the perpetration of child sexual abuse through mass media campaigns; teaching adults the skills to recognize signs of abusive behavior and to intervene before abuse occurs; challenging abusers and potential abusers to seek help; and challenging those family members and friends to confront someone who they suspect is abusive to get help. Several states including Vermont, Michigan, Georgia and Massachusetts are implementing either replications of STOP IT NOW!, or similar efforts and the Center for Disease Control is evaluating a number of these initiatives. Other initiatives, such as Darkness to Light in Charleston, South Carolina are also focusing on the responsibility of adults to protect children from sexual abuse.

## Community and Neighborhood-Based Programs

**UNIVERSAL/SELECTIVE** - Family resource centers are a way to organize and deliver services to a geographically defined community. Family resource centers may be located in schools, churches, housing complexes, hospitals or in independent facilities. These centers involve community members in planning, implementing, and evaluating services that are designed to meet the needs of the surrounding community and may serve a diverse population, depending on the services offered. Family resource centers strive to improve family well-being by providing services such as afterschool programming, parent support groups, respite care, literacy training, parent skills training, employment and assistance with employment, housing, and financial issues. Family resource centers also strive to develop a sense of community cohesion and efficacy by becoming a place where community members know one another, feel empowered, and develop bonds that create strong communities and neighborhoods. Several recent initiatives (e.g., Starting Points Initiative) have developed family resource centers as part of their efforts and focused their services on supporting the parents of young children. These

family resource centers offer single access points for health screening and care, developmental screening, parent and preschool information, and other services targeted at this developmental stages.

**Evaluation Summary:** Despite the prevalence of this model, there has been little empirical evaluation of family resource centers, particularly with regard to child maltreatment. In part, this stems from the difficulties involved with evaluating this type of service and the desire of programs to avoid labeling families as “abusive.” Nevertheless, there is a growing body of evidence that demonstrates that family resource centers can contribute to child and family well-being. For example, in a comprehensive review of family resource centers the UCLA Center for Healthier Children, Families, and Communities cites several studies that indicate that some family resource centers may be effective in improving children’s educational performance. More empirical studies of family resource centers are needed. However, these centers demonstrate promise as a strategy to strengthen families.

## Therapy/Treatment

**Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)** - Intervention designed for children and adolescents who have been sexually abused and their parents. Uses cognitive-behavioral therapy and stress inoculation training procedures to reduce children’s negative emotional and behavioral responses (e.g., post-traumatic stress) and correct maladaptive beliefs and attributions related to the abusive experiences.

*Evaluation Summary:* Multiple randomized clinical trials have found TF-CBT to be efficacious in reducing symptoms of post-traumatic stress disorder among sexually abused children, as well as symptoms of depression and behavioral difficulties. Identified as “the best practice to use with sexually abused children with post-traumatic stress symptoms” by the Kauffman Best Practice Project.

**Abuse Focused-Cognitive Behavioral Therapy (AF-CBT)** - Intervention designed for physically abused children and their offending caregivers. Uses behavioral treatment and cognitive-behavioral therapy methods that target contributors to physically abusive behavior and children’s subsequent behavioral and emotional adjustment. Components are directed at the child, the parent and the parent-child/family domains and focus on promoting pro-social/appropriate behavior and discouraging coercive or violent behavior by focusing on intrapersonal and interpersonal skills (e.g. coping skills for children, managing reactions to abuse-specific triggers and promoting self-control for parents, communication skills to encourage positive interactions).

*Evaluation Summary:* The Kauffman Best Practice Project identifies AF-CBT as a best practice for physically abused children and their families and notes that the methods incorporated in AF-CBT “have been found efficacious” in several outcome studies across various populations.

**Multi-systemic Therapy** - Home-based program that was originally developed to decrease adolescent criminal activity and antisocial behavior (including substance abuse). There have been some efforts to apply the model in the child welfare arena with positive results. The model uses trained therapists to help families and youth address challenges and develop resources/supports in multiple domains (individual, family, peer, school, community) over a four-month period. Staff are available twenty-four hours a day, seven days a week, and have small caseloads of four to six families per therapist.

