# JOINT STATE GOVERNMENT COMMISSION

**General Assembly of the Commonwealth of Pennsylvania**

## CHILD ABUSE AND NEGLECT PREVENTION PROGRAMS IN PENNSYLVANIA:

**STAFF STUDY**

**November 2014**

*Serving the Pennsylvania General Assembly Since 1937*

The Joint State Government Commission was created by the act of July 1, 1937 (P.L.2460, No.459), as amended, and serves as the primary and central non-partisan, bicameral research and policy development agency for the General Assembly of Pennsylvania.

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# JOINT STATE GOVERNMENT COMMISSION

The Joint State Government Commission was created in 1937 as the primary and central non-partisan, bicameral research and policy development agency for the General Assembly of Pennsylvania.[1]

A fourteen-member Executive Committee comprised of the leadership of both the House of Representatives and the Senate oversees the Commission. The seven Executive Committee members from the House of Representatives are the Speaker, the Majority and Minority Leaders, the Majority and Minority Whips, and the Majority and Minority Caucus Chairs. The seven Executive Committee members from the Senate are the President Pro Tempore, the Majority and Minority Leaders, the Majority and Minority Whips, and the Majority and Minority Caucus Chairs.

By statute, the Executive Committee selects a chairman of the Commission from among the members of the General Assembly. Historically, the Executive Committee has also selected a Vice-Chair or Treasurer, or both, for the Commission.

The studies conducted by the Commission are authorized by statute or by a simple or joint resolution. In general, the Commission has the power to conduct investigations, study issues, and gather information as directed by the General Assembly. The Commission provides in-depth research on a variety of topics, crafts recommendations to improve public policy and statutory law, and works closely with legislators and their staff.

A Commission study may involve the appointment of a legislative task force, composed of a specified number of legislators from the House of Representatives or the Senate, or both, as set forth in the enabling statute or resolution. In addition to following the progress of a particular study, the principal role of a task force is to determine whether to authorize the publication of any report resulting from the study and the introduction of any proposed legislation contained in the report. However, task force authorization does not necessarily reflect endorsement of all the findings and recommendations contained in a report.

Some studies involve an appointed advisory committee of professionals or interested parties from across the Commonwealth with expertise in a particular topic; others are managed exclusively by Commission staff with the informal involvement of representatives of those entities that can provide insight and information regarding the particular topic. When a study involves an advisory committee, the Commission seeks consensus among the members.[2] Although an advisory committee member may represent a particular department, agency, association, or group, such representation does not necessarily reflect the endorsement of the department, agency, association, or group of all the findings and recommendations contained in a study report.

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[1] Act of July 1, 1937 (P.L.2460, No.459), amended by the act of June 26, 1939 (P.L.1084, No.380), the act of March 8, 1943 (P.L.13, No.4), the act of May 15, 1955 (P.L.1605, No.535), the act of December 8, 1959 (P.L.1740, No.646), and the act of November 20, 1969 (P.L.301, No.128).

[2] Consensus does not necessarily reflect unanimity among the advisory committee members on each individual policy or legislative recommendation. However, it does, at a minimum, reflect the views of a substantial majority of the advisory committee, gained after lengthy review and discussion.

Over the years, nearly one thousand individuals from across the Commonwealth have served as members of the Commission's numerous advisory committees or have assisted the Commission with its studies. Members of advisory committees bring a wide range of knowledge and experience to deliberations involving a particular study. Individuals from countless backgrounds have contributed to the work of the Commission, such as attorneys, judges, professors and other educators, state and local officials, physicians and other health care professionals, business and community leaders, service providers, administrators and other professionals, law enforcement personnel, and concerned citizens. In addition, members of advisory committees donate their time to serve the public good; they are not compensated for their service as members. Consequently, the Commonwealth of Pennsylvania receives the financial benefit of such volunteerism, along with the expertise in developing statutory language and public policy recommendations to improve the law in Pennsylvania.

The Commission periodically reports its findings and recommendations, along with any proposed legislation. Certain studies have specific timelines for the publication of a report, as in the case of a discrete or timely topic; other studies, given their complex or considerable nature, are ongoing and involve the publication of periodic reports. Completion of a study, or a particular aspect of an ongoing study, generally results in the publication of a report setting forth background material, policy recommendations, and proposed legislation. However, the release of a report by the Commission does not necessarily reflect the endorsement by the members of the Executive Committee, or the Chair or Vice-Chair of the Commission, of all the findings, recommendations, or conclusions contained in the report.

A report containing proposed legislation may also contain official comments, which may be used in determining the intent of the General Assembly.[3]

Since its inception, the Commission has published more than 350 reports on a sweeping range of topics, including administrative law and procedure; agriculture; athletics and sports; banks and banking; commerce and trade; the commercial code; crimes and offenses; decedents, estates, and fiduciaries; detectives and private police; domestic relations; education; elections; eminent domain; environmental resources; escheats; fish; forests, waters, and state parks; game; health and safety; historical sites and museums; insolvency and assignments; insurance; the judiciary and judicial procedure; labor; law and justice; the legislature; liquor; mechanics' liens; mental health; military affairs; mines and mining; municipalities; prisons and parole; procurement; state-licensed professions and occupations; public utilities; public welfare; real and personal property; state government; taxation and fiscal affairs; transportation; vehicles; and workers' compensation.

Following the completion of a report, subsequent action on the part of the Commission may be required, and, as necessary, the Commission will draft legislation and statutory amendments, update research, track legislation through the legislative process, attend hearings, and answer questions from legislators, legislative staff, interest groups, and constituents.

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[3] 1 Pa.C.S. § 1939 ("The comments or report of the commission . . . which drafted a statute may be consulted in the construction or application of the original provisions of the statute if such comments or report were published or otherwise generally available prior to the consideration of the statute by the General Assembly").

**General Assembly of the Commonwealth of Pennsylvania**
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November 2014

To the Members of the General Assembly of Pennsylvania:

House Resolution 163 (Pr.'s No. 1883) directed the Joint State Government Commission to conduct a staff study to identify existing evidence-based child abuse and neglect prevention programs in this Commonwealth and nationwide, to evaluate the effectiveness and relative costs of these programs, and identify opportunities to integrate child abuse and neglect prevention methods and approaches into Commonwealth programs and policies.

Commission staff began by collecting child abuse and neglect data in order to present the scope of the problems as they currently exist. Staff then identified a broad range of established programs at national and state levels and operated by non-governmental agencies. Published empirical and observational studies reviewed by Commission staff describe a number of successful programs and initiatives; many of these currently operate in the Commonwealth. Of particular interest to staff were those child abuse prevention programs that were created through quantitative and qualitative analyses of best practices.

Importantly, Commission staff noted that the best measures of a program's success may not be directly tied to the number of clients served per dollar spent. While it is generally true that dollars per consumer is an easy, familiar way to measure a program's efficiency, it is not necessarily true that such measures accurately portray a program's success. Experts in child abuse prevention emphasize that program success must be measured based on outcomes rather than on inputs.

This report is the Joint State Government Commission's response to HR163. We are grateful for the assistance of a number of individuals who represent an array of resources and expertise in child abuse and neglect prevention, and thank them for the work they do for the residents of Pennsylvania, particularly those little ones who are most vulnerable.

Respectfully submitted,

Glenn J. Pasewicz
Executive Director

# ACKNOWLEDGMENTS

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  for Pennsylvania Commission Against Rape Children's

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# CHILD ABUSE PREVENTION: HISTORY, TRENDS, EFFECTIVE STRATEGIES

House Resolution 163 directs the Joint State Government Commission to review the child abuse prevention programs currently existing in the Commonwealth, identify best practices in Pennsylvania and nationwide, and explore ways of incorporating those practices in the state policies and practices.

Child abuse and neglect have been a matter of public concern for the past fifty years, and prevention efforts have grown considerably since the 1960s. The adoption of the state abuse reporting laws in the mid-sixties and the first Federal Child Abuse and Neglect Prevention and Treatment Act in 1974 marked a new era in the way society acknowledged and approached this problem. According to the Child Welfare Information Gateway historical review, "the 1980s represented a period of significant expansion in public awareness of child maltreatment, research on its underlying causes and consequences, and the development and dissemination of both clinical interventions and prevention strategies."[4] Based on the overview done by several researchers, CDC identified two distinct programmatic paths that emerged during the 1980s: first, interventions targeting reductions in physical abuse and neglect, including services to new parents, general parenting education classes, parent support groups, family resource centers and crisis interventions services such as hotlines and crisis nurseries; and second, interventions targeting reductions in child sexual abuse, including training designed to teach children the distinction between good, bad, and questionable touching as well as the concept of body ownership, and educational programs that encourage children who had been victimized to report these incidents and seek help.[5] By the 1990s, "emphasis was placed on establishing a strong foundation of support for every parent and child, available when a child is born and a woman is pregnant."[6] Home visiting, primarily nurse visiting during pregnancy and the first two years of the child's life, has demonstrated both short- and long-term benefits. Other home visitation models, for example Parents as Teachers and Healthy Families America, have also turned out to be helpful. Home-based interventions continue to be developed and expanded, but new strategies are also being sought.

In light of a growing awareness that successful child maltreatment prevention efforts need to go beyond helping individual families, more attention is being paid to approaches that strive for change at a community or support systems level. As the Child Welfare Information Gateway states, "the current prevention challenge is not simply expanding formal services but rather creating an institutional infrastructure that supports high-quality, evidence-based direct services."[7] Another important new trend in prevention is increasing emphasis on promoting protective factors, such as strengthening parental resilience, supporting a child's social and emotional development,

[4] Child Welfare Information Gateway. *Child Maltreatment Prevention: Past, Present, and Future*. Washington, D.C.: U.S. Department of Health and Human Services, Children's Bureau. 2011, available at https://www.childwelfare.gov/pubs/issue_briefs/cm_prevention.cfm (accessed December 23, 2013).
[5] Ibid.
[6] Ibid.
[7] Ibid.

and creating more cohesive and supportive relationships with the community.[8] While risk reduction continues to be a reasonable and necessary strategy, enhancing a parent's or child's protective factors has been more and more perceived as a promising approach lately.

### *Occurrence Nationwide*

Increased public awareness and purposeful prevention efforts have brought significant results in substantial decreases in the rates of sexual, physical, and emotional abuse.

According to the *Fourth Federal National Incidence Study on Child Maltreatment*, published in 2010, the rate of child maltreatment dropped by 19 percent compared to the previous study conducted in 1993.[9] *The Child Maltreatment Report* of the U.S. Department of Health and Human Services (HHS) issued in 2010 reflected a similar reduction in the number of physical and sexual abuse cases reported to local child welfare agencies.[10] In spite of the encouraging reduction in child abuse, millions of children in the United States remain victims of maltreatment. According to the HHS *Child Maltreatment Report* published in 2013: for the federal fiscal year 2012, the states reported 678,810 (unique count) victims of child abuse and neglect.[11] 78.3 percent of these victims suffered neglect; 18.3 percent suffered physical abuse, and 9.3 percent suffered sexual abuse.[12]

According to the previous *Child Maltreatment Report,* published in 2012, state and local protective services estimate that in 2011, 681,000 children (9.1 per 1,000) became victims of maltreatment, most of them of neglect (79 percent), while 18 percent were victims of physical abuse, 9 percent of sexual abuse, and 10 percent of other types of maltreatment.[13] Some victims suffered more than one type of abuse. The Division of Violence Prevention of the National Center for Injury Prevention and Control cites even higher rates of the potential occurrence of child maltreatment reported by studies not affiliated with child protective services: according to some of those, 1 in 7 children in this country experience some form of child maltreatment in their lifetimes.[14]

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[8] Ibid.

[9] Sedlak, A.J. e.a. *Fourth National Incidence Study of Child Abuse and Neglect (NIS-4): Report to Congress.* Washington, D.C.: U.S. Department of Health and Human Services, Administration for Children and Families, 2010, available at http://www.acf.hhs.gov/programs/opre/resource/fourth-national-incidence-study-of-child-abuse-and-neglect-nis-4-report-to (accessed December 27, 2013).

[10] U.S. Department of Health and Human Services, Children's Bureau. *Child Maltreatment 2009*, available at http://www.acf.hhs.gov/programs/cb/pubs/cm09/index.htm (accessed December 27, 2013).

[11] U.S. Department of Health and Human Services, Children's Bureau. *Child Maltreatment 2012,* available at http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf (accessed June 19, 2014).

[12] Ibid.

[13] U.S. Department of Health and Human Services, Children's Bureau. *Child Maltreatment 2011*, available at http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment (accessed December 27, 2013).

[14] U.S. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention. *Child Maltreatment: Facts at a Glance 2013*, available at http://www.cdc.gov/violenceprevention/pdf/cm-data-sheet--2013.pdf (accessed December 27, 2013).

**Table 1:** UNITED STATES

**2008 - 2012: Child Abuse & Neglect by Type**[1]

| *Year* | *Neglect* | *Medical Neglect* | *Physical Abuse* | *Sexual Abuse* | *Others* |
|---|---|---|---|---|---|
| 2012 | 531,241 | 15,705 | 124,544 | 62,936 | 57,880 |
| 2011 | 531,413 | 15,074 | 118,825 | 61,472 | 60,839 |
| 2010 | 538,557 | 16,209 | 121,380 | 63,527 | 126,029 |
| 2009 | 543,035 | 16,837 | 123,599 | 65,964 | 66,487 |
| 2008 | 539,322 | 16,783 | 122,350 | 69,184 | 68,498 |

[1]https://www.acf.hhs.gov/

**Types of Abuse**

| *Neglect or Deprivation of Necessities* | *Medical Neglect* | *Physical Abuse* | *Sexual Abuse* | *Other* |
|---|---|---|---|---|
| A type of maltreatment that refers to the failure by the caregiver to provide needed age-appropriate care although financially able to do so or offered financial or other means to do so. | A type of maltreatment caused by failure by the caregiver to provide for the appropriate health care of the child although financially able to do so, or offered financial or other means to do so. | Type of maltreatment that refers to physical acts that caused or could have caused physical injury to a child. | A type of maltreatment that refers to the involvement of the child in sexual activity to provide sexual gratification or financial benefit to the perpetrator, including contacts for sexual purposes, molestation, statutory rape, prostitution, pornography, exposure, incest, or other sexually exploitative activities. | The state coding for this field is not one of the codes in the NCANDS record layout. |

The National Survey of Children's Exposure to Violence (NatSCEV), a comprehensive telephone survey conducted in 2008, indicates a maltreatment rate of 10.2 percent, which is significantly higher than those based on official reports to child protective services (CPS).[15] NatSCEV researchers found that "overall, more than 1 in 10 children surveyed (10.2 percent) suffered some form of maltreatment (including physical other than sexual assault, psychological or emotional abuse, child neglect, and custodial interference) during the past year and nearly 1 in 5 (18.6 percent) during their lifetimes."[16] Additionally, 6.1 percent (1 in 16 children) were victimized sexually.[17]

Differences in definitions and age range account for variations between studies. While specific figures can be debated, there is general consensus that the number of officially reported cases of child maltreatment represent just a fragment of total occurrence.

An epidemiological study in North Carolina and South Carolina was undertaken to ascertain with an alternative strategy the incidence and types of child maltreatment. The study involved surveying mothers in both states regarding their own and their partners' parenting behaviors used to discipline their children, as well as their knowledge of their children's sexual victimization. Self-reporting revealed significantly higher rates of child maltreatment than were indicated by the official data.

> Nearly 11 of 1,000 children were reported by their mothers as having been sexually victimized within the past year. The incidence of physical abuse determined with maternal self-reports was 40 times greater than that of official child physical abuse reports, and the sexual abuse incidence was 15 times greater. For every 1 child who sustains a serious injury as a result of shaking, an estimated 150 children may be shaken and go undetected.[18]

Based on their findings, the authors of the Carolinas study arrived at a clear conclusion: "Official statistics underestimate the burden of child maltreatment. Supplemental data obtained with alternative strategies can assist policymakers and planners in addressing needs and services within communities and states. These data support the need for continued interventions to prevent maltreatment."[19]

National statistics clearly identify the most vulnerable population segment. The recent data confirm a special vulnerability of the youngest children. In 2011, 35 percent of victims were younger than 3 years old, with the victimization rate being the highest for children under 1.[20] In

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[15] Finkelhor, D. et al. *Children's Exposure to Violence: A Comprehensive National Survey.* Washington, D.C.:U.S. Department of Justice, Office of Justice Programs, Office of juvenile Justice and Delinquency Prevention, October 2009, available at https://www.ncjrs.gov/pdffiles1/ojjdp/227744.pdf (accessed January 2, 2014).
[16] Ibid.
[17] Ibid.
[18] Theodore, Andrea D. et al. "Epidemiologic Features of the Physical and Sexual Maltreatment of Children in the Carolinas." *Pediatrics.* Vol. 115. No. 3. March 2005, available at http://pediatrics.aappublications.org/content/115/3/e331.full.pdf+html (accessed June 25, 2014).
[19] Ibid.
[20] U.S. Department of Health and Human Services, Children's Bureau. *Child Maltreatment 2011*, available at http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment (accessed

2012, victims in the first year of age also had the highest rate of victimization at 21.9 per 1,000 children of the same age in the general population.[21] The youngest children also constitute a vast majority of child maltreatment fatalities, with over 80 percent occurring among children younger than age 4.[22]

It is estimated that in 2011, 1,750 children died from child maltreatment.[23] In 2012, the number of fatalities from abuse and neglect was estimated at 1,640, with nearly three-quarters of those (70.3%) younger than 3 years old.[24] Of all child maltreatment fatalities in 2011, "71% experienced neglect either exclusively or in combination with another form of maltreatment and 48% experienced physical abuse either exclusively or in combination with another form of maltreatment."[25] In 2012, four-fifths (80.0 percent) of child fatalities were caused by one or both parents.[26]

Along with the data on child abuse victims' age and causes of fatalities, a factor that needs to be considered in order to make prevention more effectual is that nationwide, "approximately three quarters of victims in 2011 had no prior victimization for each year from 2007-2011."[27] This highlights the importance of primary prevention.

During 2012, child protective services provided prevention services to approximately 3.2 million children.[28] "Reasons for the provision of services may include

1) preventing future instances of child maltreatment and
2) remedying conditions that brought the children and their family to the attention of the agency."[29]

Based on data from 48 states, during 2012, 1,192,635 children (60.9 percent of victims and 29.6 percent of nonvictims) received postresponse services from a CPS agency.[30]

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December 27, 2013).

[21] U.S. Department of Health and Human Services, Children's Bureau. *Child Maltreatment 2012,* available at http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf (accessed June 19, 2014).

[22] Ibid.

[23] U.S. Department of Health and Human Services, Children's Bureau. *Child Maltreatment 2011*, available at http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment (accessed December 27, 2013).

[24] U.S. Department of Health and Human Services, Children's Bureau. *Child Maltreatment 2012,* available at http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf (accessed June 19, 2014).

[25] U.S. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention. *Child Maltreatment: Facts at a Glance 2013*, available at http://www.cdc.gov/violenceprevention/pdf/cm-data-sheet--2013.pdf (accessed December 27, 2013).

[26] U.S. Department of Health and Human Services, Children's Bureau. *Child Maltreatment 2012,* available at http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf (accessed June 19, 2014).

[27] Ibid.

[28] U.S. Department of Health and Human Services, Children's Bureau. *Child Maltreatment 2012,* available at http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf (accessed June 19, 2014).

[29] Ibid.

[30] Ibid.

According to a recent report by Bruce Lesley, president of the child advocacy organization First Focus, and Dr. Glenn Flores, professor of pediatrics at the University of Texas Southwestern, one child dies every seven hours from abuse or neglect.[31] Among the specific steps that the authors of the report urge the federal government to take in order to improve child well-being in the U.S. is cutting child maltreatment deaths in half by 2018.[32]

### *Occurrence in Pennsylvania*

In Pennsylvania, 26,664 reports of suspected child and student abuse were made in 2012, which represents a 9 percent increase in the total number of reports received compared to the previous year and the highest number of reports in the history of the Commonwealth.[33] Beverley D. Mackereth, Secretary of the Pennsylvania Department of Public Welfare (DPW), perceived "a surge in awareness of and conversations around child abuse in Pennsylvania" as "a very positive step towards curbing and reporting abuse."[34] 2013 brought a further increase: "In 2013, ChildLine, Pennsylvania's child abuse hotline, registered 26,944 reports of suspected abuse or neglect; an increase of 280 reports from the previous year."[35] Almost 13 percent of these reports (3,425) were substantiated by the state.[36] In 2012, 13.4 percent of all reports of suspected child and student abuse, or 3,565 reports, were substantiated.[37] Both in 2012 and in 2013, approximately 10 out of every 1,000 children living in Pennsylvania were reported as victims of suspected abuse while approximately 1 out of every 1,000 were found to be victims of abuse as a result of subsequent investigations.[38] The substantiation rate for 2012 was 1 percent lower than for 2011.[39] This tendency continued in 2013. Thirty-three Pennsylvania children died from abuse in 2012, which is one child less than in 2011.[40] The number of fatalities was higher in 2013, when 38 Pennsylvania

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[31] Holland, Gale. "Child Poverty in U.S. Is at Highest Point in 20 Years, Report Finds." *LA Times*. October 23, 2014, available at http://www.latimes.com.science.sciencenow/la-sci-sn-child-poverty-20141021-story.html (accessed October 23, 2014.

[32] Ibid.

[33] Pennsylvania Department of Public Welfare. *Annual Child Abuse Report 2012*, available at http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/p_034463.pdf (accessed December 30, 2013).

[34] "2012 Annual Child Abuse Report Notes Increase in Reports of Suspected Abuse." *PRNewswire-USNewswire*. June 3, 2013, available at http://www.prnewswire.com/news-releases/2012-annual-child-abuse-report-notes-increase-in-reports-of-suspected-abuse-209974631.html (accessed December 30, 2013).

[35] Pennsylvania Department of Public Welfare. *Annual Child Abuse Report 2013*, available at http://www.dpw.state.pa.us/cs/webcontent/documents/report/c_086251.pdf (accessed June 18, 2014).

[36] Ibid.

[37] Pennsylvania Department of Public Welfare. *Annual Child Abuse Report 2012*, available at http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/p_034463.pdf (accessed December 30, 2013).

[38] Pennsylvania Department of Public Welfare. *Annual Child Abuse Report 2012*, available at http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/p_034463.pdf (accessed December 30, 2013).
Pennsylvania Department of Public Welfare. *Annual Child Abuse Report 2013*, available at http://www.dpw.state.pa.us/cs/webcontent/documents/report/c_086251.pdf (accessed June 18, 2014).

[39] Pennsylvania Department of Public Welfare. *Annual Child Abuse Report 2012*, available at http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/p_034463.pdf (accessed December 30, 2013).

[40] Ibid.

children died from abuse.[41] "The most common allegations in fatality incidents in Pennsylvania were lack of supervision (alleged in 32 percent of fatalities) and "other physical injuries" (26 percent of fatalities)."[42] Five of the ten fatalities included in the "other physical injuries" category were gunshot wounds inflicted by fathers in murder/suicide incidents.[43]

The newly released data, especially the highest number of the suspected child abuse reports in Pennsylvania history, has, understandably, gained a lot of attention. "This marks the second year in a row that we have set a new record in Pennsylvania for suspected reports of child abuse – a trend that quite likely has been driven in part by the increased public awareness about child abuse in the wake of the Sandusky scandal and other high-profile abuses cases," said Joan Benso, president and CEO of the child advocacy group Pennsylvania Partnership for Children.[44] In her statement accompanying the release of the *Annual Child Abuse Report 2013*, the DPW Secretary Beverly Mackereth said, "We believe the increased awareness on the issue and information available on where to go to report suspected abuse has successfully empowered people to speak up."[45] Most experts and child advocates agree that increased reporting reflects increased public awareness and enhanced training for mandatory reporters and from this perspective can be viewed as a positive sign; in effect, it is an indicator of success. Others, however, point to persistent economic difficulties and growing heroin use as two factors that might have contributed to higher child abuse incidence as both poverty and substance abuse are known risk factors for child maltreatment.

An experienced child protection advocate, Cathleen Palm, pointed out the disconcerting fact that 9 percent of substantiated reports of abuse were cases of "re-abuse."[46] While the previous cases of maltreatment might have happened in a different county and might have been committed by a different perpetrator, the significant number of substantiated "re-abuse' cases may also indicate the need for better tertiary prevention. Disturbingly, "of the 38 fatalities, over a third of children and/or families involved (37 percent) had previous involvement with County Children and Youth Agency (CCYA) but had no case open with CCYA at the time of the fatality."[47] Of the near-fatality cases, half involved children/families never known to CCYA.[48] The data presented in the latest Pennsylvania annual child abuse report will, obviously, continue to be a subject of further scrutiny and analysis.