*Evaluation:* Several controlled, random-assignment evaluations have supported the efficacy of multi-systemic therapy. Overall, results include decreased substance abuse, few arrests, less time in out-of-home placements, less aggressive behavior with peers, and less criminal activity. One randomized trial has been conducted with families who had been investigated for abuse or neglect which demonstrated positive results including parents reporting decreased psychiatric symptoms, reduced stress, and improvement in individual and family problems. Parents were better able to manage child behavior and neglectful parents were more responsive to child’s behavior. A larger, randomized trial is currently underway.

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# Key Informants - Sources and Uses of Funds for Child Abuse Prevention

To provide a picture of state and federal funding for child abuse prevention in North Carolina, PCA North Carolina contracted with Jenni Owen of the Center for Child and Family Policy at Duke University to collect information on funding streams within North Carolina public agencies, conduct a preliminary analysis of that information, and highlight key considerations for the Task Force on Child Abuse Prevention. A set of questions was developed by PCA North Carolina and Ms. Owen for use in key informant interviews. Key informants were identified for each agency and an in-person or phone interview was conducted with each informant.

## NC Children's Trust Fund

- > Amy Smith, Coordinator

## NC Division of Social Services

- > David Atkinson, Administrator, Local Support Operations Team, Family Support and Child Welfare Services Section
- > JoAnn Lamm, Section Chief - Family Support and Child Welfare Services
- > Ray Kirk, UNC School of Social Work, Intensive Family Preservation Services Evaluation

## NC Governor's Crime Commission

- > Tina Howard, Juvenile Justice Planner
- > Michelle Zechmann, Lead Juvenile Justice Planner
- > Barry Bryant, Lead Victims Planner

## NC Partnership for Children

- > Emmy Marshall, Program Consultant/Family Support Specialist

## NC Council for Women/Domestic Violence Commission

- > Leslie Starsonneck, Executive Director

## NC Department of Health and Human Services - Injury and Violence Prevention Branch

- > Jeanne Givens, Coordinator

## NC Department of Juvenile Justice and Delinquency Prevention

- > Susan Whitten, Coordinator, JCPC and Community Program Funding

## NC Division of Mental Health

- > Flo Stein, Chief, Community Policy Management Section

This is the set of questions participants were asked to respond to. The questions related to PCA North Carolina's Gaining Ground Initiative and the different roles, funding sources for and "grantmaking: activities of stakeholder agencies and organizations.

1. What definition of child abuse prevention do you use? Are you referring to primary, secondary, or tertiary prevention?
2. What types of organizations and activities do you fund? Why?
3. What process do you use for making child abuse prevention grants?
4. Who participates in that process?
5. What are the criteria considered for selection of grantees? Who mandates these criteria?
6. Is your process for grantee selection consistent or does it change from year to year?
7. As part of the process, what expertise is brought to the table concerning best practices in child abuse prevention?
8. What are the outcomes that you are trying to achieve through your funding? How are these outcomes developed?
9. Do you collaborate with other grant making entities?
10. Do you know whether your grantees receive child abuse prevention grants from elsewhere, and if so, how much and for what purpose?
11. Do you require follow-up, reporting, or evaluation of grantees? If so, what do you require?
12. What are the strengths of your grant program?
13. Are there areas for improvement? If so, what are they?
14. If PCA North Carolina were available to assist you with your child abuse prevention efforts what would you ask them to do?
15. A key goal of PCA North Carolina is the dissemination of best practice child abuse prevention programs across North Carolina. Do you believe there may be opportunities for your organizations to work together to achieve this goal? If so, please explain.

# Child Abuse Prevention Funding in NC

Compiled for the Task Force on Child Abuse Prevention

NAME OF SOURCE	SOURCE \$	AMOUNT \$	GOALS/ ALLOWABLE USES	HOW USED
NC Children's Trust Fund (DPI)	All state funds > State appropriation \$250,00 > Marriage license fees \$300,000 > License plates \$21,135 (mid 2002-June 2004)	Average \$652,402 annually since 1996	Community-based educational and service programs designed to prevent the occurrence of child maltreatment.	Child abuse prevention activities including education and broad family support activities, home visiting, and parent support.
Title IV-B, 1 Welfare Services) (DSS)	Federal and 25% match required	\$8.2 million (03-04)	Wide range of activities spanning entire scope of child welfare system - prevention, case management, placement in adoptive homes, reunification services, and residential care	County DSS (permanency (Child planning funding); statewide adoption recruitment; statewide adoption recruitment; state maternity homes; child welfare attorneys; training; LINKS; interpretation services; fingerprinting of foster/adoptive families
Title IV-B, 2 (Promoting Safe and Stable Families) (DSS)	Federal and match required	\$9.7 million (04-04)	Prevent maltreatment, assure children's safety in home and preserve intact families, whenever possible, address problems of families with children in foster care so reunification can take place and support adoptive families. Required to spend minimum: > 20% Family Support > 20% Family Preservation > 20% Family Reunification > 20% Adoption Support & Promotion 20% can be spent on evaluation, admin., etc.	This funding is combined with other funding (CBCAP and Funds for State Family Resource Centers) to distribute to local communities.  Family support funding primarily focused on family resource centers.
CAPTA/Basic State Grant (DSS)	Federal	\$553,000 (04-05)	Improve child protection systems including "developing, strengthening, and supporting child abuse and neglect, prevention, treatment and research programs in the public and private sectors.	Child protective services training; child medical evaluation program; funding for contracts for public awareness and child abuse prevention; and DV training positions.



CAPTA/CBCAP (Community-Based Child Abuse Prevention) (DSS)	Federal with match required	\$550,000 (04-05)	Support community-based services and networks of coordinated resources to reduce the likelihood of abuse and neglect with families	This funding is combined with other funding (CBCAP and Funds for State Family Resource Centers) to distribute to local communities. Family support funding primarily focused on family resource centers.
State Funds for Family Resource Centers (DSS)	State	\$900,000	Create programs in communities with high levels of children at-risk for poor school performance, families with low-incomes and crime and juvenile delinquency. "Long-term crime prevention strategy."	This funding is combined with other funding (CBCAP and Funds for State Family Resource Centers) to distribute to local communities. Family resource centers
<p>NOTE: The Division of Social Services combines the Promoting Safe and Stable Families Funding, CBCAP Funding and State Funds for Family Resource Centers into one RFP for:</p> <p>(1) family support/family resource centers (\$2.9 million)</p> <p>(2) non-intensive and intensive family preservation (\$450,000 non-intensive; \$2.7 million intensive)</p> <p>(3) respite care services (\$240,000)</p> <p>(4) time-limited family reunification services (\$1.95 million)</p> <p>(5) adoption promotion and support services (\$1.05 million)</p>				
NC Partnership for Children	State funds and private contributions	Family Support Activities \$16.5-\$17 million (annually) Health Activities \$11 million (annually)	Family Support Funds are designed to ensure that families have the needed skills and knowledge to develop their ability to provide learning opportunities, leading to school readiness, for their young children. This encompasses parenting skills/competence/confidence and family literacy/language development.  Health Funds are to ensure the children are safe and healthy (child and abuse and neglect prevention falls under this category).	Funds many different services including but not limited to home visiting; teen parent/child programs; parenting education programs; family resource centers; fatherhood initiatives; mentoring; and counseling.
Governor's Crime Commission	Federal multiple funding streams but most relevant is Juvenile Justice and Delinquency Prevention	\$1.6 million (2004)	Supports state and local delinquency prevention efforts and juvenile justice system improvements	Parent training/counseling; interpersonal skills training; tutoring. Nurse Home Visiting cited as program example in website.
Rape Prevention and Education (DPH)	Federal	\$1.1 million (2005)	Strengthen sexual violence prevention efforts by supporting increased awareness, education and training for all age groups.	Community education; forums; workshops; and trainings.

## Matrix of Participating Agencies

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\* NC Division of Public Health and PCA North Carolina lead the Child Maltreatment Prevention Leadership Team.