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[41] Pennsylvania Department of Public Welfare. *Annual Child Abuse Report 2013*, available at http://www.dpw.state.pa.us/cs/webcontent/documents/report/c_086251.pdf (accessed June 18, 2014).
[42] Ibid.
[43] Ibid.
[44] Giammarise, Kate. "State Report Sees Increase in Suspected Child Abuse Cases". *The Pittsburgh Post-Gazette.* June 6, 2014.
[45] Ibid.
[46] Ibid.
[47] Pennsylvania Department of Public Welfare. *Annual Child Abuse Report 2013*, available at http://www.dpw.state.pa.us/cs/webcontent/documents/report/c_086251.pdf (accessed June 18, 2014).
[48] Ibid.

| **Table 2:** PENNSYLVANIA | | | | | |
|---|---|---|---|---|---|
| 2008 - 2012, Child Abuse & Neglect by Type[1] | | | | | |
| *Year* | *Neglect* | *Medical Neglect* | *Physical Abuse* | *Sexual Abuse* | *Others* |
| 2012 | 113 | 110 | 1,096 | 2,261 | 18 |
| 2011 | 114 | 74 | 1,056 | 2,144 | 28 |
| 2010 | 99 | 98 | 1,178 | 2,328 | 42 |
| 2009 | 152 | 112 | 1,332 | 2,512 | 42 |
| 2008 | 157 | 126 | 1,276 | 2,502 | 47 |
| [1]https://www.acf.hhs.gov/ | | | | | |

### *Treatment versus Prevention: The Cost Factor*

In addition to devastating human costs, child abuse and neglect put a tremendous economic burden on society: the total lifetime cost of child maltreatment is estimated at $124 billion a year.[49] Using a different approach, a study commissioned by Prevent Child Abuse America calculated the costs for all current and previous victims for a single year. The report prepared by two leading researchers from the University of Pennsylvania estimated that American taxpayers would pay $80 billion to address child maltreatment in 2012.[50] Total costs are comprised of direct costs involved in immediate response to cases of child abuse and neglect (medical treatment, mental health care, child welfare system services, law enforcement) and indirect costs, associated with the long-term impact of maltreatment on children (early intervention to manage developmental delays, special education, general and mental health care across the lifespan, juvenile delinquency and adult criminal justice systems, adult homelessness, lost worker productivity). These estimates are believed to be conservative as the authors used a conservative interpretation of cost data and as there are "many additional categories of costs, beyond those included in the report, that are difficult or impossible to estimate."[51] Estimated costs for Pennsylvania in 2012 dollars amounted to 3,770,883,000.[52]

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[49] U.S. Centers for Disease Control and Prevention. *Child Maltreatment Prevention*, available at http://www.cdc.gov/violenceprevention/childmaltreatment/index.html (accessed December 27, 2013).
[50] Gelles, Richard J. and Staci Perlman. *Estimated Annual Cost of Child Abuse and Neglect.* Chicago, IL: Prevent Child Abuse America, 2012, available at https://www.preventchildabusenc.org/assets/preventchildabusenc/files/$cms$/100/1299.pdf (accessed January 6, 2014).
[51] Harding, Kathryn. *Annual Cost of Child Abuse & Neglect – State Estimates.* Chicago, IL: Prevent Child Abuse America, 2012, available at https://www.preventchildabusenc.org/assets/preventchildabusenc/files/$cms$/100/1300.pdf (accessed January 6, 2014).
[52] Ibid.

It is obvious that preventing child maltreatment from happening would not only save boys and girls from suffering and, in some cases, even death, but would also bring considerable economic and social benefits to society as a whole. The authors of "The Economic Burden of Child Maltreatment in the United States and Implications for Prevention" finish their study with a conclusion that "compared with other health problems, the burden of child maltreatment is substantial, even after conservative assumptions are used, indicating the importance of prevention efforts to address the high prevalence of child maltreatment."[53] Acknowledging the fact that the evidence base for proving the effectiveness of strategies to address child maltreatment is limited, the authors estimate that "a promising array of prevention and response programs have great potential to reduce the economic burden of child maltreatment."[54] To be successful and to bring positive results consistently, effective programs such as the Nurse-Family Partnership, Early Start, Triple P and others must be used in full, with fidelity, with ongoing monitoring and sustained resourcing. The authors of the cost study conclude that if these requirements are fulfilled, "given the substantial economic burden of child maltreatment, the benefits of prevention will likely outweigh the costs for effective programs."[55]

A study conducted by the Michigan Children's Trust Fund established that the costs of offering a comprehensive parent education program or a home visiting program to every family having its first baby in the state of Michigan would be significantly smaller than the funds required for child abuse/neglect treatment. A hybrid prevention program, where every Michigan family having its first child received one of the two services, would cost just a minor portion of the potential cost of abuse.[56] The Michigan Children's Trust Fund researchers conducted two cost-benefit analyses with an interval of ten years. Based on modest estimates of the program effectiveness, their findings indicated that if current prevention programs could reduce child maltreatment by 20 percent on average, they would be "extremely cost effective."[57] In fact, based on their comparison of the estimated child abuse costs and the costs of prevention programs, the authors stated: "The costs of prevention programming vary depending on the intensity of the services offered but are still just a fraction of the child abuse treatment costs. Cost savings ranged from 96% to 98% depending on the prevention model tested."[58]

A study on cost-effective investments in children, performed by the Brookings Institution, identified nurse home-visiting programs and programs that reduce the incidence of teenage pregnancy as two areas where there is sufficient evidence of positive outcomes and sound benefit-cost ratios to merit expanded funding even in a time of fiscal austerity.[59] The Brookings Institution researchers base their recommendation on the postulate that "the prudence of investment in a

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[53] Fang, Xiangming et al. "The Economic Burden of Child Maltreatment in the United States and Implications for Prevention." *Child Abuse and Neglect*. Vol. 36. 2012. P. 163. The article is also available at http://www.sciencedirect.com/science/article/pii/S0145213411003140 (accessed January 6, 2014).

[54] Ibid.

[55] Ibid.

[56] Caldwell, Robert A. and Ishmael Noor. *The Costs of Child Abuse vs. Child Abuse Prevention: A Multi-year Follow-up in Michigan*, available at https://www.msu.edu/~bob/cost2005.pdf (accessed September 9, 2014).

[57] Ibid.

[58] Ibid.

[59] Isaacs, Julia B. *Cost-Effective Investments in Children*. Washington, D.C. The Brookings Institution, January 2007, available at http://www.brookings.edu/~/media/research/files/papers/2007/1/01childrenfamilies%20isaacs/01childrenfamilies_isaacs.pdf (accessed June 27, 2014).

particular program depends to a large extent on whether the program has been demonstrated to have positive outcomes that result in long-term economic benefits that are larger than the program's initial costs."[60] Programs that have met the test of proven cost-effectiveness deserve primary consideration though cost-effectiveness is not the only factor that should be taken into account while investing in a particular program or policy.

### *Selection and Implementation of Quality Programs*

Effective prevention requires identifying and implementing quality programs. Admittedly, "the effectiveness of prevention services is inherently difficult to demonstrate. Successful prevention programs prevent harm from occurring, and success, as a result, must be measured by showing that a service contributed to an absence of harm – a challenging result to prove."[61] Nonetheless, new scientific discoveries in brain development, outcome research on prevention programs, and growing body of experience in program testing and implementation can assist policymakers and community leaders in selecting the most promising policies and programs and using them to the best advantage.

In its recommendations to the state lawmakers, based on the cost-benefit analysis of prevention and early intervention programs for youth, the Washington State Institute for Public Policy (WSIPP) suggests investing in research-proven "blue chip" prevention and early intervention programs and avoiding spending money on programs where there is little evidence of program effectiveness.[62] One of the pioneers in studying and evaluating evidence- and research-based prevention programs in child welfare, juvenile justice, and mental health systems, WSIPP suggested detailed, carefully crafted definitions of the terms "evidence-based," "research-based," "promising practice," and "cost-beneficial" to avoid their loose and potentially misleading usage.

These suggested definitions are as follows:

> Evidence-based: A program or practice that has been tested in heterogeneous or intended populations with multiple randomized and/or statistically-controlled evaluations, or one large multiple-site randomized and/or statistically controlled evaluation, where the weight of the evidence from a systematic review demonstrates sustained improvements in at least one of the following outcomes: child abuse, neglect, or the need for out of home placement; crime; children's mental health; education; or employment. Further, "evidence-based" means a program or practice that can be implemented with a set of procedures to allow

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[60] Ibid.

[61] Pew Charitable Trusts. *Time for Reform: Investing in Prevention: Keeping Children Safe at Home.* Philadelphia, PA; Washington, D.C., 2007, available online at http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/Fpster_care-refprm/time_for_reform.pdf (accessed June 3, 2014).

[62] Aos, Steve et al. *Benefits and Costs of Prevention and Early Intervention Programs for Youth*. Olympia, WA: Washington State Institute for Public Policy, 2004, available at http://www.wsipp.wa.gov/ReportFile/881/Wsipp_Benefits-and-Costs-of-Prevention-and-Early-Intervention-Programs-for_Youth_Summary-Report.pdf (accessed December 11, 2013).

successful replication in Washington and, when possible, has been determined to be cost-beneficial.

Research-based: A program or practice that has been tested with a single randomized and/or statistically controlled evaluation demonstrating sustained desirable outcomes, or where the weight of the evidence from a systematic review supports sustained outcomes as identified in the term "evidence-based" in RCW (the above definition) but does not meet the full criteria for "evidence-based."

Promising practice: A program or practice that, based on statistical analyses or a well-established theory of change, shows potential for meeting the "evidence-based" or "research-based" criteria, which could include the use of a program that is evidence-based for outcomes other than the alternative use.

Cost-beneficial: A program or practice where the monetary benefits exceed costs with a high degree of probability according to the Washington State Institute for Public Policy.[63]

According to the WSIPP criteria, programs that do not achieve at least 75 percent chance of positive net present value do not pass the benefit-cost test.[64]

Detailed and rigorous definitions similar to those proposed by the Washington State Institute for Public Policy can assist other states, including Pennsylvania, in their program selection process.

The WSIPP researchers also remind policymakers that "successful prevention strategies require more effort than just picking the right program."[65] To achieve "real-world" success even with programs that have already demonstrated their effectiveness, "close attention must be paid to quality control and adherence to original program designs."[66]

> Persistent discrepancies in effectiveness between model programs and many scaled-up service systems call for greater attention to the importance of quality control and the need for ongoing investigation of impacts in the implementation of large-scale programs.[67]

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[63] Washington State Institute for Public Policy. *Inventory of Evidence-Based, Research-Based, and Promising Practices for Prevention and Intervention Services for Children and Juveniles in Child Welfare, Juvenile Justice, and Mental Health Systems*, available at http://www.wsipp.wa.gov/ReportFile/1552/Wsipp_Updated-Inventory-of-Evidence-based-Research-based-and-promising-practices-for-Prevention-and-Intervention-Services-for-Children-and-Juveniles-in-the-Child-Welfare-Juvenile-Justice-and-Mental-Health-Systems_Inventory.pdf (accessed May 23, 2014).

[64] Ibid.

[65] Aos, Steve et al. *Benefits and Costs of Prevention and Early Intervention Programs for Youth*. Olympia, WA: Washington State Institute for Public Policy, 2004, available at http://www.wsipp.wa.gov/ReportFile/881/Wsipp_Benefits-and-Costs-of-Prevention-and-Early-Intervention-Programs-for_Youth_Summary-Report.pdf (accessed December 11, 2013).

[66] Ibid.

[67] Center on the Developing Child, Harvard University. *A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children*, available at

The Child Welfare League of America (CWLA) has declared protection "from abuse, neglect, maltreatment, exploitation, and abduction" one of the essential children's rights and encourages the use of evidence- and practice-based programs. It its "National Blueprint for Excellence in Child Welfare," CWLA states: "Entities should develop and implement only those programs and practices that are based upon the best available evidence."[68] CWLA also recommends further research and close collaboration between researchers and practitioners, who "should work together effectively to improve knowledge of what works in helping children, youth, and families to flourish;" measuring outcomes; and making improvements informed by evidence when a program's performance is not meeting expectations.[69]

Even when a program's effectiveness has been established, implementing it on a larger scale or utilizing it in a different community presents further challenges. Public/Private Ventures (P/PV), a national leader in creating and strengthening programs that improve lives in low-income communities, which has a wide experience in the use and strategic expansion of evidence-based models, attests that "implementing proven programs with fidelity to the established model can reproduce the positive results achieved in original research trials – and ensure a solid return on investment."[70]

In its report drawing on P/PV's seven years of working with Pennsylvania's Nurse-Family Partnership, P/PV researchers underscore that "the replication of evidence-based programs can be an enormous challenge, even for highly defined and effective programs like Nurse-Family Partnership," and "ensuring fidelity to the established program model, while allowing for local innovation, is paramount to success."[71] The most integral part of replicating a proven model, according to the P/PV, is "identifying its "essential elements" – ingredients both functional and structural that are central to the program's effectiveness – and then ensuring that these elements are strictly adhered to during implementation."[72] When evidence-based programs are replicated and expanded statewide, they often fail to yield the anticipated outcomes and cost savings demonstrated in research trials.

To ensure success, P/PV determined specific structures and processes required for the effective replication of a program's good results. Based on PP/V's experience, the following elements must be well defined before a program considers replication:

- participant characteristics (demographics, etc.);
- intensity and duration of programming;

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http://developingchild.harvard.edu/resources/reports_and_working_papers/policy_framework/ (accessed January 14, 2014).

[68] Child Welfare League of America. *CWLA National Blueprint for Excellence in Child Welfare*, available at http://www.cffutures.org/files/CWLA.pdf (accessed June 20, 2014).

[69] Ibid.

[70] Collins Stavrakos, Jennifer, Geri Summerville and Laura E. Johnson. *Growing What Works: Lessons Learned from Pennsylvania's Nurse-Family Partnership Initiative*. Philadelphia, PA; New York, N.Y; Oakland, CA: Public/Private Ventures, 2009, available at http://www.socialimpactexchange.org/sites/www.socialimpactexchange.org/files/Growing%20What%20Works.pdf (accessed June 27, 2014).

[71] Ibid.

[72] Ibid.

- content and flexibility of activities;
- key transition points for participants;
- presence and types of requirements and incentives for participation;
- performance expectations for participants and staff;
- staff qualifications and configuration;
- characteristics of the organizations that operate the program; and
- the program's relationships with other organizations or agencies.[73]

Along with answering questions regarding the program's effectiveness, the timeframe for demonstrable results and the functionality of a universal data collection system, a careful study of the above-mentioned elements prior to the program expansion is a key to success.

### *Best Practice Elements That Define Successful Interventions*

Many years of a variety of child abuse prevention efforts and ongoing research have made it possible to establish a set of practice principles that have been found effective, a set of best practice elements that lie at the core of effective interventions. The list of such best practice standards compiled by the Child Welfare Information Gateway (CWIG) includes seven principles. CWIG recommends that programs maintain these best practice fundamentals to help ensure successful outcomes:

- A strong theory of change that identifies specific outcomes and clear pathways for addressing these core outcomes, including specific strategies and curriculum content;
- A recommended duration and dosage or clear guidelines for determining when to discontinue or extend services that are systematically applied to all those enrolled in services;
- A clear, well-defined target population with identified eligibility criteria and a strategy for reaching and engaging this target population;
- A strategy for guiding staff in balancing the task of delivering program content while being responsive to a family's cultural beliefs and immediate circumstances;
- A method to train staff on delivering the model with a supervisory system to support direct service staff and guide their ongoing practice;
- Reasonable caseloads that are maintained and allow direct service staff to accomplish core program objectives;
- The systematic collection of information on participant characteristics, and participant service experiences to ensure services are being implemented with fidelity to the model, program intent and structure.[74]

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[73] Ibid.

[74] Child Welfare Information Gateway. *Child Maltreatment Prevention: Past, Present, and Future*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. 2011, available at https://www.childwelfare.gov/pubs/issue_briefs/cm_prevention.cfm (accessed December 23, 2013).

Child Trends, a respected nonprofit, nonpartisan research center focused on well-being of children and youth, proposed the following principles to guide public policies aimed at improving outcomes for children:

- **Start early**. Interventions that start early have the largest and most sustained impacts on high-risk children. There is considerable evidence of significant and sustained impacts from intensive, high-quality early childhood programs that begin at or shortly after birth.
- **Stay the course.** Staying the course means, among other things, being willing to wait for results, recognizing that improvements take time.
- **Focus on the highest-risk, hardest-to-reach children and families**. The children and families most in need of support are also often the least likely to seek out services. Yet many of the most effective interventions have their strongest impacts with just this population. Therefore, reaching and engaging these families is an important task.
- **Acknowledge the value of positive relationships.** Children need caring, consistent adults in their lives. For policies and programs, this means valuing the staff who work with children; the staff needs good working conditions and adequate training as poorly trained staff and high turnover undermine even the best programs and policies.[75]

The principles outlined by Child Trends on the basis of accumulated research and evaluation encompass a variety of children and youth programs, and they are useful in consideration of prevention programs in particular.

Child Trends also identified essential elements of effective programs and policies for children and youth. Such programs would

- Target carefully the population of children and youth in need of intensive intervention;
- Identify the outcomes to be achieved;
- Reproduce approaches that have been evaluated and found to be effective; and
- Implement these approaches fully and carefully.[76]

In unison with other experts in the field, Child Trends leaders prefer the outcome approach to the more traditional measuring the types of services delivered or the number of children served, but they also remind policymakers, policy providers, and the public that they must have clear and realistic expectations regarding a program outcome and distinguish between short-, medium-, and long-term outcomes sought by a particular program or policy.[77]

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[75] Emig, Carol and Kristin Anderson Moore. *Evidence-based Programs and Policies for Children and Youth*. In *Big Ideas for Children: Investing in Our Nation's Future.* Washington, D.C.: First Focus, 2008. P. 220-221, available at http://www.firstfocus.net/sites/default/files/r.2008-9.15.ff_.pdf (accessed December 18, 2013).
[76] Ibid.
[77] Ibid.

In other words, program evaluation needs to be based on quality of outcomes relative to expectations and goals, rather than on more easily quantified measures such as the number of people served per dollar of funding. Policymakers must use evaluation methods best suited for the evaluation, rather than the methods that are most accessible or familiar.

Additionally, Child Trends underscores that accurate and faithful implementation is critical. Oftentimes, a carefully designed program that has been proven effective fails to produce the anticipated results in a different setting because not all of its original components have been retained. An attempt to save money by omitting certain elements or replacing them with cheaper alternatives is counterproductive: "it is more cost-effective to provide a program that works, even if it is more costly, than to provide a cheap program that has no impact."[78]

### *Effective Prevention Strategies and Emerging Change*

A wide range of prevention strategies, from reducing risk factors for parents or children at highest risk to strengthening protective factors for both parents and children, from general public awareness campaigns to carefully targeted interventions, from parent education and support groups to home visitation, have demonstrated measurable positive results: reduction in child abuse and neglect reports and other child safety outcomes such as reported injuries and accidents. Nonetheless, it is important to remember that no one single approach or one particular program can guarantee universal success. The Child Welfare Information Gateway reminds policymakers and community leaders that "finding the correct leverage point or pathway for change for a specific family, community, or State requires careful assessment in which the final prevention plan is best suited to the needs and challenges presented by each situation." [79]

Looking at the future of the prevention field in light of the accumulated data as well as current demographic and fiscal realities, CWIG identified the following key challenges and opportunities states and communities should consider when deciding how to move forward:

- Improving the ability to reach all those at risk
- Determining how best to intervene with diverse ethnic and cultural groups
- Identifying ways to use technology to expand provider-participant contact and service access
- Achieving a balance between enhancing formal services and strengthening informal supports.[80]

Based on its review of current prevention efforts and the future outlook, CWIG highlights a critical factor: "Identifying and testing a range of innovations that address all of these concerns and alternatives is important. Equally challenging, however, is how these efforts are woven into

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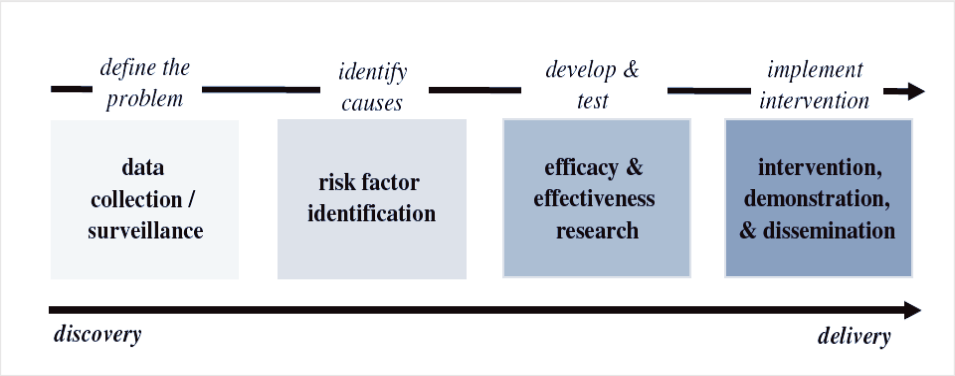
[78] Ibid.
[79] Child Welfare Information Gateway. *Child Maltreatment Prevention: Past, Present, and Future*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. 2011, available at https://www.childwelfare.gov/pubs/issue_briefs/cm_prevention.cfm (accessed December 23, 2013).
[80] Ibid.

effective prevention systems at local, state, and national levels."[81] One of the most important policy recommendations that CWIG makes is that "building on a public health model of integrated services, child abuse prevention strategies may be more efficiently allocated by embedding such services within a universal system of assessment and support." [82]

Illuminating results emerged from a project that used a public health approach to study child maltreatment by linking child protective service records and population based vital records. The 2011 study by the Center for Social Services Research at the University of California at Berkeley compared two million California birth records with over 200,000 records from the state children and youth service. The central postulate at the foundation of the study was that "a key feature of a 'public health approach' is the ability to utilize surveillance data both as a tool for the identification and tracking of the health threat at the population level and as a means of determining risk and protective factors among subgroups, information that can be used to develop targeted prevention and intervention programmes."[83] Experts agree that administrative child protective services data, often used to study victims of child maltreatment are incomplete and serve as a poor source of surveillance information. An important piece of information missing is "information on aetiological risk factors that predate a first report of maltreatment, or outcomes following contact with child protective services, both of which could be used to inform and improve decision-making."[84]

Within a public health framework, the study of child abuse and neglect can be conceptualized as a four-step process:

- Step One: Surveillance;
- Step Two: Identification of Risk and Protective Factors;
- Step Three: Development and Testing of Interventions;
- Step Four: Implementation of Effective Prevention and Control Strategies.




[81] Ibid.
[82] Ibid.
[83] Putnam-Hornstein, Emily et al. "A Public Health Approach to Child Maltreatment Surveillance: Evidence from a Data Linkage Project in the United States." *Child Abuse Review*. 2011. Vol. 20. Pp. 256-273, published online in Wiley Online Library (wileyonlinelibrary.com) DOI: 10.1002/car.1191.
[84] Ibid.

The authors emphasize that dissemination is a key feature of the final step and that continued surveillance is required over time: "Within this framework, the cycle returns to surveillance upon the widespread adoption of a prevention programme in order to assess its efficacy across the full population."[85]

Advancing a public health approach to the study of child maltreatment by providing critical surveillance information in the form of child protective service records linked to population-based vital records, the Berkeley researchers assert that "linkages with universally collected data at birth serve to aid in the identification of those groups that are at greatest risk and stand to benefit the most from targeted services."[86] Identification of such groups, with subsequent proper targeting, is critically important for effective prevention.

The public health approach is gaining more and more acclaim due to better understanding of causes and consequences of child maltreatment and to the general shift from the reactive to proactive approach to the problem. The emphasis now is on "preventing child maltreatment *before* an incident of abuse or neglect occurs."[87] In his spearheading article "A New Way of Thinking About Child Abuse and Neglect Prevention," President and CEO at Prevent Child Abuse America, James M. Hmurovich, declares, "The path to effective policy change involves a 180-degree shift in thinking – from policies that deal with abuse and neglect after they take place, to policies that focus on preventing their occurrence."[88] Hmurovich outlines six steps that must be taken for the U.S. "to embrace prevention of child abuse and neglect in a more effective and meaningful manner":

- Step One: Help the public recognize and understand the connection between child abuse and neglect and other social ills.
- Step Two: Establish a national child abuse and neglect prevention policy.
- Step Three: Analyze existing funding sources and develop fiscal policies to support activities that prevent child abuse and neglect.
- Step Four: Cultivate multiple and diverse prevention champions to rally the public support necessary to change policies to prevent child abuse and neglect.
- Step Five: Identify and strengthen governmental planning and quality assurance activities and support a national policy on child abuse and neglect prevention.
- Step Six: Ensure effective state and local planning and implementation of child abuse and neglect prevention strategies.[89]

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[85] Ibid.
[86] Ibid.
[87] Zimmerman, F. and James A. Mercy. "A Better Start: Child Maltreatment Prevention as a Public Health Priority." *Zero to Three.* May 2010, available at http://www.zerotothree.org/maltreatment/child-abuse-neglect/30-5-zimmerman.pdf (accessed December 30, 2013).
[88] Hmurovich, James M. *A New Way of Thinking About Child Abuse and Neglect Prevention.* In *Big Ideas for Children: Investing in Our Nation's Future.* Washington, D.C.: First Focus, 2008. P. 121, available at http://www.firstfocus.net/sites/default/files/r.2008-9.15.ff_.pdf (accessed December 18, 2013).
[89] Ibid.

Hmurovich's plan captures the growing shift in the child protection field when he says, "The central question that policy makers must focus on is: What can be done to move policy to prevention, so all children have the opportunity to grow up in a healthy environment that prepares them for adulthood?"[90]

Hmurovich, along with other researchers and child advocates, states that out national policy should be guided by a belief that child abuse and neglect are preventable.[91] Based on this belief and the national policy that reflects it, states should develop and implement "local coordinated service systems that promote healthy child, family, and community development."[92]

Implementation of a national child abuse and neglect prevention strategy necessarily involves reassessment and realignment of funding streams. The service system for children and families must fully incorporate services that focus on preventing child abuse and neglect. As traditionally, children and families' services operated in a reactive mode, "the challenge is how to transform the current service system that responds to child abuse and neglect after it happens into coordinated systems that provide services to all families before child abuse and neglect occur."[93]

The transformation of the existing system of social services for children and families should go hand in hand with public education efforts to change social norms and behaviors, with a wide array of prevention activities that extend beyond providing services to individual families. The National Center for Infants, Toddlers, and Families, Zero to Three, urges for a "broad-based, communitywide approach," which is often the purview of public health systems.[94] "A public health approach to child maltreatment would address the range of conditions that place children at risk for abuse or neglect, not just at the individual and family levels but also at the community and societal levels."[95] Population-based strategies, community-wide prevention efforts are increasingly perceived as a way to deal with child maltreatment.

Cathy Utz, Acting Deputy Secretary of the Pennsylvania Department of Public Welfare's Office of Children, Youth and Families, is exactly in tune with the national trend when she says that child abuse should be considered a community health problem rather than a DPW issue.[96]

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[90] Ibid. P. 122.
[91] Ibid. P. 124.
[92] Ibid.
[93] Ibid.
[94] Zimmerman, F. and James A. Mercy. "A Better Start: Child Maltreatment Prevention as a Public Health Priority." *Zero to Three.* May 2010, available at http://www.zerotothree.org/maltreatment/child-abuse-neglect/30-5-zimmerman.pdf (accessed December 30, 2013).
[95] Ibid.
[96] Meeting with the Joint State Government Commission staff on January 9, 2014.