Recommendation	Target	General Assembly	DHHS					DPI/CTF	PCA	NCPC	Other
			DPH	DMH/DD/SAS	DCD	DSS	DMA				
REPORT BACK January 2006 (or before)											
4.1	The NC General Assembly should establish a standing Child Maltreatment Prevention Legislative Oversight Council that has a diverse membership representation and strong leadership from state and local agencies and community providers.	✓	✓	✓	✓	✓	✓	✓	✓	✓	Other Agencies
4.2	The NC Department of Health and Human Services and the NC Division of Public Health should develop a Child Maltreatment Prevention Leadership Team to assist in supporting the work of the Child Maltreatment Prevention Legislative Oversight Council.	N/A	✓	✓	✓	✓	✓	✓	✓	✓	
5.1	The NC Division of Public Health's Injury and Violence Prevention Branch should work with a Technical Advisory Committee to develop a North Carolina data collection system for monitoring child abuse prevention.	N/A	✓	✓	✓	✓	✓	✓	✓	✓	Law Enforcement; Center for Health Statistics
7.3	PCA North Carolina should work with the NC Division of Medical Assistance, the NC Division of Public Health, and the Community Care of North Carolina to implement the Nurse Family Partnership Program in two to three additional sites in North Carolina.	S	✓					✓			✓ CCNC

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### Recommendation

REPORT BACK January 2006 (or before)	Target	General Assembly	DHHS				DMA	DPI/CTF	PCA	NCPC	Other
			DPH	DMH/DD/SAS	DCD	DSS					
7.4	PCA North Carolina and the NC Division of Public Health should work with the Education Begins at Home Alliance to develop a model of home visitation for families at high risk of maltreatment, based on the most current research of perinatal and early childhood home visitation programs, and from an assessment of the current resources and infrastructure for home visiting programs in North Carolina.	S	✓					✓		✓ Education Begins at Home Alliance	
8.1	The Child Maltreatment Prevention Leadership Team should work closely with the Early Childhood Comprehensive System Initiative in the development of an integrated and comprehensive early childhood system that promotes the health and well-being of young children birth through age five. Stakeholders from both initiatives should identify common outcomes and areas of focus, and integrate efforts whenever possible to maximize resources and prevent duplication.	N/A	✓					✓		✓ ECCS	

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**Recommendation**

REPORT BACK January 2006 (or before)

	Target	General Assembly	DHHS				PCA	NCPC	Other
			DPH	DMH/DD/SAS	DCD	DSS			
8.3	The NC Division of Public Health and the NC Division of Medical Assistance should strengthen the Maternity Care Coordination and Child Service Coordination programs with regard to child maltreatment prevention by requesting that prevention is included as a major goal of the programs, strengthening intervention models, and increasing training on the issue.	S	✓				✓		
8.4	The NC Division of Public Health and the NC Division of Medical Assistance should support the Children's Developmental Services Agencies is ensuring that families who are maltreating and who are at high risk of maltreating their children continue to be served.	S/I	✓				✓		✓ Family Support Network
8.5	The NC Division of Medical Assistance, the NC Office of Research, Demonstrations, and Rural Health and Development, and the NC Division of Public Health should work together to explore ways to enhance the role of primary care providers in child maltreatment prevention through the NC Medical Home Initiative and the Assuring Better Child Health and Development Project.	U	✓				✓		

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			DPH	DMH/DD/SAS	DCD	DSS				
REPORT BACK January 2006 (or before)										
8.7 The NC Division of Child Development, the NC Department of Public Instruction, and the NC Partnership for Children should work with the Early Childhood Professional Development Institute to develop a plan for increasing the training of childcare providers to better understand and to assist parents in understanding stages of child development and age appropriate child behavior, and to promote infant/child mental health and social/emotional development.	U				✓				✓	Early Childhood Professional Development Institute ✓
8.8 PCA North Carolina should work with family support organizations to increase the availability of respite care, parent support groups, parent support strategies, and to ensure that families in need of support are able to access services within their communities.	U/S						✓			Family Support Network; Cooperative Extension; Others ✓
8.10 The North Carolina State Board of Education and the NC Department of Public Instruction should identify maltreatment and their families to ensure that children are able to fulfill their academic potential in traditional schools, alternative schools, or other educational settings.	S								✓	State Board of Education ✓

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**Recommendation**

REPORT BACK January 2006 (or before)	Target	General Assembly	DHHS				PCA	NCPC	Other
			DPH	DMH/DD/SAS	DCD	DSS			
8.11	The NC Division of Social Services, the NC Association of County Directors of Social Services, and the Children's Services Advisory Committee, in conjunction with community providers, should explore ways to strengthen universal/selective child maltreatment prevention efforts by expanding prevention services through the Multiple Response System for all children and developing family strengthening/child maltreatment prevention strategies for the Work First population.	U/S							✓ NCACDSS; Children's Services Advisory Committee
8.12	The NC Division of Public Health and the NC Division of Medical Assistance should pursue a more rapid rollout of the federal Medicaid family planning waiver.	S	✓						✓

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### Recommendation

REPORT BACK January 2006 (or before)

8.16 The NC Division of Public Health should work with the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the NC Division of Social Services, the NC Division of Medical Assistance, professional associations, and appropriate health professional training schools to jointly develop a strategy to assess the prevalence of maternal and postpartum depression for North Carolina women, and examine the issues regarding screening for, access to, and availability of services for this condition.

8.17 The Child Maltreatment Prevention Leadership Team should work with the NC Coalition Against Domestic Violence and other domestic violence advocates, PCA North Carolina, the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and the NC Division of Public Health's Injury and Violence Prevention Branch to identify and pilot evidence-based or primary prevention strategies for domestic violence and child maltreatment.

	Target	General Assembly	DHHS					DPI/CTF	PCA	NCPC	Other
			DPH	DMH/DD/SAS	DCD	DSS	DMA				
8.16	U		✓	✓		✓				✓ Pediatric Society; NC Academy of Family Physicians; NC College of OB/GYN; AHEC; Others	
8.17	U/S		✓	✓				✓		✓ NCCADV	

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**Recommendation**

REPORT BACK January 2006 (or before)

8.20 The Child Maltreatment Prevention Leadership Team should work with the State Emergency Management Team and other NC disaster response professionals and rapid response professionals to increase awareness of increased risk for child maltreatment in young children, particularly inflicted traumatic brain injury, occurring immediately after and up to six months following a natural disaster, and to ensure that appropriate parent support services are in place for those families at highest risk.

9.1 The NC Department of Public Instruction should ensure that funds from the NC Children's Trust Fund are used to support a full-time administrator for the NC Children's Trust Fund whose responsibilities are solely dedicated to child maltreatment prevention efforts.

REPORT BACK July 2006 (or before)

6.1 PCA North Carolina, in partnership with the NC Division of Public Health, should take the lead in developing a public education and marketing campaign aimed at community members to encourage them to support parents by promoting positive parenting behaviors and increasing public support for programs and resources aimed at strengthening positive family interaction.

	Target	General Assembly	DHHS					PCA	NCPC	Other
			DPH	DMH/DD/SAS	DCD	DSS	DMA			
8.20	S		✓				✓		✓ State Emergency Management Team; Rapid Response Professionals	
9.1	N/A						✓			
6.1	U		✓					✓		



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### Recommendation

REPORT BACK July 2006 (or before)

	Target	General Assembly	DHHS				PCA	NCPC	Other
			DPH	DMH/DD/SAS	DCD	DSS			
6.2	PCA North Carolina, in collaboration with the NC Division of Public Health, the NC Division of Social Services, the NC Coalition Against Domestic Violence, the NC Domestic Violence Commission, the NC Partnership for Children, the NC Department of Public Instruction, and the NC Department of Juvenile Justice and Delinquency Prevention, should work with and support ongoing grassroots efforts to establish community norms that support families and healthy child development, and reduce social acceptance of violence as an appropriate response to interpersonal conflict.	U	✓			✓		✓	✓ DJJDP; NCCADV; DV Commission
7.1	PCA North Carolina, through its involvement with the Child Maltreatment Prevention Leadership Team, should convene an Expert Work Group on Evidence-Based Practice to identify, support, and disseminate information about evidence-based and promising programs in the field of child maltreatment prevention and family strengthening.	N/A					✓		