### *The CDC Approach*

The Centers for Disease Control and Prevention (CDC) has determined its strategic direction for child maltreatment prevention as "preventing child maltreatment through the promotion of safe, stable, and nurturing relationships between children and caregivers."[97] The CDC's child maltreatment prevention program is coordinated by the Division of Violence Prevention (DVP) within the National Center for Injury Prevention and Control (NCIPC). The DVP's public health approach to violence prevention emphasizes primary prevention, a commitment to a rigorous science base, a cross-cutting perspective encompassing several disciplines, and a population approach.[98]

CDC regards safe, stable, and nurturing relationships (SSNRs) between children and their parents/caregivers as "the antithesis of maltreatment and other adverse exposures that occur during childhood and compromise health over the lifespan".[99] The three overlapping but distinct dimensions of SSNRs (safety, stability, and nurture) represent important aspects of the social and physical environments that protect children and promote their optimal development. Each of them can be thought of "as being on the positive end of a continuum that extends from safe to neglectful and violent relationships/environments, from stable to unpredictable and chaotic relationships/environments, and from nurturing to hostile/cold or rejecting relationships/environments".[100]

There is substantial evidence that promoting SSNRs can reduce the incidence of child maltreatment and can thus be considered a comprehensive prevention strategy. SSNRs can be facilitated in two basic ways: by teaching parents positive child-rearing and management skills, which can be done through parent training programs or behavioral family interventions, and by providing social support to parents and families to relieve the effects of chronic and situational stress. Parenting education and training and social support can be combined in multi-component child development programs such as those run by family centers or early child home visitation programs.[101]

The DVP's strategy to prevent child maltreatment (CM) by promoting safe, stable and nurturing relationships between children and their caregivers is organized around four general areas of public health research and practice: measuring impact; creating and evaluating new approaches to prevention; applying and adapting what is learned; and building community capacity for implementing preventive strategies.

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[97] U.S. Centers for Disease Control and Prevention. *Strategic Direction for Child Maltreatment Prevention: Preventing Child Maltreatment Through the Promotion of Safe, Stable, and Nurturing Relationships Between Children and Caregivers.* Atlanta, GA, 2008, available at http://www.cdc.gov/violenceprevention/pdf/cm_strategic_direction--long-a.pdf (accessed December 27, 2013).
[98] Ibid.
[99] Ibid.
[100] Ibid.
[101] Ibid.

**Measuring Impact**

- Improve capacity to monitor nonfatal CM at national and state levels
- Improve ability to monitor fatal CM through the National Violent Death Reporting System
- Improve operationalization, measurement, and monitoring of SSNRs
- Identify and quantify the social and economic burden of CM

**Creating and Evaluating New Approaches to Prevention**

- Examine the development of SSNRs and CM perpetration to identify populations at risk, modifiable risk and protective factors, and optimal times and settings for interventions
- Evaluate the effectiveness of parenting-focused strategies for preventing CM by promoting SSNRs
- Evaluate the effectiveness of public and organizational policies for preventing CM and promoting SSNRs

**Applying and Adapting Effective Practices**

- Accelerate adoption and adaptation of evidence-based strategies for preventing CM by promoting SSNRs

**Building Community Readiness**

- Build community receptivity, capacity, and competence to implement evidence-based approaches to preventing CM
- Develop prevention and strategy tools for communities and organizations
- Establish and nurture partnerships and facilitate the dissemination and successful implementation of evidence-based CM prevention strategies in communities[102]

CDC continues to research evaluation of the effectiveness of programs and policies designed to develop such relationships, and is consequently accelerating communities' and public health agencies' adoption of effective programs and policies that promote them.

An important area of the CDC-sponsored research is the examination of attrition in parenting programs. As "even effective programs have limited impact if they are unable to reach, engage, and retain prospective participants," the CDC funded studies designed to enhance parental participation and retention in existing parenting programs that involved

- testing multifaceted conceptual models of participation,
- manipulating strategies for enhancing parental engagement and retention, and
- examining the impact of program participation on subsequent incidents of child maltreatment and other outcomes.[103]

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[102] Ibid.

[103] U.S. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention. *Using Evidence-Based Parenting Programs to Advance CDC Efforts in Child Maltreatment Prevention*. Atlanta, GA, 2004, available at http://files.eric.ed.gov/fulltext/ED486259.pdf

Finding efficacious ways of engaging parents and other child caregivers and facilitating consistent parental participation remains an important task for practitioners and policymakers interested in the success of their programs.

### *New Insights into Early Brain Development and Their Impact on Early Childhood Policies and Programs*

New insights into brain development and long-term adverse consequences of toxic stress are among pivotal recent advances in science that have a growing impact on early childhood policies and programs. The foundations for brain architecture are formed prenatally and in early childhood. The developing brain is shaped by both genes and experience. "During early sensitive periods of development, the brain's circuitry is most open to the influence of external experiences, for better or for worse."[104] Responsive, dependable interaction with caring adults ensures healthy emotional and cognitive development, while chronic or extreme adversity can disrupt normal brain development, which in turn can have a life-long negative impact on behavior, learning, and physical and mental health. To describe the detrimental impact of chronic stress, scientists use the term "toxic stress". A certain amount of adversity is unavoidable even in a most nurturing environment, and learning how to cope with it is a natural part of healthy child development. Unlike "positive stress response," characterized by a brief increase in heart rate and hormone levels, or "tolerable stress response," activating the body's systems to a greater degree as a result of more severe, longer-lasting difficulties, "toxic stress response" can occur when a child experiences "strong, frequent, and/or prolonged adversity," such as physical or emotional abuse, chronic neglect or other severe hardships, and does not have adult support.[105] Normally, when a young child experiences a stressful event, a caring adult calms him down, which allows his stress levels to drop. When stress response occurs continually and is not relieved by adequate adult support, long-lasting severe consequences can result: "This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems, and increase the risk for stress-related disease and cognitive impairment, well into adult years."[106] Early childhood toxic stress has been linked with disruptions of the developing nervous, cardiovascular, immune, and metabolic systems. Such disruptions can eventually lead to lifelong impairments in physical and mental health, behavior, and learning. Research also indicates, however, that "supportive, responsive relationships with caring adults as early in life as possible can prevent or reverse the damaging effects of toxic stress response."[107] This explains why the new developments in neuroscience have clear policy implications. A critical conclusion made by the Center of the Developing Child is as follows:

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(accessed December 11, 2013).

[104] Center on the Developing Child, Harvard University. *The Impact of Early Adversity on Children's Development*, available at http://developingchild.harvard.edu/index/php/resources/multimedia/videos/inbrief_series /inbrief_impact_of_adversity/ (accessed January 14, 2014).

[105] Center on the Developing Child, Harvard University. *Toxic Stress: The Facts*, available at http://developingchild.harvard.edu/ (accessed January 14, 2014).

[106] Ibid.

[107] Ibid.

> The basic principles of neuroscience indicate that providing supportive and positive conditions for early childhood development is more effective and less costly than attempting to address the consequences of early adversity later. Policies and programs that identify and support children and families who are at most risk for experiencing toxic stress as early as possible will reduce or avoid the need for more costly and less effective remediation and support programs down the road.[108]

The authors of the Center on the Developing Child's publication "A Science-Based Framework for Early Childhood Policy" state:

> As scientists, we believe that advances in the science of early childhood and early brain development, combined with the findings of four decades of rigorous program evaluation research, can now provide a strong foundation upon which policymakers and civic leaders with diverse political values can design a common, effective, and politically viable agenda…We believe that this combination of neuroscience, child development research, and program evaluation data can provide an informed and pragmatic framework for those engaged in policy design and implementation.[109]

Recognizing budgetary constraints, the authors of the report urge policymakers to focus on "long-term societal benefits relative to program costs."[110] Cost-benefits studies need to continue and be specific regarding child age, level of risk, and program focus. In some cases, "inexpensive services may generate sufficiently positive impacts to warrant their modest outlays" in others, expensive, comprehensive, multi-year programs may be required to provide long-term, positive returns.[111] Attempts to "scale up" a model program with proven benefits in low-cost, ineffective ways end up being counterproductive as short-term cost savings diminish the programs' positive impact and reduce their ultimate investment value.[112] The Center on the Developing Child researchers also remind policymakers that "ensuring the health and well-being of young children is an important objective in its own right, regardless of whether financial benefits can be documented in the future."[113]

Based on a rich body of scientific knowledge currently available to guide early childhood policies and practices, researchers identify four key challenges that, in their view, are worthy of sustained attention:

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[108] Center on the Developing Child, Harvard University. *The Impact of Early Adversity on Children's Development*, available at http://developingchild.harvard.edu/index/php/resources/multimedia/videos/inbrief_series/inbrief_impact_of_adversity/ (accessed January 14, 2014).

[109] Center on the Developing Child, Harvard University. *A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children*, available at http://developingchild.harvard.edu/resources/reports_and_working_papers/policy_framework/ (accessed January 14, 2014).

[110] Ibid.

[111] Ibid.

[112] Ibid.

[113] Ibid.

(1) Matching supports and services to the needs and strengths of the children and families to be served;

(2) Paying careful attention to the quality of implementation when effective model programs are taken to scale;

(3) Developing new intervention strategies for children and families for whom conventional approaches appear to have minimal impact; and

(4) Providing an environment that supports ongoing, constructive evaluation and continuous program development.[114]

Responding to these dramatic advances in developmental science, the American Academy of Pediatrics in its policy statement issued in January 2012 calls on the pediatric community "to catalyze fundamental change in early childhood policy and services".[115] Historically, the field of pediatrics has always kept prevention in the center of its activities and emphasized anticipatory guidance. Now that the long-term negative impact of toxic stress has been demonstrated, the Academy of Pediatrics is encouraging child healthcare professionals to perform a critical assessment of prevention at the practice level: "Because the essence of toxic stress is the absence of buffers needed to return the physiological stress response to baseline, the primary prevention of its adverse consequences includes those aspects of routine anticipatory guidance that strengthen a family's social supports, encourage a parent's adoption of positive parenting techniques, and facilitate a child's emerging social, emotional, and language skills."[116] The American Academy of Pediatrics' policy statement mentions Triple P, Incredible Years, and home visiting as examples of positive parenting programs that should be promoted.

State legislators in various parts of the country are demonstrating increased awareness of the new advances in science of early brain development and their policy implications. As the authors of a "State Legislatures" review point out, "increasing evidence of what works and how much money can be saved in the long term, coupled with this recent neuroscience research on how the brain develops, have combined to capture the attention of policymakers around the country."[117] The state of Washington has taken the lead in using a "science-based" approach when legislating or adopting early learning policies and laws.

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[114] Ibid.

[115] American Academy of Pediatrics. *Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science into Lifelong Health*: *Policy Statement,* available at http://pediatrics.aappublications.org/content/129/1/e224.full.pdf+html (accessed January 14, 2014).

[116] Ibid.

[117] Lipkowitz, Robyn and Julie Poppe. "Brain Matters: Research into How the Brain Develops Is Shaping Early Childhood and Programs." *State Legislatures*. January 2014. P.24.

It includes the use of an alternative response to reports of child abuse and neglect, when families determined to be at a low risk are allowed to keep their children at home but are offered alternatives to a traditional child welfare investigation.[118] Vermont, Hawaii, and Minnesota also passed legislation informed by the research from the Center on the Developing Child. Hawaii and Texas developed home-visiting programs to help children at risk for abuse and neglect.[119] State legislators are guided both by the scientific insights into early brain development and life-long detrimental consequences of toxic stress and by the cost-benefit evaluations of prevention and early intervention programs. Based on several studies, the Center on the Developing Child estimates that the range of savings for every dollar invested in early childhood programs can be between $4 and $16 for every $1 invested.[120]

### *Primary, Secondary, and Tertiary Prevention Programs*

A framework of child maltreatment prevention services consists of "three levels of services: *primary* prevention programs, which can be directed at the general population (universal); *secondary* prevention programs, which are targeted to individuals or families in which maltreatment is more likely (high risk); and *tertiary* prevention programs, targeted towards families in which abuse has already occurred (indicated)."[121]

Primary prevention activities are targeted to all members of the community. They seek to stop or significantly diminish the occurrence of maltreatment by raising the awareness of the general public, parents, service providers, and decision-makers about the scope of child abuse and neglect and specific problems associated with it. Universal approaches to primary prevention include

- Public service announcements that encourage positive parenting;
- Parent education programs and support groups that focus on child development and age-appropriate expectations and the roles and responsibilities of parenting;
- Family support and family strengthening programs that enhance the ability of families of access existing services, resources and support interactions among family members; and
- Public awareness campaigns that provide information on how and where to report suspected child abuse and neglect.[122]

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[118] Ibid.
[119] Ibid.
[120] Center on the Developing Child, Harvard University. *A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children*, available at http://developingchild.harvard.edu/resources/reports_and_working_papers/policy_framework/ (accessed January 14, 2014).
[121] U.S. Department of Health and Human Services. *Emerging Practices in the Prevention of Child Abuse and Neglect*, available at https://www.childwelfare.gov/preventing/programs/whatworks/report/report.pdf (accessed January 14, 2014).
[122] Ibid.

Secondary prevention activities are offered to families that may have one or more risk factors associated with child maltreatment, such as poverty, parental mental health or substance abuse problems, parental young age, and parental or child disabilities. Approaches to prevention that focus on high-risk populations include

- Parent education programs that are located, for example, in high schools and focus on teen parents, or within substance abuse treatment programs for mothers and families with young children;
- Parent support groups that help parents deal with everyday stresses and meet the challenges and responsibilities of parenting;
- Home visiting programs that provide support and assistance to expecting and new mothers in their homes;
- Respite care for families that have children with special needs; and
- Family service centers that offer information and referral services to families living in low-income neighborhoods.[123]

Tertiary prevention activities are targeted to families where child maltreatment has already occurred. The purpose of tertiary prevention is to reduce the negative consequences of the maltreatment and to prevent its recurrence. These prevention programs include

- Intensive family preservation services with trained mental health counselors that are available to families 24 hours per day for a short period of time;
- Parent mentor programs with stable, non-abusive families acting as "role models" and providing support to families in crisis;
- Parent support groups that help parents transform negative practices and beliefs into positive parenting behaviors and attitudes; and
- Mental health services for children and families affected by maltreatment to improve family communication and functioning.[124]

While subdividing prevention efforts into three distinct categories – primary, secondary, and tertiary prevention – is useful for a number of purposes, these distinctions do not necessarily reflect the way prevention-related services are organized and provided on the ground. Family Resource Centers can offer a range of activities attractive to a variety of families, not only those considered high-risk. Some programs such as Triple P have different levels addressed to different groups of population. As the U.S. Department of Health and Human Services' report pointed out, "prevention is increasingly recognized as a continuum."[125]

[123] Ibid.
[124] Ibid.
[125] Ibid.

### *Reorganization of Protective Efforts to Improve Child Safety Outcomes*

Realization that prevention should be recognized as a continuum can inform better organization of preventive services in a variety of ways. One of them is reassessment of risk factors. An illuminating example can be an approach to child fatalities resulting from intentional and unintentional injuries. Traditionally, "unintentional and intentional injury fatalities have been studied and treated as distinct phenomena. This conceptualization is based not only on the questionable assumption that we have the ability to correctly ascertain the manner of death, but also implies different child populations at risk and the necessity of unique prevention efforts, even though the outcome – death – is the same."[126] A recent extensive population-based study of early childhood injury mortality following a nonfatal allegation of maltreatment in California established a clear connection between nonfatal maltreatment reports and a heightened risk of unintentional and intentional injury mortality during the first five years of life. [127]

The findings indicated that "after adjusting for risk factors at birth, children with a prior allegation of maltreatment died from intentional injuries at a rate that was 5.9 times greater than unreported children."[128] A prior allegation to child protective services proved to be the strongest independent risk factor for injury mortality before the age of five.[129] Policy implications of a discovery like this are very significant. If the ultimate purpose is not to identify and punish the perpetrator but to save the child, preventive measures should clearly be directed to the family when a report of maltreatment is filed with child protective services. As it has been established that infants and young children reported to child protective services represent "a high-risk group that may be particularly vulnerable to not only inflicted fatal injuries, the most extreme result of physical abuse, but also to unintentional injury fatalities stemming from a neglect-related spectrum of parental behaviors,"[130] the child would benefit from preventive efforts regardless of the investigation outcomes.

The California study that identified a prior report of alleged maltreatment as "an independent signal of child risk"[131] may have even more far-reaching implications for Pennsylvania, with its separation of GPS and CPS. Based on the finding that "a prior allegation of maltreatment is a significant predictor of both unintentional and intentional injury death," the authors of the longitudinal California study conclude that "a more unified approach to injury intervention and prevention may be a more successful and efficient means of improving child safety."[132]

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[126] Putnam-Hornstein, Emily. "Report of Maltreatment as a Risk Factor for Injury Death: A Prospective Birth Cohort Study." *Child Maltreatment*. 2011. Vol. 16. Issue 163, available online at http://cmx.sagepub.com/content/16/3/163 (accessed December 5, 2013).
[127] Ibid.
[128] Ibid.
[129] Ibid.
[130] Ibid.
[131] Ibid.
[132] Ibid.

> The purpose of identifying high-risk subsets of children vulnerable to negative outcomes is to be able to provide narrowly targeted services in order to decrease the incidence of the outcome's occurrence. These data suggest that public health prevention campaigns, with the goal of decreasing of injury death among children, might be fruitfully targeted to families reported to CPS.[133]

Reorganization of protective efforts based on new findings, improved service targeting would improve child safety outcomes.

Careful analysis of the underlying causes of child maltreatment is essential for determining what intervention is required. Neglect, in particular, often results from families' difficulties in securing sufficient income to provide their children with food, adequate housing, health care, and other necessities. Some parents must work two or more jobs to support their families and, as a result, may struggle to offer their children appropriate supervision. For other parents, mental health conditions may undermine their ability to take proper care of their children.

For many families, community-based services and supports could prevent neglect altogether or could significantly mitigate impact of neglect on children by helping families obtain safe and affordable housing, health care, mental health and substance abuse treatment services, and legal protection when domestic abuse is an issue.[134]

Thoughtfully selected and timely provided family support services can allow many children to stay with their parents safely and get the care they need.

In the 21st century, Pennsylvania has been actively working on curbing child abuse and neglect and has been recognized as a leader in certain areas.

In its recent overview of strategies drawn from the innovative policy work undertaken by state legislators across the country, Prevent Child Abuse America identified four approaches:

- Home visitation,
- Safe Haven laws intended to prevent unsafe abandonment of newborns,
- Shaken Baby Syndrome prevention programs,
- Creation of prevention-focused task forces and councils.[135]

Pennsylvania has implemented all of these approaches.

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[133] Ibid.

[134] Pew Charitable Trusts. *Time for Reform: Investing in Prevention: Keeping Children Safe at Home.* Philadelphia, PA; Washington, D.C., 2007, available online at http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/Fpster_care-refprm/time_for_reform.pdf (accessed June 3, 2014).

[135] Crane, Kelly. *Prevention Programs and Strategies: State Legislative Experiences*, available at http://www.preventchildabuse.org/SiteAssets/docs/Prevention%20Programs%20and%20Strategies%20State%20Legislative%20Experiences.pdf (accessed July 9, 2014).

Its early selection and thoughtful implementation of the Nurse-Family Partnership, the most highly acclaimed and carefully tested home visiting program, to be used statewide put Pennsylvania in a position to take full advantage of the federal grant funding when it became available and secured the program's success. The Pew Center on the States, a division of the Pew Charitable Trusts that identifies and advocates effective policy approaches to critical issues facing the states, commended Pennsylvania for its wise investment in the Nurse-Family Partnership, "nationally recognized for setting high standards and ensuring outcomes for families and the public."[136] In its survey of state-administered home visiting programs, the Pew Center on the States selected Pennsylvania for a state snapshot as an example to illustrate how "evaluation and monitoring support smart investments."[137] Pew researchers praised the Pennsylvania Department of Public Welfare for funding PolicyLab, a nonprofit research organization, to conduct a rigorous program evaluation, focusing on two specific areas:

(1) whether programs achieved successful results immediately, or after an initial start-up period, and
(2) whether geography affected outcomes.

The results were promising: participants consistently displayed improved outcomes three years after enrollment and mothers from rural areas matched or exceeded the outcome rates of their urban counterparts. The study conducted by PolicyLab "determined that with careful monitoring and fidelity to the model, NFP can be implemented effectively across the state, assuring Pennsylvanians that they are paying for positive results."[138] In fact, the DPW's administration of the NFP program in Pennsylvania may serve as a model for the implementation of other well-tested, evidence-based preventive programs.

[136] *Pew: Federal Requirements for Home Visiting Funds Give States Right Incentives*, available at www.pewstates.org/newsroom (accessed June 27, 2014).
[137] The Pew Center on the States. *States and the New Federal Home Visiting Initiative: An Assessment from the Starting Line*. Washington, D.C.: The Pew Charitable Trusts, 2011, available at http://www.pewtrusts.org/~/media/Imported-and-Legacy/uploadedfiles/pcs_assets/2011/assessmentfromthestartinglinepdf.pdf (accessed June 27, 2014).
[138] Ibid.

# PENNSYLVANIA:
# PROGRAMS OVERSEEN BY OCYF

In Pennsylvania, under the Child Protective Services Law, county agencies are the only civil entity charged with investigating reports of suspected child abuse both at home and at school. Successful outcomes, however, do not occur without community help. "County agencies must have the cooperation of the community for other essential programs such as encouraging more complete reporting of child abuse and student abuse, adequately responding to meet the needs of the family and child who may be at risk, and supporting innovative and effective preventive programs."[139]

A significant part of the county agency activities encompasses primary and secondary prevention although the community is more familiar with its protection and tertiary services. When the county agency receives a report about suspected child abuse and starts the investigation, it must also provide services or plan for services as needed to prevent further abuse; these services include

- Multidisciplinary Teams (groups of professional consultants who assist the county in diagnosing child abuse and providing or recommending comprehensive coordinated treatment);
- Parenting Education Classes;
- Protective and Preventive Counseling Services;
- Emergency Caregiver Services;
- Emergency Shelter Care;
- Emergency Medical Services;
- Preventive and Educational Programs;
- Self-help Groups (groups of parents organized to help reduce or prevent abuse through mutual support).[140]

Services to abused and neglected children constitute a substantial part of the wide range of services Pennsylvania's child welfare system is responsible for. State and county agencies spent more than $44.571 million on investigating reports of suspected child and student abuse and related activities.[141]

[139] Pennsylvania Department of Public Welfare. *Annual Child Abuse Report 2013*, available at http://www.dpw.state.pa.us/cs/webcontent/documents/report/c_086251.pdf (accessed June 18, 2014).
[140] Ibid.
[141] Ibid.

Pennsylvania DPW uses General Fund money to operate ChildLine, a 24-hour hotline for reports of suspected child abuse, and the Child Abuse Background Check Unit that provides clearances for individuals seeking employment that involves the care or treatment of children. In 2013, ChildLine expenditures amounted to $2.60 million.[142]

Pennsylvania's child welfare system operates as state-supervised, but county-administered, which means that child welfare and juvenile justice services are organized, managed, and delivered by 67 County Children and Youth Agencies. Direct services and supports to at-risk children and their families, including prevention and intervention services, are provided by hundreds of private agencies through contracts with counties. The DPW's Office of Children, Youth and Families (OCYF) is the state agency that plans, directs, and coordinates children's programs provided statewide. "Pennsylvania provides the statutory and policy framework for delivery of child welfare services and monitors local implementation."[143] A state-supervised and county-administered system offers certain advantages such as allowing for the development of county-specific solutions based on the strengths and challenges of diverse communities. At the same time, this structure "presents challenges in ensuring consistent application of policy, regulation, and program initiatives and has impacted Pennsylvania's performance on the federal outcome measures", according to the DPW's 2013 annual child abuse report.[144]

An important tool to ensure effective state and local planning and implementation of child abuse and neglect prevention strategies is a state plan. Based upon the state needs and representing a multi-year effort, each of the fifty state plans contains benchmarks and measures to assess progress and demonstrate to the public what is being accomplished. President and CEO of Prevent Child Abuse America, James M. Hmurovich, describes state plans in the following way:

> These plans cannot merely be a written document, they should be a well-developed process that encourages states to look at inter-agency policy integration, shared funding among the various service delivery systems, information sharing, and common goals. These state plans must be a methodology to view prevention services as more than a funding stream or specific program, and instead, as an entirely new way of thinking about the long-term safety, health, growth, development, and well-being of our nation's children.[145]

### *Pennsylvania Child Abuse Prevention and Treatment Plan and Federal Funding*

State plans are used by states to receive federal matching funds through such programs as Title IV-B (Child Welfare Services), Title IV-E (Foster Care), Child Abuse Prevention and Treatment Act (CAPTA), Temporary Assistance for Needy Families (TANF), Medicaid, Maternal and Child Health, and the Early Childhood Comprehensive Systems plan. To have access to these

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[142] Ibid.
[143] Ibid.
[144] Ibid.
[145] Hmurovich, James M. *A New Way of Thinking About Child Abuse and Neglect Prevention.* In *Big Ideas for Children: Investing in Our Nation's Future.* Washington, D.C.: First Focus, 2008. P. 121, available at http://www.firstfocus.net/sites/default/files/r.2008-9.15.ff_.pdf (accessed December 18, 2013).

federal funds, states must develop their plans with the focus on nationally approved child well-being outcomes that prevent child abuse and neglect. The federal Child and Family Services Review monitors the states' conformity with the requirements of Title IV-B and CAPTA, with the ultimate purpose of improving outcomes for children and families by improving practices.

Pennsylvania's "5-year Child and Family Services Plan" (CFSP) for the federal fiscal years 2010-2014 is centered on national goals of safety, permanency, and well-being for children and families served by the child welfare and juvenile justice systems. "The 2010-2014 CFSR plan was developed using a framework that aligns and integrates PA's continuing plan for program improvement with the performance goals and objectives of the federal CFSR."[146] Prevention of child abuse and neglect occupies a prominent place in this plan. Safety from abuse and neglect is listed as the first outcome the department, along with other stakeholders, strives to achieve and maintain.[147]

Pennsylvania maintains and updates its Child Abuse Prevention and Treatment Plan, which incorporates the statutory purposes of the child protective service system established by the Child Protective Services Law (CPSL). These purposes include

(1) Encouraging more complete reporting of suspected child abuse;

(2) Involving law enforcement agencies in responding to child abuse, to the extent permitted under the law;

(3) Establishing in each county protective services for the purpose of investigating the reports swiftly and competently;

(4) Providing protection for children from further abuse;

(5) Providing rehabilitative services for children and parents involved so as to ensure the child's well-being;

(6) Preserving, stabilizing and protecting the integrity of family life wherever appropriate or to provide another alternative permanent family when the unity of the family cannot be maintained; and

(7) Ensuring that each county children and youth agency establishes a program of protective services with procedures to assess the risk of harm to a child and with the capabilities to respond adequately to meet the needs of the family and child who may be at risk and to prioritize the response and services to children most at risk.[148]

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[146] Commonwealth of Pennsylvania Department of Public Welfare, Office of Children, Youth and Families. *Annual Progress and Services Report. Federal Fiscal Year 2014,* available at http://www.dpw.state.pa.us/cs/groups/webcontent/documets/report/p_039985.pdf (accessed January 28, 2014).

[147] Commonwealth of Pennsylvania Department of Public Welfare, Office of Children, Youth and Families. *Annual Progress and Services Report. Federal Fiscal Year 2014,* available at http://www.dpw.state.pa.us/cs/groups/webcontent/documets/report/p_039985.pdf (accessed January 28, 2014).

[148] Commonwealth of Pennsylvania Department of Public Welfare, Office of Children, Youth and Families. *5-Year Child and Family Services Plan (CFSP). Federal Fiscal Years 2010-2014*, available at http://www.dpw.state.pa.us/cs/groups/webcontent/documents/report/s_002149.pdf (accessed 11/18/13).

The original plan included specific steps to be taken in order to achieve improvement in selected program areas, and the department has been consistently working on these areas. The plan also outlined activities supported with federal CAPTA funding as well as services and training provided.

In response to the 1996 and 2003 amendments to the Child Abuse Prevention and Treatment Act, Pennsylvania established Citizen Review Panels and addressed other requirements relating to child protective services, including trainings for Guardian Ad Litems and public disclosure of fatalities and near fatalities. Act 146 amended Pennsylvania's Child Protective Services Law (Title 23 Pa.C.S., Chapter 63) to address the establishment, function, membership, and reporting of Citizen Review Panels in the Commonwealth. Three Citizen Review Panels were formed in 2010 and are currently operating in Pennsylvania. These panels are located regionally (Northeast, Northwest and South Central) and cover 36 of Pennsylvania's 67 counties.[149] Members of the Citizen Review Boards are volunteers. Each panel examines policies, procedures, and practices of state and local agencies to evaluate the extent to which these agencies are effectively discharging their protective responsibilities under Section 106(b) of CAPTA.

In November 2013, the U.S. Department of Health and Human Services (HHS) Children's Bureau confirmed its review and approval of the Pennsylvania Annual Progress and Services Report, including the annual report on the use of funds under the Child Abuse Prevention and Treatment Act.[150]

Currently, the activities supported with CAPTA funds include the following:

- Continued assistance with the operation of Pennsylvania's three existing Citizen Review Panels, including continued support of the citizen review program manager position.
- Development and provision of training to mandated reporters under the Child Protective Services Law.
- Travel for State Liaison Officer and/or designee to attend annual State Liaison Officers Meeting.
- Travel for State Liaison Officer, other program staff and community partner representative to travel to CPS-related conferences and training seminars.
- Support research and evaluation work related to safety assessment.[151]

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[149] *Pennsylvania Citizen Review Panels' 2012 Annual Report*, provided to the Joint State Government Commission by the Department of Public Welfare on January 28, 2013.

[150] Letter from Lisa J. Pearson, Regional Program Manager, Children's Bureau Region III, to Cathy Utz, Acting Deputy Secretary of the Pennsylvania Department of Public Welfare Office of Children, Youth and Families, submitted to the Joint State Government Commission by Ms. Utz on January 17, 2014.

[151] Commonwealth of Pennsylvania Department of Public Welfare, Office of Children, Youth and Families. *Annual Progress and Services Report. Federal Fiscal Year 2014,* available at http://www.dpw.state.pa.us/cs/groups/webcontent/documets/report/p_039985.pdf (accessed January 28, 2014).

In November 2012, the Task Force on Child Protection recommended significant statutory changes to Pennsylvania's Child Protective Services Law (CPSL) and the child welfare system as a whole. As a result of the recommendations contained in the Task Force report, the Commonwealth has enacted a comprehensive package of legislative reforms aimed at enhancing protection of children and prevention of child abuse.[152] DPW OCYF has convened a stakeholder workgroup to assist with the development of policy, guidance, information, and training materials necessary for the successful implementation of the new statutory requirements. "The objectives of this workgroup are to develop and implement a comprehensive plan to support the consistent application of CPSL amendments and a monitoring plan to determine the fidelity of the implementation of the CPSL amendments."[153]

### *Data Collection*

Two areas essential for effective protection of children from abuse and neglect are identifying populations at greatest risk for maltreatment and data collection and analysis. The *Annual Progress and Services Report 2014* states that in accordance with Section 432(a)(10) of the Child and Family Services Improvement and Innovation Act, Pennsylvania "continues to undertake efforts to identify and describe which populations are at the greatest risk of maltreatment," how Pennsylvania has identified these populations and how services are targeted to them.[154] Presently, Pennsylvania continues to review the Program Reach and Risk Assessment conducted by the DPW Office of Child Development and Early Learning (OCDEL) to determine whether their findings and populations identified are consistent with those that would be identified through OCYF. OCYF stated in its 2014 report that it would convene a workgroup to identify additional populations and strategies to target services to the identified populations. [155]

Accuracy and completeness of state and local data on child maltreatment are critical for successful intervention and prevention, and OCYF continues to work on improvements in this area, including the AFCARS reporting. An important project is the development of a statewide information system. Phase I (Referrals) of the statewide Child Welfare Information Solution (CWIS) started in March 2013. Phase I involves a redesign of the IT applications used by DPW for reporting and tracking child abuse reports and processing child abuse clearances. The new application will streamline the processes for mandated reporters and the public to report child abuse and will allow for the electronic exchange of Child Protective Services (CPS) and General Protective Services (GPS) reports between the DPW and counties.

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[152] A list of the newly enacted statutory changes can be found in Appendix 2.
[153] Pennsylvania Department of Public Welfare. *Annual Child Abuse Report 2013*, available at http://www.dpw.state.pa.us/cs/webcontent/documents/report/c_086251.pdf (accessed June 18, 2014).
[154] Commonwealth of Pennsylvania Department of Public Welfare, Office of Children, Youth and Families. *Annual Progress and Services Report. Federal Fiscal Year 2014,* available at http://www.dpw.state.pa.us/cs/groups/webcontent/documets/report/p_039985.pdf (accessed January 28, 2014).
[155] Ibid.

Transmitting information electronically will make hotline and county caseworkers' operations more efficient. Phase I is scheduled to be completed in December 2014. "At the end of this phase, the following key features will be available:

- Collect and record CPS and GPS cases at the state level;
- Electronically transfer the CPS and GPS cases to appropriate county for investigation;
- Electronically transfer the investigation/assessment results from the county to the state;
- View, at the state level, the investigation/assessment status, outcomes and whether services were provided;
- Modernized technology for obtaining child abuse clearances;
- Single access point for counties;
- Enhanced reporting and visibility to Child Welfare data including canned reports, dashboard, and ad-hoc reporting capabilities."[156]

The majority of child abuse and prevention programs do not operate separately; they are part of more comprehensive programs aimed at family preservation and family support. They anticipate improving outcomes across several domains.

### *Funding Requirements and Evaluation*

There are two main funding streams: Title IV-B Part 2 and Community-Based Child Abuse Prevention (CBCAP). Title IV-B Part 2 has a more comprehensive goal of improving the quality of care services provided to children and families and of preventing the unnecessary separation of children from their families. The special purpose of CBCAP is to support community-based efforts to develop, operate, and enhance initiatives aimed at the prevention of child abuse and neglect. CBCAP, which provides community-based grants for the prevention of child abuse and neglect, emphasizes program accountability and evaluation, with a strong preference for evidence-based practice. Priority areas that the state lead agencies should focus their efforts on include parent education programs and support groups, respite care, fatherhood programs, home visitation, early care and education, family resources and support centers as well as positive youth development to prevent child abuse.[157]

In Pennsylvania, OCYF is the state's CBCAP lead agency. It oversees Family Centers, Fatherhood Initiative, Family Support Alliance, and Parent to Parent Initiative, along with other preventative programs financed through Title IV-B Part 2, such as Safe Haven and Parent Child Home Program.

The FRIENDS National Resource Center for CBCAP has developed toolkits to assist family support and child abuse prevention programs conduct evaluation of their services. The FRIENDS also performed an overview and compiled a directory of various evidence-based and

[156] Ibid.
[157] *CBCAP Priority Areas*, available at http://friendsnrc.org/cbcap-priority-areas (accessed October 31, 2013).

evidence-informed programs that states can use while developing their strategies for preventing child abuse and neglect.[158] States' CBCAP lead agencies are required to spend a growing percentage of CBCAP funds on evidence-informed and evidence-based programs (EI/EB). There are four categories of EI/EB: Emerging (Evidence-Informed), Promising, Supported, and Well-Supported, with Supported and Well-Supported programs having the strongest level of evidence for effectiveness. States are encouraged to base their program selections on multiple factors, including appropriateness for the population served, community needs, and the agency capacity to implement services with fidelity. At the same time, all services funded must meet at least the minimum criteria for Emerging/Evidence-Informed programs, which means they must have "a logic model, a theory of change based on the best research literature available, ongoing evaluation, a manual or set of policies and procedures, and a commitment to continuous quality improvement."[159]

FRIENDS designed the Matrix of Evidence-Based and Evidence-Informed Programs and Practices (EI/EBPs) by reviewing information on the existing EBP registries and classifying relevant programs to align with the CBCAP EI/EB definitions. The nationally recognized registries used are California Clearinghouse on EBP in Child Welfare, the Substance Abuse and Mental Health Services Administration (SAMHSA) Model of the National Registry of Evidence-based Programs and Practices (NREPP), the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Programs Guide, and the Promising Practices Network.[160] The Matrix is intended as a tool that can assist states' CBCAP lead agencies in their selection of the most effective programs in the field of child maltreatment prevention and family support.

OCYF makes continuous efforts to ensure effectiveness of the publicly funded programs. It currently takes outcomes into consideration "but understands the need for more evaluation and is taking steps to move towards performance-based effectiveness of specific programs and a process of evaluating key outcomes."[161] At present, counties are required to report outcomes and assessed needs in justifying the programs they fund. The statewide database that is currently being developed by DPW will allow more data collection and analysis. It will allow OCYF to perceive the trends and to evaluate outcomes and results based on certain programs so that funding can be provided to the most effective services. Once the information becomes available, DPW will be able to follow a family's trajectory after the use of certain programs to see if they were effective in avoiding system involvement. In addition, some counties are also focusing on evaluating and funding services based on outcomes by creating performance-based contracts with their service providers.[162]

Currently, OCYF uses the evidence-based service catalogues compiled by the Clearinghouse and the Child Information Gateway in order to justify the use of evidence-based programs chosen by the county. The fidelity of these evidence-based programs is monitored by their developers. DPW would like to enhance its own internal evaluations of effectiveness and

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[158] FRIENDS National Resource Center for CBCAP. *Evidence-Based and Evidence-Informed Programs: Prevention Program Descriptions Classified by CBCAP Evidence-Based and Evidence-Informed Categories*. Chapel Hill, N.C., September 2009, available at http://friendsnrc.org/joomdocs/eb_prog_direct.pdf (accessed January 30, 2014).
[159] Ibid.
[160] Ibid.
[161] Information provided to the Joint State Government Commission by DPW on July 28, 2014.
[162] Information provided to the Joint State Government Commission by DPW on July 28, 2014.

outcomes. The Pennsylvania Commission on Crime and Delinquency and the Penn State EPISCenter partner with DPW and assist the Department with monitoring some outcomes and fidelity of programs in Pennsylvania.[163]

The Title IV-E waiver demonstration project is an example of how DPW has utilized data to drive the selection of appropriate evidence-based programs and practices. Having a flexible use of federal funds, the IV-E demonstration project allows counties to fund more evidence-based programs, which helps fund secondary prevention measures and reduce the amount of re-abuse. The official implementation of the Title IV-E waiver began on July 1, 2013. Initially, it involved five counties: Allegheny, Dauphin, Lackawanna, Philadelphia, and Venango. These counties represented over 50 percent of the state child welfare expenditure. The first two concurrent phases of the project involved implementing or expanding the use of family engagement strategies and functional assessments targeted at identifying child and family strengths and needs. These activities were the impetus for the third phase of the demonstration project: the implementation of evidence-based practices that are specific to the identified county needs. As of July 1, 2014, the five counties began the implementation of the programs they had selected. The University of Pittsburgh is conducting rigorous cost, progress, and outcome evaluations as part of the Department's waiver responsibilities. The selected programs include Homebuilders, Multi-Systemic Therapy, Parent-Child Interaction Therapy, Trauma-Focused Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Triple P (Positive Parenting Program), SafeCare, Functional Family Therapy, and Parents as Teachers. On July 1, 2014, Crawford County has been added to the demonstration project. For the first year, it will be implementing the family engagement strategies and functional assessment with a goal of beginning the implementation of evidence-based practices in July 2015.[164]

Utilizing newly opening federal-funding opportunities to start new projects, OCYF continues its monitoring and support of Family Centers, Fatherhood Initiative, and the Pennsylvania Family Support Alliance, which are responsible for the bulk of child abuse and neglect prevention services in the Commonwealth.

### *Family Centers*

Family Centers are the core of community-based services in Pennsylvania. They play "a significant role in service delivery in communities, preventing children and families from entering into the formal child welfare system, and achieving outcome goals that have a broad influence in their communities".[165] Family Centers are based on the philosophy that "the most effective way to ensure the healthy growth and development of children is to support their families and the communities they live in."[166] Family Centers are easily accessible to families and are designed to become an integral part of the communities they serve.

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[163] Information provided to the Joint State Government Commission by DPW on July 28, 2014.
[164] Information provided to the Joint State Government Commission by DPW on July 28, 2014 and on August 5, 2014.
[165] Commonwealth of Pennsylvania Department of Public Welfare, Office of Children, Youth and Families. *Annual Progress and Services Report. Federal Fiscal Year 2014,* available at http://www.dpw.state.pa.us/cs/groups/webcontent/documets/report/p_039985.pdf (accessed January 28, 2014).
[166] Ibid.

There are currently 31 Family Centers in Pennsylvania, at over 65 sites.[167] Services are offered to families at no charge. Collectively, Family Centers serve over 12,000 participating families.[168] OCYF supports Family Centers with grants based on the evaluation of applications submitted by Family Centers. These OCYF grants are state and federal grants given to county governments and school districts. Two federal funding streams are used to support Family Centers: Title IV-B Part 2 and CBCAP. The annualized funding for Family Centers for the spending period from 10/1/2012 to 9/30/14 was 450,607 from CBCAP and 5,246,000 from Title IV-B Part 2.[169]

Family Centers offer a variety of services including direct contact and various activities at the Family Center and home visitation; they also provide referrals to other community organizations when needed. The latest DPW progress report points out a special Centers' achievement of engaging in "targeted outreach and innovative, non-traditional, service delivery approaches that enable families to access services that in the past may have been inaccessible due to geographic isolation or other barriers."[170] In fact, some of the more successful Family Centers in Pennsylvania have become so popular within the community they serve that they feel they need to suspend advertising efforts temporarily as word of mouth and referrals bring a lot of people to them and they are already full to capacity.[171]

*Parents as Teachers*

Pennsylvania Family Centers use the Parents as Teachers (PAT) program as a model for their curriculum for enrolled families. The PAT program serves parents with children from birth to 5 years old. It focuses on child development and recommends activities that promote it; it also strengthens the parent/child relationship. PAT has four main components:

- personal home visits,
- group meetings,
- developmental screenings, and
- connection to community resources.

Parents as Teachers National Center, Inc., developed a detailed set of requirements regarding parent educators' educational background and experience, duration and frequency of services, family assessment and goal setting, supervision and ongoing training of parent educators and evaluation of program implementation by its affiliates. The program focus is on early development. PAT recommends three years of services, with at least two years provided between prenatal and kindergarten entry. PAT affiliates are expected to run programs all 12 months of the year.

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[167] Information provided to the Joint State Government Commission by DPW on November 21, 2013.
[168] DPW Budget Request for Fiscal year 2014-2015. Community Based Family Centers, available at *www.dpw.**state.pa**.us/cs/.../p_010955.pdf* (accessed February 25, 2014).
[169] Data provided to the Joint State Government Commission by DPW on November 21, 2013.
[170] Commonwealth of Pennsylvania Department of Public Welfare, Office of Children, Youth and Families. *Annual Progress and Services Report. Federal Fiscal Year 2014,* available at http://www.dpw.state.pa.us/cs/groups/webcontent/documets/report/p_039985.pdf (accessed January 28, 2014).
[171] Telephone interview with Ms. Nelly A. Jimenez-Arevalo, Director of the Kennett Square Family Center, on November 14, 2014.

To ensure effective and faithful implementation of the program by all affiliates, the Parents and Teachers National Center has developed a toolkit to assist staff in the screening, assessment, and evaluation.

The Parents as Teachers program has been found to lead to reductions in child maltreatment, along with other positive outcomes.[172]

The primary service delivery component is personal visits, which last for approximately one hour and may occur monthly, bi-weekly or weekly, dependent on the needs of the family. During these visits, parent educators inform parents about child development, address parental concerns, engage the family in activities that provide meaningful parent/child interaction and opportunities for the child's development. Monthly parent group meetings last approximately two hours; they provide parents opportunities to exchange information about parenting issues and child development, support each other, and practice parenting skills. Formal developmental, general health, vision and hearing screening must be performed annually.

An essential part of parent educators' job is to connect families to resources they need and to help them overcome barriers to access. Active collaboration with community resources is necessary to complement PAT services.

Implementation cost is estimated to be $2,000-$2,500 per family per year.[173] A sample budget for PAT's Born to Learn program lists an annual cost of $2,621.[174] Duration of participation costs estimates range from $1,450 to $5,125.[175]

It should be noted that a benefit-cost analysis of Parents as Teachers recently performed by the Washington State Institute for Public Policy established comparatively low odds of a positive net present value (36 percent) while an effective and widely used Triple P Parenting Program is estimated to yield $1,127 net present value, with 100 percent odds of positive net present value, and the benefit-to-cost ratio of $8.74.[176] Earlier reports prepared by the Washington State Institute for Public Policy presented a more encouraging picture of PAT's monetary value, estimating its

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[172] Avellar, S. et al. *Home Visiting Evidence of Effectiveness Review: Executive Summary.* Washington, D.C.: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, September 2013, available at http://homvee.acf.hhs.gov/HomVEE_Executive_Summary_2013.pdf#exec_summary (accessed May 5, 2013).

[173] FRIENDS National Resource Center for CBCAP. *Evidence-Based and Evidence-Informed Programs: Prevention Program Descriptions Classified by CBCAP Evidence-Based and Evidence-Informed Categories*. Chapel Hill, N.C., September 2009, available at http://friendsnrc.org/joomdocs/eb_prog_direct.pdf (accessed January 30, 2014).

[174] Burwick, Andrew et al. *Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment: Cross-Site Evaluation Cost Study Background and Design Update*. Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. April 2012, available at http://www.supprtingebhv.org/home (accessed November 14, 2013).

[175] Ibid.

[176] Washington State Institute for Public Policy. *January 2014 Inventory of Evidence-Based, Research-Based, and Promising Practices For Prevention and Intervention Services for Children and Juveniles in Child Welfare, Juvenile Justice, and Mental Health Systems*, available at http://www.wsipp.wa.gov/ReportFile/1552/Wsipp_Updated-Inventory-of-Evidence-based-Research-based-and-Promising-Practices-for-Prevention-and-Intervention-Services-for-Children-and-Juveniles-in-the-Child-Welfare-Juvenile-Justice-and-Mental-Health-Systems_Inventory.pdf (accessed July 22, 2014).

total benefit-to-cost ratio at $1.39 in 2008[177] and $1.18, with 57 percent odds of a positive net present value, in 2012.[178] It is important to understand that monetary benefits and costs of public programs and policies can fluctuate and that cost effectiveness is not the only factor to be considered in the process of program selection.

*Strengthening Families*

Several of Pennsylvania Family Centers and other family support agencies use the Strengthening Families program created by the Center for the Study of Social Policy (CSSP). It is a nationally and internationally recognized family skills training program. This prevention program was originally developed and tested in the mid-1980s by Dr. Karol Kupfer for high-risk families and later expanded to be used for other families as well. In contrast to some other approaches that seek to address risks and deficits, the Strengthening Families program focuses on the positives: on protective and also "promotive" factors that build family strengths and a family environment that promotes optimal child development.[179] OCYF endorsed Strengthening Families and added the language used by CSSP to the Family Centers' application for the state fiscal year 2012-2013 because the five protective factors that are the foundation of the Strengthening Families approach closely mirror the outcomes expected from the Family Centers, as a means to lower the risk of child abuse and neglect.[180] These five protective factors include

- Parental resilience,
- Social connections,
- Concrete support in times of need,
- Knowledge of parenting and child development, and
- Social and emotional competence of children.[181]

Strengthening Families includes separate sessions for adults and for children, along with combined family sessions. Parenting skills sessions address positive communication, family functioning, and discipline and guidance topics. The children's sessions focus on social-emotional development, communication skills, and healthy behavior. The family sessions offer structured activities and the opportunity to practice newly learnt skills.[182]

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[177] Lee, Stephanie, Steve Aos, and Mama Miller. *Evidence-Based Programs to Prevent Children from Entering and Remaining in the Child Welfare System. Benefits and Costs for Washington*. Olympia, WA: Washington State Institute for Public Policy, July 2008, available at http://www.wsipp.wa.gov/ReportFile/1020 (accessed July 24, 2014).

[178] Lee, Stephanie et al. *Return on Investment: Evidence-based Options to Improve Statewide Outcomes: April 2012 Update*. Washington, Olympia, WA: Washington State Institute for Public Policy, April 2012, available at http://www.wsipp.wa.gov/ReportFile/1102/Wsipp_Return-on-Investment-Evidence-Based-Options-to-Improve-Statewide-Outcomes-April-2012-Update_Full-Report.pdf (accessed July 25, 2014).

[179] *The Protective Factors Framework*, available at http://www.cssp.org/reform/strengthening-families/the-basics/protective-factors (accessed February 21, 2014).

[180] Commonwealth of Pennsylvania Department of Public Welfare, Office of Children, Youth and Families. *Annual Progress and Services Report. Federal Fiscal Year 2014,* available at http://www.dpw.state.pa.us/cs/groups/webcontent/documets/report/p_039985.pdf (accessed January 28, 2014).

[181] *The Protective Factors Framework*, available at http://www.cssp.org/reform/strengthening-families/the-basics/protective-factors (accessed February 21, 2014).

[182] FRIENDS National Resource Center for CBCAP. *Evidence-Based and Evidence-Informed Programs: Prevention Program Descriptions Classified by CBCAP Evidence-Based and Evidence-Informed Categories*. Chapel Hill, N.C., September 2009, available at http://friendsnrc.org/joomdocs/eb_prog_direct.pdf (accessed January 30, 2014).

The program has been used for families with children ages 6 to 17. Numerous studies and randomized control trials have found positive results with families in many different ethnic groups.[183]

Approximate costs for implementation of group-based parent education curricula range from $600 to $1000 per family.[184]

*1-2-3 Magic*

Some parents resort to spanking and other kinds of physical discipline because they are frustrated and because they are unaware of other means to maintain control and enforce desirable behavior. Equipping them with acceptable strategies may help them achieve their goal, avoid risks of child abuse, and improve outcomes for both the children and the parents. A comparatively new but already successful program used by several Family Centers in Pennsylvania is 1-2-3 Magic: Effective Discipline for Children. The program was developed by Dr. Thomas W. Phelan in mid-1990s. Its main focus is on developing positive discipline strategies for parents between two and twelve years of age. 1-2-3 Magic subdivides parenting activities into three general categories: controlling negative behavior, encouraging good behavior, and strengthening the child-parent relationship. The program's goal is to improve discipline and parental guidance skills and reduce arguing, yelling, or spanking. 1-2-3 Magic can be used for the general population as well as for parents of children with special needs. It can be delivered in a group setting or in a one-on-one coaching environment. The program should be administered by mental health professionals or teachers.

Approximate costs for implementation of group-based parent education curricula range from $600 to $1,000; participant booklets cost $50.[185]

*Additional Programs Hosted by Family Centers*

In addition to PAT, Strengthening Families, and 1-2-3 Magic, which are the programs that Family Centers operate on their own, the Centers often become sites for optional programs and services offered by other agencies. A wide array of these programs also contribute to mitigating child maltreatment risks and to promoting child well-being in general.

These provisional services and programs may include

- Child Support (e.g., developmental screenings, summer/after-school programs, and parent/child interaction groups);
- Parent/Family Support (e.g., child development/parent education, peer and parent support groups, respite care, and family activities);

[183] *Strengthening Families Program*, available at http://www.strengtheningfamiliesprogram.org (accessed February 21, 2014).
[184] Ibid.
[185] FRIENDS National Resource Center for CBCAP. *Evidence-Based and Evidence-Informed Programs: Prevention Program Descriptions Classified by CBCAP Evidence-Based and Evidence-Informed Categories*. Chapel Hill, N.C., September 2009, available at http://friendsnrc.org/joomdocs/eb_prog_direct.pdf (accessed January 30, 2014).

- Health Services (e.g., adult and child health classes, Well Baby clinics, Women Infant and Children (WIC) services, and child and family safety services);
- Mental Health Services (e.g., counseling, support groups, anger management, drug/alcohol programs, and life skills);
- Adult Self-Sufficiency Services (e.g., Adult Basic Education/General Education Diploma (GED), English-as-a-Second Language, money management counseling, transportation services, job training and placement services);
- Emergency Services (e.g., food, fuel, housing, clothing, domestic violence and crisis intervention services, and child abuse services).[186]

Getting access to these services at one location, often already familiar to the families involved, increases the likelihood of timely and effective intervention. The holistic approach used by most Family Centers allows for early identification of risk factors. For example, all families are tested for depression, and all children are screened for developmental delays. If any treatment is required, it can be provided in a timely fashion, which eliminates or mitigates the risks.