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**Recommendation**

**REPORT BACK July 2006 (or before)**

	Target	General Assembly	DHHS				DMA	DPI/CTF	PCA	NCPC	Other
			DPH	DMH/DD/SAS	DCD	DSS					
7.2	Public and private funders should place priority on funding evidence-based and promising child maltreatment prevention and family strengthening programs. When those programs are not available for a specific population, public and private funders should give funding priority to those programs that are theory-based and incorporate elements identified in the research literature as critical elements of effective programs.	N/A								✓ Public and Private Funders	
7.5	The Child Maltreatment Prevention Leadership Team should work to pilot or replicate promising child maltreatment prevention programs such as Parent-Child Interaction Therapy, the Strengthening Families Program, and the Chicago Child-Parent Centers and to evaluate their effectiveness with a North Carolina population.	S	✓					✓		✓ Child Maltreatment Leadership Team to Designate Leads	

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	Target	General Assembly	DHHS					DPI/CTF	PCA	NCPC	Other
			DPH	DMH/DD/SAS	DCD	DSS	DMA				
<b>Recommendation</b>											
<b>REPORT BACK July 2006 (or before)</b>											
7.6	The Child Maltreatment Prevention Team should work to ensure community-based family resource centers offer or link to evidence-based and promising prevention programs; require use of social support and parent education programs that have been evaluated and show evidence/promise in preventing maltreatment; re-target funding for school-based child sexual abuse prevention programs to promising models; develop an evaluation process for family support and child maltreatment prevention programs using a shared set of research-based intermediate indicators for child maltreatment, nurturing parent-child interaction, and healthy child development.	U/S/I	✓			✓		✓	✓	✓ ECCS	
7.7	The Child Maltreatment Prevention Leadership Team should work with the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and other agencies and private providers providing oversight or treatment for children who have experienced abuse or neglect to encourage the use evidence-based models identified by the Kaufmann Best Practice Initiative, Substance Abuse Mental Health Services Administration, and the Centers of Excellence.	I	✓	✓					✓	✓ Agencies/Providers of Mental Health Services	

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Recommendation		Target	General Assembly	DHHS					PCA	NCPC	Other
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REPORT BACK July 2006 (or before)											
8.2	The NC Division of Medical Assistance, the NC Division of Public Health - Women and Children Section, PCA North Carolina, and other appropriate partners should work with the Education Begins at Home Alliance to ensure a coordinated and effective system of prenatal and early childhood home visitation programs across North Carolina, which are voluntary and appropriately match services to families' risks and needs.	U/S/I		✓					✓		✓ Education Begins At Home Alliance
8.6	The Child Maltreatment Prevention Leadership Team and the Early Childhood Comprehensive System Initiative should work together in identifying the needs of families and other caregivers in promoting young children's social/emotional health, identifying effective strategies to meet these needs, and enhancing the capacity of multiple provider systems to coordinate and deliver services to those caregivers and children.	U/S/I		✓					✓		✓ ECCS; Head Start; Private Practitioners

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### Recommendation

REPORT BACK July 2006 (or before)

	Target	General Assembly	DHHS					DPI/CTF	PCA	NCPC	Other
			DPH	DMH/DD/SAS	DCD	DSS	DMA				
8.9	The NC Department of Health and Human Services should ensure that a theory-based strengthening parenting component is included across state programs that serve families, including culturally appropriate programmatic strategies that will support and strengthen parent-child relationships, especially during pregnancy and the first two years of the child's life.	U/S/I	✓	✓	✓	✓	✓				✓ DHHS
8.13	The NC General Assembly should appropriate additional stable funding to the NC Division of Public Health to expand the Teen Pregnancy Prevention Initiative and revise G.S. 115C-81 (e3-8) to ensure that students are receiving medically accurate information and that schools are using evidence-based approaches to prevent unwanted pregnancies and the transmission of STD/HIV.	U/S	✓								
8.14	The NC Division of Public Health should assess the potential costs and benefits to the state of providing some level of service to all pregnant adolescents and adolescent parents by reviewing evaluation data from programs serving these populations across the country.	S	✓								