*Family Centers and Their Communities*

Kennett Square

Successful Family Centers are closely knit to their communities; they select and adapt their programs to meet their communities' needs. A good example of this is the Kennett Square Family Center in Chester County. The Kennett Square Family Center has become a safe haven for many families in the community. It has become a site where round tables with the police can be organized, to discuss potentially sensitive issues and to establish better understanding between the local public and law enforcement.

Similar to other Family Centers in the Commonwealth, the Kennett Square Family Center uses Parents as Teachers Born to Learn home-visiting model. As there is a significant Spanish-speaking population in the area, many of them recent immigrants from Mexico, its parent educators are bilingual and bicultural. Families they serve perceive them as part of their own community and are comfortable discussing their problems with them. The entire Family Center staff comes from the community. They have a good knowledge of the community values, the challenges parents may be facing, and the motivation behind their acts. Families coming from a different cultural background are often unfamiliar with the U.S. educational system; informing them about kindergarten and subsequent schooling becomes an important task. Various cultures have different ways to enforce discipline in the home. What may be considered acceptable physical discipline in Mexico may be regarded as physical abuse in the United States, and parents need to be cautioned about that. At the same time, they need to be provided with different tools to maintain discipline at home. As Ms. Nelly A. Jimenez-Arevalo, Director of the Kennett Square Family Center, pointed out in a telephone interview with the Commission staff, if parents are just told they cannot do what

[186] Commonwealth of Pennsylvania Department of Public Welfare, Office of Children, Youth and Families. *Annual Progress and Services Report. Federal Fiscal Year 2014,* available at http://www.dpw.state.pa.us/cs/groups/webcontent/documets/report/p_039985.pdf (accessed January 28, 2014).

their parents used to do, they may withdraw from taking control of their children and therefore, run the risk of being either abusive or neglectful. To avoid this, the Family Center employees not only explain them the law but also teach them new disciplining skills.[187] 1-2-3 Magic, a child discipline program for children ages two to twelve, is a useful tool in this regard.

A round table is often a preferred format at the Kennett Square Family Center because the Center's leaders believe that it is important to give parents an opportunity to share. Listening to the clients is essential, as Ms. Jemenez-Arevalo pointed out in her interview. Round tables help the staff identify the parents' actual concerns and challenges, which may sometimes be different from expected, and target them promptly.[188]

The Family Center facilitates and encourages parent-to-parent connections. It provides families various opportunities for group connections so that they could interconnect and build relationships.

In addition to organizing a variety of attractive activities at the Center, the Kennett Square staff also visit many families at home. Children living in isolated families, in rural areas, and at isolated farms are more at risk. Recognizing these risks, the Kennett Square Family Center has made a special effort to deliver their services to those families. Staff members visit them where they reside and ensure the children are safe and have access to all the necessary services.

Another particular targeted population group is teen and young adult parents. The Kennett Square Family Center runs a special program for them, in collaboration with the school district. The Young Parents Program targets parents age 15-24 and helps them learn about the responsibilities of parenting and overcome the special challenges they may face in their attempts to become successful parents.[189] As teen and young adult parents represent one of the risk groups for child abuse and neglect, providing them with specifically targeted help and guidance is a beneficial prevention strategy.

The Kennett Square Family Center has a wide range of community partners, from the Health Department to West Chester University and Saint Joseph University, to local churches and businesses. These connections increase the Center's visibility and the number of referrals as well as the kind of services it can offer. Active partnerships with various local organizations enable the Kennett Square Family Center to offer such helpful services as dental cleaning and vaccination.

McKean County

Most of the Family Centers in Pennsylvania, while using Parents as Teachers as their approved core service component, have their own focal areas based on the specific needs of the communities they serve and on the issues, they believe to be important. McKean County has been identified by the Pennsylvania Office of Child Development and Early Learning as high-risk

[187] Telephone interview with Ms. Nelly A. Jimenez-Arevalo, Director of the Kennett Square Family Center and Community Relations Director of the Maternal and Child Health Consortium, on November 14, 2014.
[188] Ibid.
[189] *Maternal and Child Health Consortium of Chester County Family Center Programs*, available at http://www.ccmchc.org/programs/family-center/ (accessed November 15, 2013).

county eligible for Maternal, Infant, Early Childhood Home Visiting (MIECHV) funds. According to the McKean County Family Center Director, Ms. Lee Sizemore, "child abuse and neglect is the number one social concern" in this county.[190] MIECHV funds allowed the county Family Centers to expand the PAT program. The McKean County Family Centers put emphasis on redefining the concept of "home" to include prisons, shelters, and in-patient treatment centers so that parents can participate in PAT in a variety of settings when their lives are in transition.[191] Their innovative strategy is a special effort to increase outreach so as not to permit a parent's incarceration or a family's homelessness to preclude helping the family. Another distinguishing feature is their commitment to work with both parents and extended families in cases of divorce or separation and to promote fathers' involvement in the lives of their children. Specialized services for fathers are provided by a certified male staff person. Expanding PAT services to include those of a registered nurse when the child is vulnerable or at risk of abuse is another preventive measure. All five Family Centers in the McKean County are community-based and housed in downtown storefront locations.

The McKean County Family Centers pride themselves on providing extra training and thorough supervision of their PAT staff. In addition to required PAT training, Parent Educators in McKean County receive annual training on child abuse prevention, cultural competency, response to cultural poverty and other risk factors.[192] Family development specialists help families stabilize their lives, find employment, and enhance their community involvement, all of which contributes to the child's safety and well-being.

Erie County

The Erie County Family Center for Child Development began to implement the Healthy Families America home visitation model, which aligns well with Parents as Teachers and doubles the number of families the staff is able to serve.[193]

The Erie County Family Center runs several regular programs such as Motherhood Support Initiative, Foundations for Fatherhood, 1-2-3 Magic, and Strengthening Families programs for parents and children of different age groups. All these prevention programs are free for the families that register for them. Workshops are conducted in several convenient locations and at convenient times. It is worth noting that the Family Center offers childcare and transportation assistance when needed. All these parent-education programs are aimed at improving family management and parenting skills and thus decrease risks of child abuse and contribute to the child's safe and healthy development.

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[190] Personal e-mail from Ms. Lee Sizemore, Director of the McKean County Family Center, to the Joint State Government Commission, received on November 10, 2013.
[191] Personal e-mail from Ms. Lee Sizemore, Director of the McKean County Family Center, to the Joint State Government Commission, received on November 10, 2013.
[192] Ibid.
[193] Commonwealth of Pennsylvania Department of Public Welfare, Office of Children, Youth and Families. *Annual Progress and Services Report. Federal Fiscal Year 2014,* available at http://www.dpw.state.pa.us/cs/groups/webcontent/documets/report/p_039985.pdf (accessed January 28, 2014).

Delaware County

The Delaware County Family Center in partnership with the County Children and Youth Agency and the local school district began to offer the teen pregnancy program called Project Elect. It is based in schools and provides continuity for the families served by the other Center programs. As children born to teenage mothers are at increased risk for abuse and neglect, supporting these mothers and helping them to provide adequate care for their children while at the same time continuing their own education and acquiring employment is a good example of a carefully targeted prevention program.

A complex of programs and services provided by the Family Centers in Pennsylvania helps achieve the goal of child maltreatment prevention in a variety of ways. It lowers risk factors such as parental stress and poverty/unemployment, social isolation of families, parents' lack of understanding of child development and children's needs, and family disorganization, and it increases protective factors such as parental employment and adequate housing, increased family involvement in the community, enhanced parenting skills, improved stability and integrity of the family, improved access to health care and social services. Timely parent and child screenings help in prevention, early identification and mitigation of such risk factors as physical and mental health problems, physical and developmental disabilities that may increase caregiver burden and parental stress. Family and community involvement ensures even better outcomes.

### *Fatherhood Initiative*

The second major initiative funded by OCYF with Community-Based Child Abuse Prevention (CBCAP) federal funds is Fatherhood Initiative. During the state fiscal year 2011-2012, 2,629 fathers and 3,615 children were served by the Promoting Responsible Fatherhood Initiative (PRF) grant.[194] The current annualized funding of $589,000 supports 20 fatherhood projects in 17 counties.[195] Fatherhood Initiative grants in Pennsylvania are mainly administered through Family Centers. Additional funding sources come from other departments, such as the federal HHS - Community Services Block Grant (CSBG) and the Pennsylvania Department of Community and Economic Development (DCED). The purpose of the Fatherhood Initiative is to

- Increase the involvement of fathers in the lives of their children;
- Improve parenting knowledge, attitude and skills;
- Increase fathers' education level and job skills;
- Increase the financial support provided by non-custodial fathers; or
- Encourage and support fathers as positive role models.[196]

[194] Commonwealth of Pennsylvania Department of Public Welfare, Office of Children, Youth and Families. *Annual Progress and Services Report. Federal Fiscal Year 2014,* available at http://www.dpw.state.pa.us/cs/groups/webcontent/documets/report/p_039985.pdf (accessed January 28, 2014).
[195] Information provided to the Joint State Government Commission by DPW on November 21, 2013.
[196] *Pennsylvania Fatherhood Initiative*, available at http://www.pacwrc.pitt.edu/FamilyCenters/FatherhoodOverview.pdf (accessed February 27, 2014).

While specific strategies may differ dependent on the community needs, all fatherhood projects include the following components:

- Outreach services;
- Individual and group support services and activities for fathers;
- Education/skill training opportunities; and
- Adult education, pre-employment and job skills training.[197]

There is no required curriculum. Providers use their own curricula, which are approved by OCYF. In their grant applications, project managers are required to describe their target population, program outcomes/goals, services to be provided, strategies and activities to be implemented, and the number of fathers and children that will be served in each area in twelve months.[198] Applicants are also expected to explain how the Fatherhood Initiative responds to the community needs.

The Promoting Fatherhood Initiative grant uses a variety of evidence-based and evidence-informed practices and models such as

- Inside/Out for Dads for incarcerated fathers;
- 24/7 Dad;
- Doctor Dad;
- Fatherhood 101 for teen dads;
- Fatherhood Development;
- Partners for Fragile Communities;
- Incredible Infants;
- 1,2,3,4 Parents!;
- Active Parenting Now;
- Active Parenting for Teens;
- The Nurturing Program;
- Dad and Me;
- Step; and
- 1,2,3 Magic.[199]

All these programs and activities can assist men in understanding their role in the child's life, in learning about their children's development and becoming a good father. They can also enhance their ability to support their children and reduce risk factors for child abuse.

Pennsylvania became the 25th U.S. state to standardize Inside/Out Dad, the nation's only evidence-based program designed specifically for working with incarcerated fathers, across its state correctional facilities. After the Pennsylvania Department of Corrections (DOC) Secretary John Wetzel decided to adopt the program for use in the state's adult male correctional facilities,

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[197] Ibid.
[198] Information provided to the Joint State Government Commission by DPW on July 31, 2013.
[199] Commonwealth of Pennsylvania Department of Public Welfare, Office of Children, Youth and Families. *Annual Progress and Services Report. Federal Fiscal Year 2014,* available at http://www.dpw.state.pa.us/cs/groups/webcontent/documets/report/p_039985.pdf (accessed January 28, 2014).

the National Fatherhood Initiative (NTF) provided program training for the DOC staff members on how to deliver the program to incarcerated fathers across the state. The program was met with enthusiasm by the DOC staff and by the participating inmates.[200]

### *Pennsylvania Family Support Alliance*

The Pennsylvania Family Support Alliance (PFSA), founded in 1978, is a statewide organization that plays an important part in child abuse education and prevention in the Commonwealth. DPW rates highly the Family Support Alliance "as a statewide leader in the fight against child abuse for more than 30 years" and attests that PFSA "established a reputation for providing quality, confidential, community-based programs that parents and caregivers feel safe to attend."[201]

The Pennsylvania Family Support alliance administers three main prevention initiatives: the Family Support Program, the Front Porch Project, and training for mandated reporters of suspected child abuse. It has two contracts with DPW; one is for support groups and the other is to provide training to mandated reporters. According to the OCYF program budget request for fiscal year 2013-14, $272,000 was assigned to PFSA for child abuse prevention education, through the combination of CBCAP and state funds.[202] Mandated reporter training is funded exclusively with CAPTA funds; in fiscal year 2013-14, the amount was $538,445.[203] The Front Porch Project currently has no secured, ongoing funding. According to the PFSA Executive Director Ms. Angela Liddle, PFSA has relied upon private donations and "has received support for the program in targeted counties from local foundations" for this initiative.[204]

*The Family Support Program*

The Family Support Program (FSP) involves "the development and support of local, professionally facilitated mutual support groups in which individuals in a parenting role are empowered to own the groups and discuss a variety of issues impacting their families in an effort to reduce the risk of child abuse and neglect and improve overall family functioning."[205] PFSA works collaboratively with local organizations across the state to provide family support and positive parenting programs to at-risk parents and caregivers. These programs may be comprised of weekly parenting classes, support groups, or in-home visits, along with complimentary services such as meals, child care, transportation to services, and social activities. PFSA trains staff to offer

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[200] *National Fatherhood Initiative Trains Pennsylvania Department of Corrections on Delivering Fatherhood Programming to Inmates Across the State*, available at http://www.prweb.com/releases/pennsylvania-doc/insideout-ded/prweb10456267.htm (accessed February 27, 2014).

[201] Commonwealth of Pennsylvania Department of Public Welfare, Office of Children, Youth and Families. *Annual Progress and Services Report. Federal Fiscal Year 2014,* available at http://www.dpw.state.pa.us/cs/groups/webcontent/documets/report/p_039985.pdf (accessed January 28, 2014).

[202] Data provided to the Joint State Government by DPW on January 17, 2014.

[203] Data provided to the Joint State Government by DPW on January 17, 2014.

[204] Data provided in a personal e-mail to the Joint State Government Commission by Ms. Angela M. Liddle on November 22, 2013.

[205] Commonwealth of Pennsylvania Department of Public Welfare, Office of Children, Youth and Families. *Annual Progress and Services Report. Federal Fiscal Year 2014,* available at http://www.dpw.state.pa.us/cs/groups/webcontent/documets/report/p_039985.pdf (accessed January 28, 2014).

education and support to parents on topics such as child development, alternatives to physical discipline, stress and anger management, creating structure and routine for the children at home, and self-care for parents. Some programs meet in community settings and are open to any parent, while others meet in shelters, corrections settings, and other "closed" environments.

The collaboration between PFSA and local organizations maximizes resources and enhances the development of quality child abuse prevention programs. Local organizations recruit families for their programs and act as direct service providers. PFSA provides its local affiliates with "training (both initially to new staff or as new programs begin, and ongoing skills building sessions), educational materials for parents, resources for staff to use in parent group meetings, technical assistance, outcome measurement and evaluation tools and networking opportunities."[206] PFSA conducts regular site visits to programs in order to assess effectiveness, ensure quality of service, and offer assistance when needed. Participants' surveys confirm improved knowledge of various ways to discipline children and of techniques to control their own emotions and stress as well as better awareness of resources available in the community.

Family support programs affiliated with PFSA serve significant numbers of people: each year, they impact the lives of approximately 5,000 families, racially and ethnically diverse.[207] According to the DPW OCYF "Annual Progress and Services Report" for the federal fiscal year 2014, PFSA operated 167 parent support groups in 49 counties in the state fiscal year 2011-12.[208] In fiscal year 2012-13, there were 168 groups, and in fiscal year 2013-14, 173 groups.[209] Along with its affiliate agencies, in fiscal year 2013-14, PFSA ran over 50 family support and education programs statewide.[210] By addressing several risk factors and providing additional oversight to vulnerable children, the PFSA Family Support Program appears to be an effective prevention initiative.

*The Front Porch Project*

The Front Porch Project (FPP) is a general education project aimed at increasing public awareness of child abuse and neglect and at encouraging safe intervention in cases of perceived maltreatment. The FPP training is designed for the general public: anyone who is concerned about children and is interested in child abuse prevention may attend. This community-based initiative is built upon the belief that people who are concerned about the safety and well-being of children in their communities need to be encouraged to help and taught how to do it safely and effectively. The concept – and the name of the program – brings to mind "a good neighbor sitting on the "front

[206] Data provided in a personal e-mail to the Joint State Government Commission by Ms. Angela M. Liddle on November 22, 2013.
[207] Data provided in a personal e-mail to the Joint State Government Commission by Ms. Angela M. Liddle on November 22, 2013.
[208] Commonwealth of Pennsylvania Department of Public Welfare, Office of Children, Youth and Families. *Annual Progress and Services Report. Federal Fiscal Year 2014,* available at http://www.dpw.state.pa.us/cs/groups/webcontent/documets/report/p_039985.pdf (accessed January 28, 2014).
[209] Data provided in a personal e-mail to the Joint State Government Commission by Ms. Angela Liddle on June 2, 2014.
[210] Pennsylvania Family Support Alliance. *Creating a Culture that Cares for Kids Together: 2013-14 Annual Report*. Harrisburg, PA, 2014, available at http://www.pa-fsa.org/assets/2013-2014Annual%20ReportFinal.pdf (accessed October 10, 2014).

porch" in years past, who would have been aware of and helpful in solving problems affecting families they knew."[211] Belief that increased general public awareness and involvement is a powerful tool to prevent abuse and neglect before they occur impelled the Pennsylvania Family Support Alliance to sponsor this innovative, grass-roots initiative. The project was developed by the American Humane Association in 1997 and became associated with the Butler Institute for Families (University of Denver) in 2012. In view of PFSA, the strength of the Front Porch Project is "its unique focus on educating and empowering *concerned citizens* on the role they can have in protecting children and supporting families."[212]

The Front Porch Project is currently offered in three different formats: the original two-day/12-hour training, a one-day/six-hour and refresher/six-hour sessions for past participants. The format can be customized for each community and group requesting training. As PFSA defines it, the primary learning objective of this prevention initiative "is that participants will be able to identify situations in which they can comfortably and safely intervene to help a child or support a parent and to demonstrate possible responses and strategies for helping in these situations."[213] PFSA also specifies other learning objectives of the Front Porch Project:

- Understand definitions, dynamics and indicators of child abuse and neglect, as well as how the public welfare system responds to reports of suspected child abuse;
- Identify and develop comfort with diverse parenting approaches;
- Increase comfort level and confidence to step in and help children;
- Describe complex issues facing families today and how these issues impact parenting;
- Understand how culture, gender and socioeconomic status can impact the effectiveness of intervention;
- Demonstrate an understanding of resiliency in children and the importance of individual adults connecting with children in positive ways.[214]

These learning objectives are well-defined and detailed enough to deserve consideration by other child abuse prevention programs intended for the general public.

The FPP training sessions involve brief trainer presentation, small group discussions, video clips, and interactive exercises based on real-life scenarios. The training is provided by one or two experienced and highly-motivated trainers who were trained by American Humane at the beginning of the project.

Since its inception in Pennsylvania in 2011, the Front Porch training sessions have been held in fourteen counties across the state. A local sponsor – nonprofit organization, business, county or city government, or a group of interested citizens – provides the meeting space and lunch

[211] Pennsylvania Family Support Alliance. *Front Porch Project: Learn How to Protect PA's Kids from Abuse.* Harrisburg, PA 2013, available at http://www.pa-fsa.org/assets/FPP_status_report_2-11-2-13.pdf, accessed December 3. 2013.
[212] Ibid.
[213] Ibid.
[214] Ibid.

for the maximum of thirty people and organizes marketing within the community, in cooperation with the PFSA. In 2011-2013, such local partners included a variety organizations, from the Child Abuse Prevention and Outreach Committee (York County) to the Family Services of Western PA-Parent WISE (Westmoreland County), from the Children's Aid Society (Clearfield County) to the Catholic Social Services (Philadelphia), and from the University of Pittsburgh Office of Child Development (Allegheny County) to the Heart 2 Heart Parent Support Network (Venango County).

The Pennsylvania Family Support Alliance provides a certified trainer, all participant handout materials and training supplies, news releases and other promotional materials for the event; it also conducts participant registration and performs evaluation after the training. Cumulative results of these evaluations consistently show that participants feel more comfortable intervening with struggling parents, understand child abuse and neglect better, and are more willing to step in to help. Although increased awareness and changed attitudes are in themselves desirable outcomes, PFSA believes that "the true value of the Front Porch Training is its focus on providing strategies for helping that can be implemented immediately after the training" as "ultimately, the measure of success of the training lies in whether participants actually intervene when they see situations of concern regarding a child or family."[215]

Judging by the follow-up surveys of the training participants that PFSA conducts, this goal appears to be achieved in many cases: 85 percent of survey respondents stated that they had used their Front Porch Project experience to step in to help at least one child, with almost 35 percent helping a child more than five times. In addition, most of the respondents shared the information with other adults.[216]

In 2013-14, PFSA conducted 15 Front Porch sessions, with a total of nearly 400 participants, throughout Pennsylvania. Overall, over 800 people were trained in 44 Front Porch Project sessions.[217]

The Front Porch Project is a good example of a well-designed and well-executed community-based, general-public initiative that may play a notable part in facilitating primary prevention in the community.

*Mandated Reporter Training*

A substantial part of the prevention activities performed by PFSA is training it provides to mandated reporters of child abuse under the Child Protective Services Law. Since 1995, the Pennsylvania Family Support Alliance has been the premier provider of such training to non-medical professionals who are required by law to report suspected child abuse. Under contract with DPW, PFSA has developed a curriculum for education, childcare, and community service

[215] "Front Porch Project = Lasting Strategies to Protect Kids." *The Alliance*. Fall 2014, available at http://www.pa-fsa.org/assets/files/Fall%202014%20Alliance.pdf (accessed September 4, 2014).
[216] "Front Porch Project = Lasting Strategies to Protect Kids." *The Alliance*. Fall 2014, available at http://www.pa-fsa.org/assets/files/Fall%202014%20Alliance.pdf (accessed September 4, 2014).
[217] Pennsylvania Family Support Alliance. *Creating a Culture that Cares for Kids Together: 2013-14 Annual Report*. Harrisburg, PA, 2014, available at http://www.pa-fsa.org/assets/2013-2014Annual%20ReportFinal.pdf (accessed October 10, 2014).

professionals. Other trainees include law enforcement personnel, residential facility staff, and religious organizations. The funding for this program comes solely from CAPTA; in the fiscal year 2013-14 the amount is $538,445.[218] PFSA provides over a thousand hours of onsite training each year. In addition, it offers webinars and asynchronous online training.[219] The training sessions are free for organizations approved by DPW as long as the funding is available under the DPW contract. Training sessions for mandatory reporters are conducted by experienced facilitators. Each participant receives training materials such as participant guides, resource guides, and other educational supplies.[220]

In fiscal year 2012-13, PFSA provided training for 11,875 of Pennsylvania's mandated reporters.[221] In 2013-14, the number of participants trained increased by 30 percent and reached over 16,300 mandated reporters.[222] More than 400 training sessions for professionals who work with children included child care agencies, faith-based organizations, schools, universities, Head Start, residential facilities, foster care agencies, community service agencies, law enforcement agencies, juvenile justice agencies, libraries, and treatment agencies.[223] PFSA continuously strives to employ innovative technologies. In 2013-14, along with face-to-face training, it offered training through interactive webinars and is currently getting ready to introduce interactive virtual training later this year.[224]

Recent statutory changes introduced on the recommendations of the Task Force on Child Protection[225] have expanded the number of mandatory reporters and, accordingly, will require additional funding in the future. Act 126 of 2012 that currently regulates mandatory reporters training became effective January 2013. Along with other oncoming legislation, it has increased the demand for training mandatory reporters in the Commonwealth.

The PFSA's mandated reporter training program was evaluated by the Johns Hopkins University. These evaluations demonstrated significant improvement of the participant knowledge of the Child Protective Services Law and reporting requirements.[226] As these requirements have recently changed, updated training and continuing education of mandated reporters are of the essence.

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[218] Data provided to the Joint State Government Commission by DPW on January 17, 2014.
[219] Data provided in a personal e-mail to the Joint State Government Commission by Ms. Angela M. Liddle on November 22, 2013.
[220] Ibid.
[221] Data provided in a personal e-mail to the Joint State Government Commission by Ms. Angela M. Liddle on June 2, 2014.
[222] Pennsylvania Family Support Alliance. *Creating a Culture that Cares for Kids Together: 2013-14 Annual Report*. Harrisburg, PA, 2014, available at http://www.pa-fsa.org/assets/2013-2014Annual%20ReportFinal.pdf (accessed October 10, 2014).
[223] Ibid.
[224] Ibid.
[225] Joint State Government Commission. *Child Protection in Pennsylvania: Proposed Recommendations: Report of the Task Force on Child Protection*. Harrisburg, PA: Joint State Government Commission, 2012.
[226] Data provided in a personal e-mail to the Joint State Government Commission by Ms. Angela M. Liddle on June 2, 2014.

In addition to running three major prevention initiatives, the Pennsylvania Family Support Alliance distributes a quarterly newsletter, leads the observance of Child Abuse Prevention Month every April, and generally remains a leader in child abuse awareness and prevention in the Commonwealth.

In May 2014, PFSA issued a research study to examine prevailing attitudes to child abuse in order to identify actionable ways to assure better child protection. The study "Childhood at Risk: An Exploration of Perceptions and Attitudes Regarding Child Abuse" is based on a series of statewide consumer focus groups and a statewide consumer survey. It is a combined effort of PFSA and Franklin & Marshall College. Franklin & Marshall College's Center for Opinion Research conducted a telephone survey of over a thousand adult Pennsylvania residents in November and December 2013. The focal topics included awareness of the problem, impediments to reporting or intervention, best predictors for reporting abuse, and others.

The study identified four variables that increase the likelihood of reporting suspected child maltreatment:

(1) Those who attended child abuse training were more likely to have seen and reported abuse.
(2) Those who reported they definitely knew how to report abuse were more likely to have seen and reported abuse.
(3) Those who believe neglect and abuse is a very serious problem were more likely to have seen and reported abuse.
(4) Those who personally experienced mental or physical abuse as a child were more likely to have seen and reported abuse.[227]

These findings suggest the importance of training and educating both mandated reporters and the general public.

An area of concern that emerged as a result of the PFSA study is that only one third (32 percent) of respondents who had suspected child abuse called ChildLine.[228] The rate of reporting was found higher among mandated reporters (52 percent) than permissive reporters (22 percent), but the fact that only half of those who are mandated by law to report suspected child abuse, actually, reported it indicates that training for mandated reporters is insufficient and inconsistent and needs to improve. PFSA is well-positioned to continue and expand this training.

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[227] Pennsylvania Family Support Alliance. *Childhood at Risk: An Exploration of Perceptions and Attitudes Regarding Child Abuse*. May 2014, available at http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/Foster_care_reform/time_for_reform.pdf (accessed May 6, 2014).

[228] Pennsylvania Family Support Alliance. *Childhood at Risk: An Exploration of Perceptions and Attitudes Regarding Child Abuse*. May 2014, available at http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/Foster_care_reform/time_for_reform.pdf (accessed May 6, 2014).

# PENNSYLVANIA:
# CHILD ABUSE PREVENTION IN THE MEDICAL FIELD

### *Suspected Child Abuse and Neglect (SCAN) Program*

*Mandated Reporter Training*

While the Pennsylvania Family Support Alliance provides mandated reporter training to non-medical professionals, SCAN targets doctors, nurses, and other medical practitioners who are mandated reporters of suspected child abuse and neglect under the Pennsylvania Child Protective Services Law. The Suspected Child Abuse and Neglect Program is run by the Pennsylvania Chapter of the American Academy of Pediatrics (PA AAP) under contract with the Pennsylvania Department of Public Welfare. It is funded by DPW. The amount for fiscal year 2013-14 is $285,496.[229]

Started in 1999, the SCAN program was the first child abuse education program in the Commonwealth focused on medical providers. The SCAN Program Director Ms. Teresa Olsen points out that "as the respected professional organization of pediatricians statewide, the PA AAP is uniquely positioned to deliver this training."[230] Since the program's initiation in October 1999 to November 30, 2013, over 200 SCAN presenters across the state have conducted 1,150 presentations to 25,433 people.[231] The SCAN program has been presented at several state and national conferences including the American Professional Society on the Abuse of Children (APSAC), the Pennsylvania Emergency Medical Services, the National Association of School Nurses, the Pennsylvania Association of School Nurses and Practitioners, and the National Emergency Nurses Association.

SCAN training sessions are conducted by a physician and a local Children and Youth worker. By pairing practitioners from these two fields, the SCAN presentation team "has served as a model of the collaboration that is possible – and needed – between the medical community and child protective services."[232] Thus, the training not only enhances the participants' knowledge of the signs and indicators of child maltreatment and reviews their role and responsibilities as mandated reporters under the law, but also familiarizes them with the Children and Youth's investigative process.

[229] Data provided to the Joint State Government Commission by DPW on January 17, 2014.
[230] Personal e-mail from Ms. Teresa Olsen to the Joint State Government Commission, received on December 16, 2013.
[231] Data provided to the Joint State Government Commission by Ms. Teresa Olsen on December 16, 2013.
[232] Ibid.

The Pennsylvania Chapter of the American Academy of Pediatrics currently offers five educational programs designed to help medical professionals recognize and report suspected child maltreatment:

- EPIC-SCAN: Educating Physicians in their Community on Suspected Child Abuse and Neglect for primary care practices;
- SCAN Express: A shortened version of EPIC-SCAN for primary care practices;
- SCAN-SN: Suspected Child Abuse and Neglect Education for School Nurses;
- SCAN-HS: Suspected Child Abuse and Neglect for Hospital Staff;
- SCAN-EMS: Suspected Child Abuse and Neglect Education for Emergency Medical Services personnel.[233]

All programs are provided on-site and free of charge, including training materials.

EPIC-SCAN focuses on peer-to-peer education that takes place at the pediatric or family practice location and includes the entire office staff. It is designed to encourage change in the day-to-day practice procedures. EPIC-SCAN is a 1 ½-hour PowerPoint presentation, often offered during the office lunch break. CME/CEU credits are awarded to eligible staff for participation in the program. Each practice site receives a Child Abuse Office Kit, which includes contact information, prevention materials, forms, recommended office protocol, and a brochure of Frequently Asked Questions. By the end of 2013, over 8,200 people participated in EPIC-SCAN presentations.[234]

SCAN Express is a shortened version of EPIC-SCAN, lasting for 45 minutes. It includes an overview of what to look for, how to report, and what happens after a report of suspected child abuse is made. The same training materials are distributed to participants. By the end of 2013, over 2,600 people received the SCAN Express training.[235]

SCAN-SN, the Suspected Child Abuse and Neglect Education Program for School Nurses, is designed to address the clinical and legal issues confronted by school nurses in Pennsylvania. The presentation lasts for an hour and a half; each participant receives a guidebook. This program is primarily offered as an in-service training through the Intermediate Units and also at regional and state conferences. SCAN-SN is approved as Act 126 credit by the Pennsylvania Department of Education. By the end of 2013, SCAN-SN presentations were given to over 2,700 school nurses.[236]

[233] Data provided to the Joint State Government Commission by Ms. Teresa Olsen on December 16, 2013.
[234] Ibid.
[235] Ibid.
[236] Ibid.

SCAN-HS, the Suspected Child Abuse and Neglect Education Program for Hospital Staff, is a one-hour program that is usually offered during Grand Rounds and department meetings and covers the basics of identification and reporting of suspected child abuse. By the end of 2013, over 4,700 attended these presentations.[237]

SCAN-EMS, the Suspected Child Abuse and Neglect Education Program for Emergency Medical Service Providers, is the latest SCAN model, introduced in 2004. Its targeted audience includes EMTs, paramedics, and pre-hospital registered nurses in Pennsylvania. This is a three-hour continuing education program presented by an EMT instructor, emergency department nurse or physician, and a local Children and Youth worker. It is offered at regional and state conferences as well as on-site for larger EMS groups. SCAN-EMS emphasizes the importance of scene assessment, documentation, and teamwork in the recognition and reporting of suspected child abuse. Each participant receives a training packet. By the end of 2013, over 6,000 people attended the SCAN-EMS presentations.[238]

According to Ms. Olsen, the SCAN program director, another group that could benefit from it is early intervention therapists who provide services in the home of children with special needs, and the program leaders will develop a SCAN curriculum for this group if additional funding becomes available.[239]

*Physician Education*

Child Abuse Preceptorship

Recognizing the need for more in-depth training for practicing physicians on the thorough evaluation and diagnosis of physical and sexual abuse, in 2008 the PA AAP established a Child Abuse Preceptorship. The preceptroship is designed for physicians who conduct exams in their community and are interested in improving their skills. It covers issues such as the role of the medical provider, evaluation, and diagnosis of child physical and sexual abuse, interpretation, and documentation of findings, testifying as a medical expert, use of technology, networking, and team development.[240]

The 60-hour preceptorship includes 16 hours of didactics and 44 hours of observation with the child abuse team at the Children's Hospital in Philadelphia, Children's Hospital of Pittsburgh, and the Children's Resource Center in Harrisburg. Three participants are selected each year with special consideration given to those affiliated with a Child Advocacy Center and also those in geographic locations that are a significant distance from major medical centers.[241] Funding is available to offset the cost of travel, meals, and lodging. By the end of 2013, 31 physicians have completed the preceptorship with 15 of those directly working with Child Advocacy Centers in

[237] Ibid.
[238] Ibid.
[239] Personal e-mail from Ms. Teresa Olsen to the Joint State Government Commission, received on December 16, 2013.
[240] Data provided to the Joint State Government Commission by Ms. Teresa Olsen on December 16, 2013.
[241] Ibid.

eleven counties.[242] With the state-wide emphasis on adding more Child Advocacy Centers, physicians' interest in the preceptorship is expected to increase.

Cheat Sheet

To increase healthcare providers' ability to recognize signs of child abuse and to choose an appropriate line of action, the SCAN Advisory Board created a yellow laminated card called "Just a Cheat Sheet for the Initial Evaluation of Suspected Child Physical Abuse" to help medical professionals, especially in the hospital setting, know what to do when confronted with suspected abuse. Content is based on guidelines set forth by the American Academy of Pediatrics. The cheat sheet has been sent to hospitals, primary care providers, and medical schools throughout the Commonwealth. Practitioners have, apparently, found the Cheat Sheet useful as the SCAN program continues to receive requests for additional copies.[243]

*General Public Education and Primary Child Abuse Prevention*

In addition to mandatory reporters' training and other initiatives targeted at medical professionals, the Pennsylvania Chapter of the American Academy of Pediatrics contributes to child abuse prevention by distributing Help cards and Crying cards.

The Help card encourages parents to ask for and accept help caring for their child if they need it. The card contains helpful tips and suggestions to parents and offers guidance for those who are concerned about the health and safety of other children. Pocket-size Help cards are printed in English and Spanish. They are free of charge and come in packs of a hundred. By the end of 2013, 383,000 Help cards had been given to police departments, social service agencies, and various community organizations throughout the state.[244]

As it is well known that infant crying can be a trigger for child abuse, PA AAP created the Crying card. Laminated cards available in English and Spanish offer tips to help calm a crying baby. They are free of charge and come in pack of a hundred. Over 673,000 Crying cards have been distributed to parents of newborns through hospitals, family and pediatric practices, the Pennsylvania Shaken Baby Education Program, and organizations that work with high-risk populations.[245]

### *Prevent Child Abuse Pennsylvania (PCA PA)*

Another way that the Pennsylvania Chapter of the American Academy of Pediatrics contributes to child maltreatment prevention is through Prevent Child Abuse Pennsylvania (PCAP PA). This is the only state where the state chapter of Prevent Child Abuse America is directly connected to the state chapter of the American Academy of Pediatrics. In fact, Ms. Olsen, SCAN Program Director, is also the Acting Director for the PCA PA.

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[242] Ibid.
[243] Ibid.
[244] Data provided to the Joint State Government Commission by Ms. Teresa Olsen on December 16, 2013.
[245] Ibid.

Prevent Child Abuse America (PCA America), founded in 1972 in Chicago, is an organization striving to prevent child maltreatment and ensure the healthy development of children nationwide. It has 50 chapters and nearly 600 Healthy Families America home visiting sites in 39 states.[246] While similar in their shared focus on child maltreatment prevention and in many of the activities they support and implement such as advocacy, public awareness, training/education, prevention programming, coalition building, and Child Abuse Prevention Month activities among others, PCA America's state chapters are also independent of one another and unique in terms of the kinds of strategies and programs they offer.[247]

Prevent Child Abuse Pennsylvania is a young chapter of the PCA America. It held its first organizational meeting in March 2009 and was accepted as a Chartered Chapter of Prevent Child Abuse America in November 2010.[248] With the mission of preventing child abuse before it happens anywhere in Pennsylvania, PCA PA seeks an approach that is locally based and statewide in coverage. It defines its focal areas as

- Public awareness of child abuse;
- Public participation in prevention of child abuse;
- Public policy and advocacy to promote prevention;
- Utilization and promotion of evidence-based prevention programs for children, caregivers and parents.[249]

PCA PA participates in the national campaign called "The Pinwheels for Prevention", that was launched by the PCA America in 2008 in order to increase public awareness of child maltreatment and to generate funds for prevention. The pinwheel, which symbolizes a carefree childhood for all children, has been established as the new symbol of child abuse prevention. Agencies and individuals can order the pinwheels through the PCA PA website, where they can also find helpful advice regarding creative use of pinwheels in various community activities and projects.[250]

Striving to increase public involvement in child abuse prevention, PCA PA has introduced the program One Kind Word. The program was first presented by PCA PA to a group of people working for a client-serving organization in Philadelphia. The Acting Director of PCA PA, Ms. Teresa Olsen, has also trained staff at two other Philadelphia locations: at Friend's Hospital (caseworkers who work with clients in the home) and for caseworkers at Congreso. PCA PA has selected as the primary audience for this program employees in public areas who regularly interact with families, and the goal is to extend this to the medical community.[251]

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[246] *Prevent Child Abuse America,* available at http://www.preventchildabuse.org/index.php (accessed March 25, 2014).
[247] *Prevent Child Abuse America. Our State Chapters,* available at http://pcadb.cyberwoven.com/public/chapters/index.cfm (accessed March 25, 2014).
[248] *Prevent Child Abuse Pennsylvania*, available at http://preventchildabusepa.org/about/who-we-are (accessed March 25, 2014).
[249] Ibid.
[250] *Prevent Child Abuse Pennsylvania*. *Pinwheels for Prevention Campaign*, available at http://preventchildabusepa.org/component/k2/item/44-pinwheels-for-prevention (accessed March 25, 2014).
[251] Personal e-mail to the Joint State Government Commission from Ms. Teresa Olsen received on March 21, 2014.

Dr. Maria McColgan implemented One Kind Word in her family Zone Project at St. Christopher's Hospital for Children. All staff members were trained, and the initial data suggest that employees' use of One Kind Word has had a noticeable impact for both staff and visiting families.[252] PCA PA is planning to offer One Kind Word training to more organizations in the future.

One Kind Word workshops are intended to teach individuals who work in public areas and client-serving employees the skills to identify families who are in conflict, parents and caretakers who are in distress, and children who are unsafe, and subsequently, to use empathy to address the conflict or unsafe situation with one of three strategies:

- distract,
- connect,
- assist.[253]

The program is a call to action and a reminder to anyone who sees a stressed parent or an unsafe child to be supportive and step in to diffuse conflict and ensure the child's safety. One Kind Word uses "a train-the-trainer model for enhanced sustainability and capitalization on employees' buy-in."[254]

Family Resources, which is based in Pittsburgh, has conducted One Kind Word training for a variety of companies and agencies in the area, including Early Head Start of Allegheny County, Girl Scouts of Western PA, Pittsburgh Zoo and PPG Aquarium, Women, Infants & Children (Allegheny County) and others. The results indicate that One Kind Word workshops increase awareness of parent-child conflict and child safety situations, improve participants' attitudes from negative and judgmental to friendly and empathetic, and increase the likelihood of trainees to take action in such circumstances.[255]

### *Prevention Programs in Health Care Settings*

The past decade has brought growing attention to behavioral interventions and counseling to prevent child abuse and neglect in health care settings. It is well known that medical professionals are mandatory reporters of suspected child maltreatment and should receive quality training on the ability to recognize signs of child abuse and the current procedures of reporting. A more recent development is the understanding that pediatric doctors and nurses also have opportunities to play significant roles in primary prevention. Several clinic-based prevention programs have emerged and have shown promising results.

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[252] Ibid.
[253] *One Kind Word: A Program of Family Resources*. Materials submitted to the Joint State Government Commission by Ms. Teresa Olsen on March 21, 2014.
[254] Ibid.
[255] Ibid.

A recent meta-analysis of randomized trials of risk assessment and interventions for child abuse and neglect in health care settings indicated "reduced physical assault, Child Protective Services (CPS) reports, nonadherence to medical care, and immunization delay among screened children" for a pediatric clinic for children aged 5 years or younger, and positive though inconsistent results for early childhood home visitation programs.[256] Most people agree that "physicians and other health care providers who care for children and families are uniquely situated to identify children at risk for abuse and neglect during well-child and other visits and to initiate interventions to prevent harm."[257] Although pediatricians feel screening for maltreatment is one of their important roles, data show many of them do not do it on a regular basis. "Barriers to screening include lack of experience, training, and confidence in handling abuse cases."[258] This underscores the importance of physician training that would make medical professionals more comfortable in performing risk assessment and interventions.

The review included studies "if they enrolled children without obvious signs or symptoms of abuse or neglect, used a method to identify families or children at risk that was applicable to primary care, evaluated an intervention that primary care clinicians could access or provide referral for, and compared outcomes between intervention and nonintervention groups."[259] Potential adverse effects were also considered. The reviewers concluded that "trials of risk assessment and behavioral interventions and counseling in pediatric clinics and early childhood home visitation programs indicated reduced abuse and neglect outcomes for young children, although all trials had limitations and trials of home visitation reported inconsistent results."[260] The authors think that more research is needed.

In addition to mandatory training and physician education initiatives directly run by the Pennsylvania Chapter of the American Academy of Pediatrics and its affiliate Prevent Child Abuse Pennsylvania, several other physician education programs have been established in the Commonwealth. One of them is Family Safe Zone, a project led by Dr. Maria McColgan at St. Christopher's Hospital for Children. Family Safe Zone is run in collaboration with the Institute for Safe Families (ISF) & St. Joseph University and the Congreso & Children Crisis Treatment Center (CCTC). The program's goal is to improve parenting and discipline practices through a multi-level parenting intervention in pediatric setting. Family Safe Zone includes training for providers and staff, parenting intervention and evaluation. The Partnering with Parents (PwP) curriculum offered by the ISF includes the discussion of negative effects of corporal punishment, alternative forms of positive discipline, and providers' screening of discipline practices and anticipatory guidance in effective discipline. One Kind Word curriculum teaches health care professionals and staff to intervene in a positive manner when witnessing harsh parenting in public spaces.[261] An onsite-parenting specialist provides education and support to at-risk parents and caregivers. Evaluation is performed by clinic waiting room observations, providers and staff surveys as well as parents pre- and post-surveys. Providers' surveys indicate increased

[256] Selph, Shelley S. et al. "Behavioral Interventions and Counseling to Prevent Child Abuse and Neglect: A Systematic Review to Update the U.S. Preventive Services Task Force Recommendation." *Annals of Internal Medicine*. Vol.158. No.3. P. 179.
[257] Ibid. P. 180.
[258] Ibid. P. 180.
[259] Ibid. P. 180.
[260] Ibid. P. 188.
[261] One Kind Word program is described in more detail on p. 58.

compassion for stressed and distracted parents and increased comfort in intervening. Parents showed significant reductions in stress and corporal punishment after counseling.[262]

Another program aimed at educating physicians on child abuse and neglect prevention is Purposeful Parenting. It was developed by the Ohio Chapter of the American Academy of Pediatrics. One of the three developing pilot sites is located in Pittsburgh. Purposeful Parenting offers pediatricians developmentally aligned anticipatory guidance for parents during successive visits to the doctor's office at birth, 9 months, 18 months, and 36 months.[263]

Both Family Safe Zone and Purposeful Parenting rely on the recent developments in early brain development research. They seek to help parents decrease toxic stressors, such as physical punishment or lack of safety, and thus, make the child's environment more conducive to growth and healthy development.

Maryland has been successfully using another program aimed at integrating the screening and management of psychosocial issues into the delivery of well-child health care: SEEK. The SEEK project, funded by the U.S. Department of Health and Human Services, Administration on Children and Families, the CDC, and the Doris Duke Foundation, "offers a practical approach to the identification and management of targeted risk factors for child maltreatment for families with children aged 0-5, integrated into pediatric primary care."[264] This is how the University of Maryland Medical Center, that developed the program, describes the program goals: "By addressing these problems, SEEK aims to strengthen families, support parents, and thereby enhance children's health, development and safety, while helping to prevent child maltreatment."[265] The SEEK model includes four main components:

- Training health professionals to briefly assess and initially manage identified problems;
- Using the Parent Screening Questionnaire to identify several common problems that are risk factors for child maltreatment, such as maternal depression, alcohol and substance abuse, and parental stress and difficulty coping;
- Collaborating with a social worker to help address problems, including referrals to community resources;
- Distributing simple, one-page parent handouts covering approximately ten common problems and customized for each practice location, including information on local resources.[266]

[262] Information about the Family Safe Zone program provided by Dr. Maria McColgan in her presentation at the SCAN Advisory Board meeting on December 12, 2013.
[263] Information about the Purposeful Parenting program provided to the Joint State Government Commission by Ms. Patricia Sprague on December 11, 2013.
[264] University of Maryland Medical Center. *SEEK Project*, available at http://umm/edu/programs/childrens/services/child-protection/seek-project (accessed June 30, 2014).
[265] Ibid.
[266] Ibid.

SEEK and Purposeful Parenting deserve consideration for implementing in the Commonwealth as they can assist pediatricians in addressing critical psychosocial issues in the child's environment and thus, reducing the risk of child maltreatment.

*Penn State Hershey Center for the Protection of Children* (CPC)

The Center for the Protection of Children (CPC) was launched in December 2011. It is based at the Penn State Hershey Children's Hospital on the campus of the Penn State Milton S. Hershey Medical Center and the Penn State College of Medicine. CPC is supported by a portion of the University's 2011 Big Ten Bowl proceeds and by the Penn State Hershey Children's Hospital. The Center leadership also seeks public and private philanthropic contributions.

The Penn State Hershey Center for the Protection of Children brings together an interdisciplinary group of clinicians and researchers whose goals are to

- Provide comprehensive care for children who have experienced abuse;
- Improve reporting and early identification of suspected abuse;
- Advance knowledge about how best to protect and support vulnerable children and their families; and ultimately
- Prevent maltreatment.[267]

In addition to in-patient activities within the Penn State Children's Hospital, the Division of Child Abuse Pediatrics has established an outpatient presence that will grow into the TLC (Transforming the Lives of Children) Clinic, which will serve as a "medical home" clinic for at-risk children in out-of-home placement. When victims of child abuse are placed in out-of-home foster care, their lives often lack the stability and continuity every child needs for healthy development, including continuity of medical care. Often, they suffer from a variety of medical, psychological and developmental problems that may not be adequately addressed in a foster-care setting. In some cases, there is also risk for further abuse. The TLC Clinic is intended to provide primary care to such children and coordinate all the necessary interventions they require.

CPC has developed several electronic projects that are currently in various stages of completion.

"Look Out for Child Abuse" is the web site collaborative of the Penn State Children's Hospital, the Penn State Department of Humanities, and the Center on Children and the Law of the Penn State Dickinson School of Law. The site was designed to be a repository of information regarding child abuse and neglect. This online resource provides information about various aspects of child maltreatment, including education on legal issues, prevention strategies, education on how to recognize child abuse and how to respond to it, and resources for victims and survivors. "Look Out for Child Abuse" also provides an opportunity for electronic reporting of suspected child abuse.

[267] Information about the Center for the Protection of Children provided to the Joint State Government Commission by Dr. Benjamin H. Levi, Director of the CPC, on November 21, 2013.

In conjunction with the Penn State Hershey's Department of Public Health Sciences and Information Technology Department, CPC is developing a relational database that will allow Penn State clinicians and researchers to catalogue and analyze a wide array of data on children evaluated and treated for suspected abuse. This database will allow researchers to

- Identify/quantify risk factors and findings (physical, social, etc.) that influence child protection efforts;
- Assess the quality of medical care provided, especially vis-à-vis professional standards;
- Perform multifactorial analysis to examine the relationship between grouped variables, including demographic factors (child's sex, age, socio-economic status, etc.), clinical features (severity of head trauma, kind of abuse, etc.), interventions (medical treatments, mental health services, etc.), outcomes (physical, developmental, psychological, etc.), and so forth;
- Examine utilization rates, efficacy of clinical interventions, outcomes optimization, etc.;
- Perform and represent the results of regression analysis using advance data dashboard functionality.[268]

All of these can facilitate child abuse research and treatment and, ultimately, lead to better outcomes for Pennsylvania children.

Another CPC electronic project is iLook out for Child Abuse. It involves creating multi-media, interactive, eLearning modules to prepare individuals to be responsible mandated reporters of suspected child abuse. The curricular goals are to

- Provide a broad overview of the five types of abuse and their occurrence;
- Explain the threshold that should trigger mandated reporting of suspected abuse, and share resources for helping individuals better recognize signs of abuse;
- Change learners' attitude by
    a) Helping them identify with the vulnerability of children at risk for abuse,
    b) Demonstrating that they as individuals can make a difference,
    c) Evoking a sense of responsibility to protect children at risk for abuse,
    d) Motivating them to take action.[269]

The intended audience is early childhood educators, staff, and administrators. The project will be available free of charge to early childhood education practitioners throughout Pennsylvania.

[268] Information provided to the Joint State Government Commission by Dr. Benjamin Levi on November 21, 2013.
[269] Information provided to the Joint State Government Commission by Dr. Benjamin Levi on November 21, 2013.

CPC has also introduced a simulation center project to prepare pediatric residents how to initiate a constructive and effective dialogue with parents when evaluation for child abuse is warranted.[270]

To improve identification of children who are at-risk for abuse and their medical treatment, CPC has launched a number of clinical initiatives. One of them, developed in collaboration with the Penn State Hershey Information Technology Department, is the creation of a Pop-Up Alert that will fire when clinical staff first opens the electronic medical record of a child at risk. The Alert reads: "Abuse or suspected abuse has previously been considered for this child. See chart for additional details." This Alert will remain active for 18 months for any child referred to Children Youth Services for suspected abuse, and until age 18 for any child for whom "Child Abuse" was added to the "problem list" within the electronic medical record.[271]

CPC is actively engaged in educating healthcare medical staff both internally and externally on child abuse issues.