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**Recommendation**

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			DPH	DMH/DD/SAS	DCD	DSS	DMA			
8.15 The Child Maltreatment Prevention Leadership Team should work with the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and other substance abuse treatment organizations to increase the number of substance abuse treatment programs with a particular focus on gender specific programs for pregnant women and women with children, and increase outreach to identify women in need of these services.	S/I		✓	✓				✓	Substance Abuse Treatment Organizations	
8.18 The NC Office of Education Services should work with PCA North Carolina to strengthen early intervention services with regard to parent-child interaction and child maltreatment prevention for families of children with special needs enrolled in their services.	S/I							✓	Office of Education Services	

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Recommendation		Target	General Assembly	DHHS					DPI/CTF	PCA	NCPC	Other
				DPH	DMH/DD/SAS	DCD	DSS	DMA				
REPORT BACK July 2006 (or before)												
8.19	The Child Maltreatment Prevention Leadership Team should work with the Early Childhood Comprehensive System Initiative, the NC Partnership for Children, the NC Division of Child Development, and other appropriate organizations to identify strategies to increase the availability of affordable, quality childcare and request that the NC General Assembly increase funding for childcare subsidies to county departments of social services offices to ensure that 1% of additional families needing childcare subsidies are served each year until at least 50% of eligible families are being served. U/S/I	U/S/I		✓		✓			✓		✓	ECCS; Other Organizations
8.21	The Child Maltreatment Prevention Leadership Team should work with state and local nonprofit organizations to increase the capacity of local communities to identify and implement research-based strategies focused on the primary prevention of child maltreatment among military families and communities.	U/S		✓					✓			✓ Community Organizations

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**Recommendation**

**REPORT BACK July 2006 (or before)**

	Target	General Assembly	DHHS				DPI/CTF	PCA	NCPC	Other
			DPH	DMH/DD/SAS	DCD	DSS				
8.22	The Child Maltreatment Prevention Leadership Team should work with the NC Department of Corrections to examine whether incarcerated parents have a higher risk of future child maltreatment, and if so, develop recommendations to address this issue.	S	✓				✓		✓ NC Dept. of Corrections	
9.2	The NC General Assembly should make necessary funds available to implement the recommendations of the Task Force on Child Abuse Prevention through the implementation of an additional fee on birth certificates, marriage licenses, and divorce decrees, or through a check-off on income taxes for the NC Children's Trust Fund, and to appropriate funds to replicate specific programs identified as evidence-based or promising in preventing child maltreatment or strengthening families.	N/A	✓							
9.3	The Child Maltreatment Leadership Team should work to increase funds available to implement the recommendations of Task Force on Child Abuse Prevention with a specific focus on the support of evidence-based and promising child maltreatment prevention programs.	N/A	✓				✓			



# References

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- 2 Dr. Dana Hagele, Presentation to the NC IOM Task Force on Child Abuse Prevention on Child Abuse Prevention, October 8, 2004. The Child Abuse Prevention and Treatment Act defines child maltreatment as “Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk of serious harm. {(42 USCA, 5106g(2) West Supp.1998)}
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- 11 Fromm, S. *Total Estimated Cost of Child Abuse and Neglect in the United States: Statistical Evidence. 2001*. Available from Prevent Child Abuse America at URL: [http://www.preventchildabuse.org/learn\\_more/research\\_docs/cost\\_analysis.pdf](http://www.preventchildabuse.org/learn_more/research_docs/cost_analysis.pdf)
- 12 Child Abuse and Neglect in Children Birth to Age Three: An Approach to Primary Prevention. Prevent Child Abuse North Carolina. White Paper 2004.
- 13 The goals of the Gaining Ground initiative were to:
  - Σ Adopt a shared statewide vision for preventing child abuse and neglect that is based on empirical research
  - Σ Identify or develop committed and active leadership for child maltreatment prevention within governmental and non-governmental agencies
  - Σ Develop recommendations for the use of additional measures that more accurately reflect the incidence of child abuse and neglect and prevention efforts
  - Σ Adopt empirically based child maltreatment prevention strategies among both public and private systems serving families and children
  - Σ Identify, prioritize, and implement policy changes to prevent child maltreatment with the support of key policy leaders
  - Σ Maximize existing funding for child maltreatment prevention and exploring new revenue sources
  - Σ Promote child maltreatment prevention public awareness efforts that move beyond recognizing abuse and neglect to promoting behavior change among parents and those who support parents.
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