### *Pennsylvania Shaken Baby Syndrome Prevention and Awareness Program*

One of the prevention programs most widely applied in medical setting in Pennsylvania is the Shaken Baby Syndrome Prevention & Awareness Program. Started in 2003, it eventually involved all maternity hospitals in the Commonwealth and by 2006 was reaching nearly 90 percent of newborn babies.[272]

Abusive head trauma (AHT), also known as Shaken Baby Syndrome (SBS), is one of the most severe forms of child abuse. It is caused by the violent shaking of the baby with or without impact against an object and can lead to devastating consequences. The majority of victims are less than one year old. Up to one-quarter or even one-third of these infants die as a result of direct brain injuries.[273] Thousands of survivors suffer permanent neurological damage such as blindness, seizures, paralysis, and cognitive insufficiencies. In addition to tragic human costs, the financial costs to society are also enormous, with initial inpatient hospitalization averaging $18,000 to $70,000 and ongoing medical costs exceeding to hundreds of thousands.[274]

Shaken Baby Syndrome is a preventable tragedy. A parent or caregiver may start shaking a baby violently if the baby would not stop crying. Since unstoppable crying is the primary reason that infants are shaken, it is important to inform parents how to deal with the frustrations of a crying baby and to equip them with effective coping strategies. Educated parents would not only

[270] Information provided to the Joint State Government Commission by Dr. Benjamin Levi on November 21, 2013.
[271] Information provided to the Joint State Government Commission by Dr. Benjamin Levi on November 21, 2013.
[272] Data provided to the Joint State Government Commission by Dr. Mark Dias, Principal Investigator (Head of the Program), on April 1, 2014.
[273] Dias, Mark S. et al. "Preventing Abusive Head Trauma Among Infants and Young Children: A Hospital-Based, Parent Education Program." *Pediatrics*. 2005. Vol. 115. No. 4. P. 470.
[274] Ibid.

avoid this dangerous behavior in the future, but would become advocates for their child's safety, sharing the information they learnt with their relatives, friends, and child care providers.[275]

The Shaken Baby Syndrome Prevention & Awareness Program was developed in 1998 in Upstate New York by Dr. Mark Dias, pediatric neurosurgeon. It is a coordinated, hospital-based parent education program, targeting parents of all new-born infants. When used as a pilot in several New York counties, the program showed very promising results: the incidence of abusive head injuries decreased by 47 percent.[276] The program's expansion to pediatric offices in 2005 brought an additional 10 percent decrease in infant abusive head injuries.[277]

Inspired by the success of the Shaken Baby Syndrome program in New York State, Pennsylvania started the identical program. Piloted in Central Pennsylvania in 2002, it was later expanded to the entire state, with all birthing and children's hospitals participating in what came to be known as the Pennsylvania Shaken Baby Syndrome Prevention & Awareness Program. The program was supported by the Shaken Baby Syndrome Education Act of 2002 and received its funding from the Pennsylvania Department of Health. In October 2007, the Centers for Disease Control awarded the Pennsylvania Shaken Baby Syndrome Prevention & Awareness Program a five-year $2.8 million dollar grant to expand the prevention efforts by adding a "booster" at pediatric and family practice offices in 16 counties in Central Pennsylvania. This complimentary education was presented at the 2-month, 4-month, and 6-month immunization visits.[278]

As in the past two decades public awareness of the dangers of violently shaking the baby had increased, the program creators decided that offering it to new parents at a specific time might be more effective than simply expanding general education efforts. As Dr. Dias suggested, "the role of prevention might be not to educate the general public but to remind the right people at the right time".[279] He posited that "a simple program containing a powerful message, administered at the appropriate moment and requiring very little effort or time on the part of those who deliver the message and those who receive it, has the greatest chance of success."[280] Parents of all newborn infants were provided with educational materials about violent baby shaking, first and foremost, a brief video, and asked to sign a voluntary commitment statement confirming their participation.

Regrettably, the Pennsylvania Shaken Baby Syndrome Prevention & Awareness Program failed to replicate the New York state success; in spite of the staff's diligence and dedication, it did not reduce the incidence of abusive head trauma in the Commonwealth. In fact, according to the study performed by Dr. Dias, the incidence rose during the intervention period.[281]

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[275] *Pennsylvania Shaken Baby Syndrome Program*, available at http://www.pennstatehershey.org/web/shakenbaby/home/aboutus (accessed April 5, 2014).
[276] Dias, Mark S. et al. "Preventing Abusive Head Trauma Among Infants and Young Children: A Hospital-Based, Parent Education Program." *Pediatrics*. 2005. Vol. 115. No. 4. P. 470.
[277] *Pennsylvania Shaken Baby Syndrome Program*, available at http://www.pennstatehershey.org/web/shakenbaby/home/aboutus (accessed April 5, 2014).
[278] *Pennsylvania Shaken Baby Syndrome Program*, available at http://www.pennstatehershey.org/web/shakenbaby/home/aboutus (accessed April 5, 2014).
[279] Dias, Mark S. et al. "Preventing Abusive Head Trauma Among Infants and Young Children: A Hospital-Based, Parent Education Program." *Pediatrics*. 2005. Vol. 115. No. 4. P. 471.
[280]Dias, Mark S. et al. "Preventing Abusive Head Trauma Among Infants and Young Children: A Hospital-Based, Parent Education Program." *Pediatrics*. 2005. Vol. 115. No. 4. P. 475.
[281] Data provided to the Joint State Government Commission by Dr. Dias on April 1, 2014.

The stark contrast in the results observed between the two regions in New York and Pennsylvania can be explained by various reasons, from the difficulty in operationalizing such a study with fidelity on a statewide level, to the insufficient exposure of some parents to the program, to inaccurate ascertainment of incidence in Pennsylvania before the intervention. Another reason may be an unfortunate coincidence of the program implementation in the Commonwealth with the national recession, which has caused a substantial rise in abusive head trauma incidence rates.[282]

The program principal investigator, Dr. Dias, and his team have carefully examined all possible reasons for the unexpected differences in the results. They noted that there has been the relative risk reduction in both states and that it may take longer for such an intervention to have a significant impact on incidence rates in a state as large as Pennsylvania compared with smaller regions such as Upstate New York. The program leaders were pleased with the parents' assessment of the intervention. The overwhelming majority of parents exposed to the program indicated in their surveys that they feel it imparts a high degree of educational value. One of the findings that researchers found most encouraging was that almost three-quarters of respondents reported that they had recalled the information at exactly the right time: when their infant was crying.[283] Parents also reported that the information they received from the nurse trainers helped them choose other caregivers for their infant more carefully.

In addition to these positive responses, an advantage of the Shaken Baby Syndrome Prevention & Awareness Program is its low cost: "when the costs for the research component are excluded, the costs for developing, implementing and monitoring the intervention, at $2.98 per infant, are significantly less than the cost of single immunization."[284] This excludes the printing and distributing the materials, which in this case, were provided by the Pennsylvania Department of Health. The cost of the time a nurse trainer would spend delivering the program (an average of 10 minutes) would add $5.44 per infant.[285] Low costs are critical for primary prevention.

One of the important conclusions is the recognition of formidable challenges that arise when a program is implemented and disseminated on a large scale.

As the latest study on the Pennsylvania Shaken Baby Syndrome Prevention & Awareness Program failed to demonstrate a statistically significant decline in AHT incidence as a result of the hospital-based intervention similar to the one observed in Upstate New York, further research may be required. Dr. Dias maintains the hypothesis that a repeated exposure to the information about infant crying and the dangers of violent shaking, along with demonstrating alternative ways to handle the situation and with providing parents support in their time of need through community resources, may reduce the incidence of abusive head trauma. He also believes that as the latest study has demonstrated that although a program of hospital-based parent education by maternity nurses can be readily implemented with high compliance, reasonable fidelity, high parental acceptance, and relatively low cost, it may be insufficient to significantly impact the incidence of abusive head trauma; therefore, other public health measures need to be identified and studied.[286]

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[282] Ibid.
[283] Ibid.
[284] Data provided to the Joint State Government Commission by Dr. Dias on April 1, 2014.
[285] Ibid.
[286] Ibid.

### *Safe Haven*

Pennsylvania hospitals are instrumental in the implementation of the Safe Haven program. All Pennsylvania hospitals serve as safe havens.

Safe haven laws have been enacted to address infant abandonment and infanticide. These laws were designed as in incentive for parents in crisis to safely relinquish their newborn babies to designated locations where the babies are protected and provided with medical care until a permanent home can be found for them. The purpose of these laws is to prevent babies from being abandoned at places where they may come to harm or from becoming victims of violence. Safe haven laws generally allow the parent to remain anonymous and to be shielded from prosecution for abandonment or neglect when surrendering the baby to a safe haven. To date, all fifty states, the District of Columbia, and Puerto Rico have enacted safe haven legislation.[287]

Safe Haven of Pennsylvania, also known as the Newborn Protection Act, was enacted in 2002. It defines a newborn as a child less than 28 days of age as reasonably determined by a physician and states that any parent may leave the newborn baby in the care of a hospital without being criminally liable as long as the baby is not harmed.[288] The Safe Haven home page, posters, brochures, and crisis cards are designed to inform pregnant girls and young women who are "desperate or hiding their pregnancies…that their baby can be kept healthy and safe without anyone knowing they gave birth and without any criminal repercussions."[289] No personal information is asked when babies are left at the hospital. Parents may provide medical information for the baby or take a health history form with them to fill out and mail in anonymously, but it is not required. After the baby is left at the hospital, it will be examined by the doctor and receive any medical care needed. Then, the local county children and youth agency will take custody of the child. "Safe Haven gives mothers a safe, legal and confidential alternative to abandoning their baby."[290]

In addition to custodial care of the Safe Haven babies, county children and youth agencies are required to provide outreach and counseling services to prevent newborn abandonment and to continue the prevention of newborn abandonment publicity and education program.[291]

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[287] Child Welfare Information Gateway. *Infant Safe Haven Laws.* Washington, D.C.: U.S. Department of Health and Human Services, Children's Bureau, 2013, available at https://www.childwelfare.gov/systemwide/laws_policies/statutes/safehaven.cfm (accessed June 2, 2014).

[288] 23 Pa.C.S. §§ 6502, 6503.

[289] Safe Haven. *Educate others about Safe Haven*, available at http://www.secretsafe.org/Educate.asp (accessed May 19, 2014).

[290] Safe Haven. *FACT SHEET Pennsylvania's Safe Haven Law*, available at http://www.secretsafe.org/FactSheet.asp (accessed May 19, 2014).

[291] Pennsylvania Department of Public Welfare. *Annual Child Abuse Report 2013*, available at http://www.dpw.state.pa.us/cs/webcontent/documents/report/c_086251.pdf (accessed June 18, 2014).

To ensure that accurate information about Safe Haven is available to all Commonwealth residents, the Department of Public Welfare maintains a statewide, toll-free helpline, 1-866-921-7233 (SAFE), and the Safe Haven website, www.secretsafe.org.[292] The helpline gives callers the opportunity to speak with a person regarding Safe Haven and to find out the location of the nearest hospital. The Safe Haven website is tailored to expectant mothers and has education materials available for download.[293]

To increase public awareness about the Safe Haven program, the Department of Public Welfare extends various outreach efforts. DPW provides educational materials such as brochures, posters, and crisis cards to all hospitals and county children and youth agencies. Radio and online advertisements run throughout the year. Public Service Announcements run in three of Pennsylvania's media markets, Philadelphia, Pittsburgh, and Harrisburg, which cover 70 percent of Pennsylvania's population.[294] Statewide campaigns run online (Google, Facebook, Pandra radio) and on digital billboards; all of them direct audiences to the toll-free helpline number and to the Safe Haven website.

Act No. 91, signed by the Governor on July 2, 2014, adds a police station to the Pennsylvania Safe Haven Law. Act No. 91 amends Title 18 Section 4306 and Title 23 Chapter 65 in order to allow a police officer at a police station to accept newborn from parents under the Safe Haven law. The Act requires a police officer at a police station to take the newborn into protective custody, ensure the newborn is transported to a hospital, and place the newborn into the care of a healthcare provider at the hospital. As is the case with leaving the baby at the hospital under the Safe Haven law, a parent will not be held criminally liable for leaving a newborn with the police officer at a police station as long as the newborn is not a victim of child abuse or criminal conduct. Act No. 91 creates another venue for a parent in crisis to safely relinquish her baby without fear of repercussions and thus, decreases the chance of possible child abuse and neglect.

[292] Ibid.
[293] Ibid.
[294] Ibid.

# PENNSYLVANIA:
# PROGRAMS OVERSEEN BY OCDEL

The DPW Office of Child Development and Early Learning (OCDEL) oversees several programs that play a part in child maltreatment prevention: Early Head Start, Parents as Teachers, Nurse-Family Partnership, Health Families America, and Parent-to-Parent. Some of these programs are home visiting, others are school-based. The office also administers the Pennsylvania Children's Trust Fund.

An important federal source of funding for most of these programs is the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), established by the Patient Protection and Affordable Care Act. MIECHV provides money to the states to establish home visiting programs for at-risk pregnant women and children from birth to age 5. As the Act stipulates that 75 percent of the funds must be used for home visiting models with evidence of effectiveness based on rigorous evaluation research, the Home Visiting Evidence of Effectiveness (HomVEE) was launched in 2009 to conduct a thorough and transparent review of the home visiting research literature and to provide an assessment of the existing models to assist the states in their program selection. Each year, the HomVEE team conducts a broad search for literature on home visiting program models and publishes a review of the most prevalent home visiting program models currently funded and implemented. In addition, it reviews new models and updates the results for those previously reviewed. These reviews are a helpful tool for the state policymakers and program administrators to ensure compliance with the Act and select program models that have been proven to produce the best results.

### *Home Visiting Programs: Varied Models and Levels of Effectiveness*

Home visiting programs have been providing services to families with young children in this country for many years, dating back to the mid-1880s.[295] It is estimated that presently, "home-visiting programs serve between 400,000 and 500,000 children, about 5 percent of the estimated 10.2 million American children under the age of 6 years who are living in low-income families."[296] Millions of dollars from both public and private sources are used to support a variety of these programs. It is important to remember that "*home visiting* is an umbrella term that implies a strategy of delivering a service, rather than a type of intervention, per se."[297]

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[295] Sweet, Monica A. and Mark I. Appelbaum. "Is Home Visiting an Effective Strategy? A Meta-Analytic Review of Home Visiting Programs for Families With Young Children." *Child Development*. September/October. 2004. Vol. 75. No. 5. P. 1435.

[296] Office of Child Development, University of Pittsburgh. *Revisiting Home Visitation: The Promise and Limitations of Home-Visiting Programs,* available at http://ocd.pitt.edu/Default.aspx?webPageID=246 (accessed May 9, 2014).

[297] Sweet, Monica A. and Mark I. Appelbaum. "Is Home Visiting an Effective Strategy? A Meta-Analytic Review of Home Visiting Programs for Families With Young Children." *Child Development*. September/October. 2004. Vol. 75. No. 5. P. 1435-1436.

Programs vary in their program models, the targeted population groups, the outcomes sought, the content of the curriculum, the intensity of the intervention, the staff professional level, and other factors. Most of these programs address goals in several domains. Some of the home visiting models include the goal of preventing or reducing the incidence of child abuse and neglect.

> To achieve this goal, home visitors typically work with parents to improve knowledge, skills and behaviors that are associated with maltreatment. For example, they may educate parents on how to interact with their children in a more responsive manner, teach them alternative ways to discipline their children, or provide strategies for meeting their children's developmental needs. They may also attempt to decrease the number of stressors that may make families vulnerable to inappropriate parenting.[298]

Child maltreatment outcomes are harder to measure than some other outcomes such as preterm births, infant deaths, closely spaced second births, or full immunizations. One of the few meta-analytic reviews confirmed that "actuality and possibility of abuse was lower for home-visited children than for control group children."[299] At the same time, the authors pointed out inconsistency in findings and concluded that further research of specific program models and their delivery is required to establish the efficacy of home visiting as a prevention strategy.[300]

Assessing rates of child maltreatment among families participating in clinical trials presents a number of difficulties. One of them is the difference in surveillance between the treatment and control groups. Frequent contact with home visitors increases the likelihood of child abuse and neglect being identified and reported among families in the intervention group, whereas it may go unnoticed in the control group. Some researchers point to surveillance bias as a way to explain lack of measurable effects on rates of abuse and neglect in families served by home-visiting programs.[301] It has been suggested that child abuse and neglect reports may not be the best outcome measure by which to assess the effectiveness of home visiting or similar types of programs.[302]

> Instead, proxy measures such as child health and safety (for example, well-child and dental visits, number of injuries, and emergency room visits) may provide greater insight into the way that parenting practices directly bear on child well-being. In addition, programs that alter parenting behaviors, such as responsivity, sensitivity, and harshness, as well as those that improve the quality of the home

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[298] U.S. Department of Health and Human Services, Administration of Children and Families. *Home Visiting Evidence of Effectiveness. Reductions in Child Maltreatment: Overview*, available at http://homvee.acf.hhs.gov/document.aspx?sid=4&rid=2&mid=1 (accessed May 5, 2014).

[299] Sweet, Monica A. and Mark I. Appelbaum. "Is Home Visiting an Effective Strategy? A Meta-Analytic Review of Home Visiting Programs for Families With Young Children." *Child Development*. September/October. 2004. Vol. 75. No. 5. P. 1445-1446.

[300] Ibid. Pp. 1448-1450.

[301] Howard, Kimberly S. and Jeanne Brooks-Gunn. "The Role of Home-Visiting Programs in Preventing Child Abuse and Neglect." *The Future of Children*. Vol. 19. No. 2. Fall 2009, available at http://files.eric.ed.gov/fulltext/EJ856318.pdf (accessed June 25, 2014).

[302] Ibid.

> environment and maternal mental health, will likely also be associated with positive effects on children's well-being.[303]

If certain families are struggling to adapt successfully to the challenges of caring for a young baby, home visiting services can provide critical support and have positive impact in several areas, including child maltreatment. Not all home visiting programs, however, have proven equally effective. As formulated by a leading researcher from Princeton Pamela Kato Klebanov, "one important question facing home visiting programs is not whether they work, but under what conditions."[304] Research suggests that home visiting programs are more likely to be effective and bring measurable benefits if they serve carefully targeted, narrowly selected populations, if they are provided by well-trained and adequately supervised professional staff who implement a range of services and who are successful in engaging families for the duration of the program.[305] Conscientious and well-prepared paraprofessional home visitors, especially when carefully matched up with parents in terms of personality and personal history, have also been able to achieve good results in some programs, though not in others. Other important factors include adherence to a clear theoretical foundation, sufficient intervention dosage, fostering good relationship between home visitors and participants, and embedding home visitation in an integrated system of care.[306]

> If home-visiting programs are to have their maximum impact, service providers must follow carefully the guidelines mandated by the respective programs, use professional staff whose credential are consistent with program goals, intervene prenatally with at-risk populations, and carry out the programs with fidelity to their theoretical models.[307]

> Both fidelity to the model and quality of implementation are critical.[308]

One of the important conclusions researchers have reached is that "home visiting programs should target families who are most in need of services. Families who are not in need of services

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[303] Ibid.

[304] Klebanov, Pamela Kato. *Variation in Home Visiting over the First Three years of Life: Links to Family Characteristics, Aspects of Home Visits, and Child Outcomes*, available at http://www.pewstates.org/uploadedFiles/PCS_Assets/2013/Infant_Health_and_Development_Program_report.pdf (accessed May 15, 2014).

[305] Center on the Developing Child, Harvard University. *A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children*, available at http://developingchild.harvard.edu/resources/reports_and_working_papers/policy_framework/ (accessed January 14, 2014).

[306] Office of Child Development, University of Pittsburgh. *Revisiting Home Visitation: The Promise and Limitations of Home-Visiting Programs,* available at http://ocd.pitt.edu/Default.aspx?webPageID=246 (accessed May 9, 2014).

[307] Howard, Kimberly S. and Jeanne Brooks-Gunn. "The Role of Home-Visiting Programs in Preventing Child Abuse and Neglect." *The Future of Children*. Vol. 19. No. 2. Fall 2009, available at http://files.eric.ed.gov/fulltext/EJ856318.pdf (accessed June 25, 2014).

[308] Bergin, Christi. *Evaluating the Effectiveness of a Home Visitation Program Using a Randomized Controlled Trial.* Assessment Resource Center, University of Missouri, available at http://www.pewtrests.org/uploadedFiles/wwwpewstrustorg/Reports/Foster_care_reform/time_for_reform.pdf (accessed May 7, 2014)

are less likely to participate and to benefit; families with greater need are more likely to participate and to reap the most benefit.[309]

One cost-benefit analysis indicated that evidence-based home-visiting programs serving high-risk populations generate nearly twice the returns of programs serving all families.[310] Consequently, "states can do more to ensure that programs prioritize the highest-risk families so that taxpayer investments generate the greatest possible returns."[311]

Kimberley S. Howard and Jeanne Brooks-Gunn, who closely reviewed evaluations of nine home-visiting programs, were able to identify the group that benefits the most from such programs: low-income, first-time adolescent mothers.[312] This conclusion is significant both theoretically and in its policy implications. Home-visiting programs appear to be able "to prevent first-time mothers, who have never engaged in poor parenting or child abuse and neglect, from ever doing so in the first place".[313]

> In contrast, mothers who already have children or who were enrolled postnatal, may already be acting on ingrained patterns of poor parenting that place their children at risk. In such cases, the goal of the program is not simply to prevent a behavior from occurring, but to intervene and change a pattern of behaviors to prevent recurrence. Previous research has suggested that it is much more difficult to prevent recurrence of child abuse than to prevent it from happening in the first place.[314]

Obviously, to prevent child abuse from ever happening is the most desirable goal. Knowing that home-visiting programs are particularly effective in preventing child maltreatment among first-time adolescent mothers, practitioners can select low-income pregnant teenagers as their primary target.

In its extensive nationwide survey of home visiting programs, the Pew Center on the States confirmed that "with their potential to reduce the demands on cash-strapped health care and child welfare systems, home visiting programs are a smart investment for both the short- and long-term strength of families and states' economies".[315] At the same time, the Pew researchers underscored

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[309] Klebanov, Pamela. Op.cit.

[310] Karoly, L. A. et al. *Investing in Our Children: What We Know and Don't Know About the Costs and Benefits of Early Childhood Programs*. Santa Monica, CA; Washington, D.C. RAND Corporation, 1998, available at http://www.rand.org/content/dam/rand/pubs/monograph_reports/1998/MR898.pdf (accessed July 11, 2014).

[311] The Pew Center on the States. *States and the New Federal Home Visiting Initiative: An Assessment from the Starting Line*. Washington, D.C.; Philadelphia, PA: The Pew Charitable Trusts, 2011, available at http://www.pewtrusts.org/~/media/Imported-and-Legacy/uploadedfiles/pcs_assets/2011/assessmentfromthestartinglinepdf.pdf (accessed July 11, 2014).

[312] Howard, Kimberly S. and Jeanne Brooks-Gunn. "The Role of Home-Visiting Programs in Preventing Child Abuse and Neglect." *The Future of Children*. Vol. 19. No. 2. Fall 2009, available at http://files.eric.ed.gov/fulltext/EJ856318.pdf (accessed June 25, 2014).

[313] Ibid.

[314] Ibid.

[315] The Pew Center on the States. *States and the New Federal Home Visiting Initiative: An Assessment from the Starting Line*. Washington, D.C.; Philadelphia, PA: The Pew Charitable Trusts, 2011, available at

that "to achieve these outcomes, states need to adopt models with scientifically documented effectiveness, set clear standards for child and family outcomes and monitor state-funded programs to ensure that they meet these goals."[316] The authors of the Pew study also recommended that states require programs to "set clear, evidence-based eligibility guidelines and develop systems to ensure compliance" and "use the best available data about families to determine appropriate home visiting allocations and to establish a realistic plan for expansion."[317]

In Pennsylvania, a group of stakeholders convened at the initiative of DPW - the MIECHV/Home Visiting Stakeholder round table - identified the following core components of high-quality home-visiting services in the Commonwealth:

- Voluntary and delivered primarily within the home of the parent(s)/guardian(s) and child;
- Intentional in engaging, assessing and strengthening the capacity and confidence of a child's first protector and teacher – the parents;
- Focused on the whole family – across generations – to promote
  - improved prenatal health,
  - positive maternal and infant birth outcomes,
  - family well-being and economic self-sufficiency,
  - early childhood health, safety, development and education;
- Operates with fidelity to an evidence-based model or a research-based or evaluated assessment and curriculum that specifies the purpose, outcomes, duration, and frequency of services;
- Employs well-trained and culturally competent staff and provides continual professional development relevant to the specific program model or research-based curricula being utilized;
- Demonstrates strong understanding of and linkage to other community-based cross-systems services, and
- Demonstrates effectiveness with a commitment to measure and report outcomes and continuous improvement.[318]

The Home Visiting Stakeholders table reaffirmed Pennsylvania's commitment to "ensuring that existing or future public investments are intentionally targeted to highest risk families and most often into services that are evidence-based."[319] The group was comprised of various kinds of organizations such as Allegheny County Health Department, Erie Family Center for Child Development, Capital Area Head Start, Community Prevention Partnership of Berks County, Office of Child Development University of Pittsburgh, Pennsylvania Chapter of the

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http://www.pewtrusts.org/~/media/Imported-and-Legacy/uploadedfiles/pcs_assets/2011/assessmentfromthestartinglinepdf.pdf (accessed July 11, 2014).

[316] Ibid.

[317] Ibid.

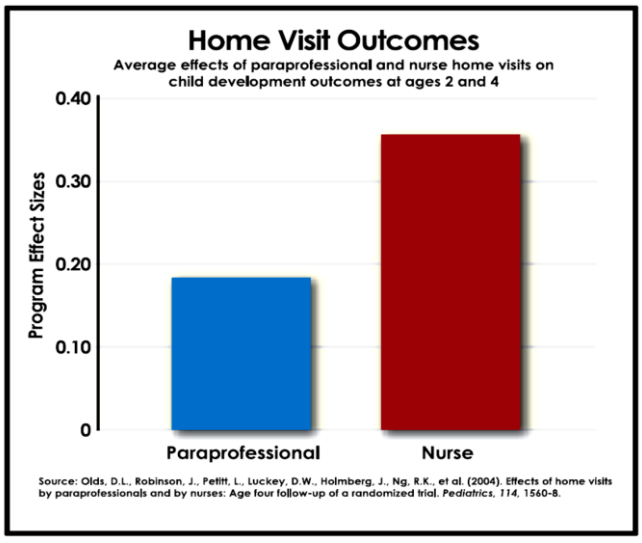
[318] Information provided to the Joint State Government Commission by Ms. Cathleen Palm on November 9, 2013.

[319] Ibid.

American Academy of Pediatrics, Nurse-Family Partnership – National Service Office, PA Child Welfare Resource Center, Chester County Health Department, Pennsylvania Partnerships for Children, Protect Our Children Committee, Center for Schools and Communities/ PA Parents As Teachers (PAT) State Office, the Guidance Center, and others. The Stakeholders table participants believe that the diversity of those contributing to the dialogue was important, productive, and worth modeling into the future.[320]

### *Nurse-Family Partnership*

Nurse-Family Partnership (NFP) is probably the most highly respected community health program, with a long record of proven success. The Nurse-Family Partnership program provides home visits by specially trained registered nurses to first-time low-income mothers, beginning during pregnancy and continuing through the child's second birthday. The primary goals cover a variety of areas, including improving child health and safety by promoting competent care-giving and enhancing parent life-course development. Women enroll voluntarily. The program focuses on developing a healthy, supportive relationship between the mother and home visitor; the latter can also serve as a valuable link to community resources. As the Nurse- Family Partnership program is delivered by registered nurses, who are perceived as trusted and competent professionals, they can establish a powerful bond with participating mothers and can have significant impact on their lives. In fact, "an experiment comparing program impacts when home visits were provided by paraprofessionals (versus skilled nurses) found positive effects roughly twice as large for the nurse-delivered intervention."[321]




[320] Ibid.

[321] Center on the Developing Child, Harvard University. *A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children*, available at http://developingchild.harvard.edu/resources/reports_and_working_papers/policy_framework/ (accessed January 14, 2014).

The NFP promotes several CBCAP protective factors: knowledge of parenting and child and youth development, nurturing and attachment, parental resilience, and social connections.

The Nurse-Family Partnership program was originally developed by Dr. D. L. Olds. It has been successfully replicated in diverse communities and populations. Several randomized, controlled trials demonstrated its effectiveness. Research includes measurements of child abuse and neglect prevention.[322]

> The evidentiary standards for the Nurse-Family Partnership program are among the strongest available for preventive interventions offered for public investment. In fact, in medical and scientific journals, Nurse-Family Partnership is most often cited as the most effective intervention to prevent child abuse and neglect, which contributes to childhood injury. Injury, in turn, is the leading cause of death for children from age one to early adulthood.[323]

Dr. Olds and his colleagues postulated that prenatal and infancy home visitation by nurses would be a potent means of preventing maltreatment, in addition to other health and developmental problems with children born to first-time mothers who were teenagers, unmarried, or of low socioeconomic status. His first trial, performed in the mid-eighties, confirmed the expected outcomes: "Among the women at highest risk for care-giving dysfunction, those who were visited by a nurse had fewer instances of verified child abuse and neglect during the first 2 years of their children's lives … they were observed in their homes to restrict and punish their children less frequently, and they provided more appropriate play materials; their babies were seen in the emergency room less frequently during the first year of life."[324] Positive outcomes continued into the following year. The difference between the visited group and the control group was considerable: "During the first 2 years of the children's lives, 19% of the comparison group at greatest risk (the poor, unmarried teens) and 45 of their nurse-visited counterparts had abused or neglected their children".[325] The researchers also noted "a trend for the nurse-visited teenagers to have fewer confirmed reports of abuse and neglect than the teenagers in the comparison group".[326] Another important observation was that "in the comparison condition the incidence of abuse and neglect increased as the number of risk factors accumulated, but in the nurse-visited condition, the incidence of abuse and neglect remained relatively low, even in those groups at higher risk".[327] A 15-year follow-up study of the Elmira trial families provided the first evidence from a randomized trial for the long-term effects of home visitation on reducing child maltreatment. The results were impressive: they showed that nurse-visited families had approximately half as many child

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[322] See, e.g., Olds, David L. et al. "Preventing Child Abuse and Neglect: A Randomized Trial of Nurse Home Visitation." *Pediatrics.* Vol. 78. No. 1. July, 1986. Pp. 65-78 and Eckenrode, J. et al. "Preventing Child Abuse and Neglect with a Program of Nurse Home Visitation: The Limiting Effects of Domestic Violence." *Journal of the American Medical Association*. 2000.Vol. 284. No. 11. Pp. 1385-1391, also available online at http://jama.jamanetwork.com/article.aspx?articleid=193089 (accessed April 22, 2014).

[323] Nurse-Family Partnership. *Proven Results: Preventing Child Abuse and Neglect*, available at http://www.nursefamilypartnership.org/proven-results/Preventing-child-abuse-and-neglect (accessed July 8, 2014).

[324] Olds, David L. et al. "Preventing Child Abuse and Neglect: A Randomized Trial of Nurse Home Visitation." *Pediatrics.* Vol. 78. No. 1. July, 1986. P. 65.

[325] Olds, David L. Op. cit. P. 71.

[326] Ibid.

[327] Ibid.

maltreatment reports as families in the comparison group.[328] Participation in the program also reduced the number of subsequent births and increased the interval between the birth of the first and a second child, which are both viewed as favorable outcomes. Some of researchers believe that "one of the largest effects of the NFP is a delay in the timing of second births among teenagers, which in and of itself can have ripple effects on the child and on the mother's life course."[329] As unplanned, unwanted or coerced pregnancies, recognizably, create the potential for child maltreatment, reducing the number of such pregnancies may play an important part in child abuse prevention.

Several longitudinal studies of randomized trials confirmed that "families receiving home visitation during pregnancy and infancy had significantly fewer child maltreatment reports involving the mother as perpetrator or the study child as subject than families not receiving home visitation."[330]

A summary of credible and consistent evidence from a systematic review of 30 NFP evaluation reports performed by Ted Miller led him to the conclusion that first-time low-income mother's participation in the NFP program can bring a 31 percent reduction in child maltreatment, ages 4-15.[331] Miller estimates that "on average, enrolling 1,000 low-income families in NFP will prevent … 240 child maltreatment incidents."[332]

The Pew Charitable Trusts report cites another evaluation that found a 48 percent lower level of abuse and neglect for children served through the NFP program than children in the control group.[333]

A recent article based on a twenty-year follow-up of a randomized clinical trial stated that the NFP intervention may have longer-term beneficial effects on health and mortality as the mothers and their children grow older. The researchers made a conclusion that "prenatal and infant/toddler home visitation by nurses is a promising means of reducing all-cause mortality

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[328] Olds, David L. et al. "Long-term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect: 15-year Follow-up of a Randomized Trial." *Journal of the American Medical Association*. 1997. Vol. 278. No. 8. Pp. 637-643, available at http://www.columbia.edu/cu/psychology/courses/3615/Readings/JAMA_1997_Olds.pdf (accessed April 30, 2014).

[329] Howard, Kimberly S. and Jeanne Brooks-Gunn. "The Role of Home-Visiting Programs in Preventing Child Abuse and Neglect." *The Future of Children*. Vol. 19. No. 2. Fall 2009, available at http://files.eric.ed.gov/fulltext/EJ856318.pdf (accessed June 25, 2014).

[330] Eckenrode, J. et al. "Preventing Child Abuse and Neglect with a Program of Nurse Home Visitation: The Limiting Effects of Domestic Violence." *Journal of the American Medical Association*. 2000. Vol. 284. No. 11, available online at http://jama.jamanetwork.com/article.aspx?articleid=193089 (accessed April 22, 2014).

[331] Miller, Ted R. *Nurse-Family Partnership Home Visitation: Costs, Outcomes, and Returns on Investment*. *Executive Summary*. Beltsville, Maryland: H.B.S.A., Inc., September 2012. Revised April 30, 2013, available at http://www.pewstates.org/uploadedFiles/PCS_Assets/2013/Costs_and_ROI_executive_summary.pdf (accessed May 2, 2014).

[332] Ibid.

[333] Pew Charitable Trusts. *Time for Reform: Investing in Prevention: Keeping Children Safe at Home.* Philadelphia, PA; Washington, D.C., 2007, available online at http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/Fpster_care-refprm/time_for_reform.pdf (accessed June 3, 2014).

among mothers and preventable-cause mortality in their first-born children living in highly disadvantaged settings".[334]

Some of the studies performed since the initiation of the NFP program investigated variables and tried to identify subgroups that could benefit the most from the program as well as factors that could limit the program's effect. One of those limiting factors turned out to be domestic violence.

A longitudinal trial results indicated that "the presence of domestic violence may limit the effectiveness of interventions to reduce incidence of child abuse and neglect."[335] Research aimed at identifying groups of individuals for whom the program fails to reach intended outcomes is important as once it is done, new approaches may be devised to strengthen services.

> Careful analyses that examine groups for which the program is more and less effective will enable policy makers to focus scarce resources on those who benefit the most and encourage the continuous search for more effective ways of serving those who fail to respond as expected.[336]

The ongoing studies of the NFP are a good example of the value research has for making policy decisions and for improving service outcomes.

The NFP National Service Office provides support for program development and implementation, and many states have access to additional technical assistance resources, including nurse consultants. Every agency that wants to implement the NFP must assure its intention to deliver the program with fidelity to the model tested. Such fidelity requires adherence to all of the eighteen Nurse-Family Partnership model elements. Quality program replication is possible due to detailed performance measurement at every NFP site using the national NFP data collection and reporting system.

Implementation costs are estimated to be approximately $5,000 per family per year.[337] Different sites estimates range from $4,500 to $6,463 annually and from $3,227 to $9,140 for the duration of participation.[338]

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[334] Olds, David L. et al. "Effect of Home Visiting by Nurses on Maternal and Child Mortality: Results of a 2-decade Follow-up of a Randomized Clinical Trial." *JAMA Pediatrics*. Published online July 7, 2014, available online at jamapediatrics.com. *JAMA Pediatr.* doi:10.1001/jamapediatrics.2014.472.

[335] Eckenrode, J. et al. Op. cit.

[336] Ibid.

[337] FRIENDS National Resource Center for CBCAP. *Evidence-Based and Evidence-Informed Programs: Prevention Program Descriptions Classified by CBCAP Evidence-Based and Evidence-Informed Categories*. Chapel Hill, N.C., September 2009, available at http://friendsnrc.org/joomdocs/eb_prog_direct.pdf (accessed January 30, 2014).

[338] Burwick, Andrew et al. *Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment: Cross-Site Evaluation Cost Study Background and Design Update*. Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. April 2012, available at http://www.supprtingebhv.org/home (accessed November 14, 2013).

A thorough, comprehensive study aimed at analyzing costs, life status benefits, financial outcomes, and return on investment in NFP services, performed by Ted R. Miller, confirmed the program effectiveness. Even though Miller's calculation of the NFP costs average ($8,734 per family served) is higher than the one quoted by FRIENDS, he still finds significant savings that the program can bring. According to his estimates, "net of program costs, resource costs savings are $2,356 ($10,936 resource cost savings minus $8,580 program costs). That means NFP saves society money out of pocket. Less tangible savings total $42,154."[339] Miller's calculations indicate a benefit-cost ratio of 6.2.[340] "By the child's 18th birthday, government savings per family served average $23,485 (discounted present value of $19,054 or 2.2 times the present value of NFP costs ($19,054/$8,580))."[341] Miller's analysis leads him to an unequivocal conclusion that "federal and state government both benefit handsomely from NFP services," that "public NFP finding is a wise investment" and that "braiding public and private funding increases and accelerates government's return on NFP investment."[342]

The RAND Corporation reports that for every dollar a community invests in NFP, it can see up to $5.70 in return for a higher-risk sample and $2.88 for a full sample.[343]

The recent Washington State Institute for Public Policy (WSIPP) benefit-cost analysis has confirmed the NFP as an evidence-based program with high odds of a positive net present value.[344] In Pennsylvania, according to well-established and conservative economic analyses performed by the Penn State Prevention Research Center, the statewide economic benefit for each dollar invested in the Nurse-Family Partnership program is $3.59, with the total potential economic benefit statewide to reach $119,574,400.[345] 12.7 percent of economic benefits are related to reduction in child abuse rates.[346]

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[339] Miller, Ted. R. *Nurse-Family Partnership Home Visitation: Costs, Outcomes, and Returns on Investment*. *Executive Summary*. Beltsville, Maryland: H.B.S.A., Inc., September 2012. Revised April 30, 2013, available at http://www.pewstates.org/uploadedFiles/PCS_Assets/2013/Costs_and_ROI_executive_summary.pdf (accessed May 2, 2014).

[340] Ibid.

[341] Ibid.

[342] Ibid.

[343] Karoly, Lynn A., Kilburn, Rebecca M. and Jill S. Cannon. *Early Childhood Interventions: Proven Results, Future Promise.* Santa Monica, CA: RAND Corporation, 2005, available online at www.rand.org (accessed April 29, 2014).

[344] Washington State Institute for Public Policy. *January 2014 Inventory of Evidence-Based, Research-Based, and Promising Practices For Prevention and Intervention Services for Children and Juveniles in Child Welfare, Juvenile Justice, and Mental Health Systems*, available at http://www.wsipp.wa.gov/ReportFile/1552/Wsipp_Updated-Inventory-of-Evidence-based-Research-based-and-Promising-Practices-for-Prevention-and-Intervention-Services-for-Children-and-Juveniles-in-the-Child-Welfare-Juvenile-Justice-and-Mental-Health-Systems_Inventory.pdf (accessed July 22, 2014).

[345] Jones, Damon et al. *The Economic Return on PCCD's Investment in Research-based Programs: A Cost-Benefit Assessment of Delinquency Prevention in Pennsylvania*. Prevention Research Center for the Promotion of Human Development, the Pennsylvania State University, March 2008, available at http://prevention.psu.edu/pubs/research_Reports.html (accessed April 29, 2014).

[346] Ibid.

*NFP in Pennsylvania*

The first three NFP sites in Pennsylvania started operating in 1999 through the Pennsylvania Commission on Crime and Delinquency (PCCD). In 2001, the Governor and the Department of Public Welfare used part of the unspent TANF funds to help open 20 additional NFP locations throughout the Commonwealth. Currently, the Nurse-Family Partnership serves 44 of Pennsylvania's 67 counties. Significant expansion of the Nurse-Family Partnership services in 2012 was made possible through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, a mandatory state grant allocation made available through the Patient Protection and Affordable Care Act.[347]

The Department of Public Welfare provided the following description of the Pennsylvania NFP funding stream:

| Pennsylvania: Nurse-Family Partnership (NFP) Funding Stream | |
|---|---|
| State General Dollars | $11.978 |
| Medicaid | $2.544* |
| Maternal Infant Early Childhood Home Visiting (MIECHV) | $296,744** |
| MIECHV Competitive | $5,449,000.00** |
| *Federal with State match.<br>**Federal formula. | |

Local contribution is unknown, but represents approximately 15-20 percent of overall operating costs of NFP in Pennsylvania.[348]

Local and private organizations and foundations supporting the Nurse-Family Partnership in Pennsylvania include United Way, Carlisle Area Health and Wellness Foundation, Jameson Health System, Brandywine Health Foundation, Inspire Children Foundation, Heinz Foundation, and others.[349]

The Pennsylvania initiative was one of the first and largest statewide replications of the Nurse-Family Partnership model. When in the late 1990s the Commonwealth of Pennsylvania

[347] *Nurse-Family Partnership in Pennsylvania: State Profile 2013*, available at http://www.nursefamilypartnership.org/assets/PDF/Communities/State-profiles/PA_State_Profile.aspx (accessed April 29, 2014).
[348] Data provided to the Joint State Government Commission by DPW on September 5, 2013.
[349] *Nurse-Family Partnership in Pennsylvania: State Profile 2013*, available at http://www.nursefamilypartnership.org/assets/PDF/Communities/State-profiles/PA_State_Profile.aspx (accessed April 29, 2014).

made a strategic decision to direct funds into research-based prevention and intervention programs, the NFP was one of those selected. Public/Private Ventures (P/PV) was engaged to oversee the program expansion throughout the state. In partnership with the NFP National Service Office (NSO), Public/Private Ventures has helped regional sites implement the model and adhere to the model's essential elements.

One of the important tasks before beginning large-scale replications is to avoid duplication of already existing services and to assess known indicators of quality for potential NFP implementing agencies. Key indicators include

- An established community need for the program;
- Organizational capacity to implement the model with fidelity;
- Adequate community linkages for referrals and resources;
- Ability to recruit and retain qualified home visitors, and
- Demonstrated commitment to sustainability.[350]

P/PV partnered with NSO to provide site development and site management throughout the Commonwealth. It helped ensure the program was well received and integrated into local communities, which is especially important for a state-funded effort. It established structured opportunities for skills training and team building, and it encouraged experienced sites to support newer ones. It assisted with monitoring program results to promote quality on the basis of the national performance objectives developed by the Nurse-Family Partnership NSO to help measure performance across sites. Successful implementation of evidence-based programming requires a rigorous approach – "one that emphasizes adherence to the program's essential elements, quality-assurance mechanisms and, in case of Nurse-Family Partnership, specific clinical competences".[351] A key to successful replication is thoughtful and deliberate support. P/PV's experience in Pennsylvania demonstrates that spending resources on evidence-based models and their careful replication is a wise investment for the state as it brings significant financial gains and extensive non-monetary benefits of reductions in child abuse and neglect, along with other social problems.

### *Healthy Families America*

Healthy Families America (HFA) advertises its approach as designed to help families manage life's challenges by building on their strengths rather than focusing on their weaknesses. The target population is single parents or families with low income, substance abuse, or domestic violence. The HFA model was developed in 1992 by Prevent Child Abuse America, in partnership with Ronald McDonald House Charities, and currently operates in 40 states.[352] The program

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[350] Collins Stavrakos, Jennifer, Geri Summerville and Laura E. Johnson. *Growing What Works: Lessons Learned from Pennsylvania's Nurse-Family Partnership Initiative*. Philadelphia, PA; New York, N.Y; Oakland, CA: Public/Private Ventures, 2009, available at http://www.socialimpactexchange.org/sites/www.socialimpactexchange.org/files/Growing%20What%20Works.pdf (accessed June 27, 2014).

[351] Ibid.

[352] *Healthy Families America*, available at http://www.healthyfamiliesamerica.org/about_us/index.shtml (accessed June 30, 2014).

model offers weekly home visits beginning prenatally or within the first three months of the child's birth and continuing through the first three to five years of life. In contrast to the Nurse-Family Partnership model, these visitors are paraprofessionals. HFA home visitors, called family support workers, are selected based on their personal characteristics and willingness to work in culturally diverse communities. They must complete special HFA training.

Average implementation costs are approximately $3,000-$3,500 annually (from about $2,000 to over $5,500).[353] The HFA programs in Pennsylvania receive federal funding: Maternal Infant Early Childhood Home Visiting (MIECHV).

Similar to other home visiting programs, HFA addresses several domains and has demonstrated positive outcomes in all of them. According to the Department of Health and Human Services report on various home visiting models, "Healthy Families America has the greatest breadth of total findings, with favorable impacts on primary and/or secondary measures in all eight domains" while Nurse-Family Partnership "had the greatest breadth of favorable primary findings, with favorable impacts on primary measures in six outcome domains".[354]

A recent review of home visiting effectiveness programs performed for the Department of Health and Human Services confirmed reductions in child maltreatment as one of the HFA outcomes.[355]

*Other States*

A review of various trials indicates that the results for the HFA are not quite as consistent or convincing as those for the NFP.[356] Indeed, a survey of the Healthy Family evaluations performed in 2005 by Mark Chaffin, an expert in development and implementation of evidence-based practice models in multi-agency public systems and the founding editor of the journal "Child Maltreatment," led him to the conclusion that the data were "discouraging" and that it might be time to "rethink" the program.[357] On the other hand, several HFA studies demonstrated positive impacts on child abuse and neglect. The Home Visiting Evidence of Effectiveness review indicates

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[353] Burwick, Andrew et al. *Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment: Cross-Site Evaluation Cost Study Background and Design Update*. Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. April 2012, available at http://www.supprtingebhv.org/home (accessed November 14, 2013).

[354] Avellar, S. et al. *Home Visiting Evidence of Effectiveness Review: Executive Summary.* Washington, D.C.: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, September 2013, available at http://homvee.acf.hhs.gov/HomVEE_Executive_Summary_2013.pdf#exec_summary (accessed May 5, 2013).

[355] Avellar, S. et al. *Home Visiting Evidence of Effectiveness Review: Executive Summary.* Washington, D.C.: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, September 2013, available at http://homvee.acf.hhs.gov/HomVEE_Executive_Summary_2013.pdf#exec_summary (accessed May 5, 2013).

[356] See, e.g., Center on the Developing Child, Harvard University. *A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children*, available at http://developingchild.harvard.edu/resources/reports_and_working_papers/policy_framework/ (accessed January 14, 2014).

[357] Chaffin, Mark. "Is It Time to Rethink Healthy Start/Healthy Families?" *Child Abuse & Neglect*. 2004. Vol. 28. No. 6. Pp.589-595.

that several studies of the HFA model did not demonstrate favorable primary outcome measures in the child maltreatment domain; other studies demonstrated favorable secondary outcome measures.[358]

A collaborative, experimental study focused on six Healthy Family Alaska programs indicated "no overall program effect on maltreatment reports, and most measures of potential maltreatment" and "no program impact on parental risks".[359] Though the researchers were able to note less frequency in psychological aggression, mild physical assault, and common corporal punishment, they saw no impact on primary outcomes. Therefore, the researchers concluded that the program did not prevent child maltreatment due to contradictions in the model that compromised effectiveness and recommended further research to develop and test strategies to improve the effectiveness of home visiting.[360]

A randomized, controlled trial of Healthy Families Massachusetts, a statewide child maltreatment prevention home visiting program, produced inconsistent findings regarding its impact on child maltreatment. Though the program appeared to succeed in lowering parenting stress among its participants, the number of substantiated reports of child maltreatment for mothers who participated in the program was, actually, higher than for the control group in one sample; another sample did not produce significant results.[361]

There are various explanations for mixed or inconclusive results. Researchers mention a surveillance bias as one of the factors at play.[362] However, policymakers and administrators need to be aware of the different program evaluation results and of the increasingly heard experts' caution that paraprofessional home visiting programs like Healthy Families may provide more benefits for high-risk families in other areas than in child maltreatment prevention.[363]

Florida and New York showed success in implementation of the Healthy Families model. Florida has one of the largest home visiting programs in the country, and its evaluation found that the program has had "a positive impact on preventing child maltreatment, showing that children in families who completed or had long-term, intensive HFF intervention experienced significantly less child maltreatment than did comparison groups with little or no service."[364] This finding was based on a quasi-experimental design using several comparison groups. In addition, maltreatment

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[358] U.S. Department of Health and Human Services, Administration of Children and Families. *Home Visiting Evidence of Effectiveness. Reductions in Child Maltreatment: Summary of Findings*, available at http://homvee.acf.hhs.gov/document.aspx?sid=4&rid=2&mid=1 (accessed May 5, 2014).

[359] Duggan, A. et al. "Impact of Statewide Home Visiting Program to Prevent Child Abuse." *Child Abuse & Neglect*. 2007. No. 8. Pp. 801-27. Summary of findings available at http://homvee.acf.hhs.gov/effects.aspx?rid=2&sid=4&mid=3&oid=10 (accessed May 6, 2014).

[360] Ibid.

[361] Easterbrooks, M. A. et al. *Initial Findings from a Randomized, Controlled Trial of Healthy Families Massachusetts: Early Program Impacts on Young Mothers' Parenting,* available at http://www.pewstates.org/uploadedFiles/PCS_Assets/2013/Healthy_Families_Massachussetts_executive_summary.pdf (accessed June 3, 2014).

[362] Ibid.

[363] See, e.g., Rubin, D.M., Curtis, M.L. and M. Matone. "Child Abuse Prevention and Child Home Visitation: Making Sure We Get It Right." *JAMA Pediatrics*. January 2014. Vol. 168, No. 1.

[364] Madison, Stern & Associates. *Healthy Families Florida Evaluation Report*. Miami, FL, February 2005, available at http://www.healthyfamiliesfla.org/pdfs/Final_Evaluation_Ex_Sum_1999-2003.pdf (accessed May 6, 2014).

rates among children participating in the program were compared with rates among children living in the targeted service areas. Although there were some methodological limitations with the study design, "the finding that people who completed or had long-term, intensive HFF intervention experienced significantly less child maltreatment held in four comparisons"[365]

The researchers found that "children in the NO HFF Service Group were 3.7 times more likely to have been victims of maltreatment than children in the HFF Completes Group during the first two years of their life."[366] At three years, "children in the Comparison Group were two times more likely to have been victims of maltreatment as children in the High Fidelity Group."[367] Ninety-five percent of all children who participated in Healthy Families Florida were free from maltreatment a year after the program completion, which was the state goal.[368] Similar to other studies, the Florida evaluation confirmed the importance of fidelity in the program implementation and the length of participation.

A randomized controlled trial of Healthy Families New York (HFNY) demonstrated the program's success and led to valuable conclusions. HFNY mothers reported committing one-quarter as many acts of serious abuse at age 2 as control mothers. Compared to the control group, HFNY mothers were also less likely to engage in minor physical aggression and harsh parenting.[369] Effects were more noticeably pronounced among women who were "psychologically vulnerable": they were one-quarter as likely to report engaging in serious abuse and neglect as mothers in the control group (5 percent versus 19 percent) at age 2.[370]

The New York trial findings highlighted the importance of the targeted group in explaining the differential effectiveness of home visitation programs. The researchers came to the conclusion that "improved effects may be realized by prioritizing the populations served or by enhancing the model to meet program objectives for hard-to-serve families."[371]

The longitudinal trial allowed to trace sustainability of impact and differences between subgroups. For the High Prevention Opportunity (HPO) subgroup, which consisted of young, first-time mothers who initiated home visiting prenatally, "differences in the cumulative rate of confirmed CPS reports for physical abuse or neglect were observed for the period from ages five through seven: 19.3% of the target children in the control group had a confirmed report versus 9.9% of the HFNY group ($p<.05$)."[372]

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[365] Ibid.
[366] Ibid.
[367] Ibid.
[368] Ibid.
[369] DuMont, K. et al. "Healthy Families New York (HFNY) Randomized Trial: Effects on Early Child Abuse and Neglect." *Child Abuse & Neglect.* 2007. No. 3. Pp.295-315.
[370] Ibid.
[371] Ibid.
[372] DuMont, K. et al. *A Randomized Trial of Healthy Families New York (HFNY): Does Home Visiting Prevent Child Maltreatment?* January 2011, available at http://www.ncjrs.gov/pdfiles1/nij/grants/232945.pdf (accessed November 14, 1013).

The researchers observed what they described as "unexpected and unprecedented differences in rates of subsequent reports for HFNY mothers in the RRO subgroup",[373] a group that included women who had had at least one substantiated child protective services report (as a non-victim) prior to random assignment. HFNY mothers from this subgroup, as compared to their counterparts in the control group, had

- lower rates of confirmed CPS reports for any type of abuse or neglect (41.5 percent versus 60.4 percent, $p<.10$);
- lower rates of reports when the study mother was the confirmed subject (38.2 percent versus 57.4 percent, $p<.10$);
- lower rates of confirmed reports involving physical abuse (3.3 percent versus 13.4 percent, $p<.10$);
- a smaller number of total confirmed reports for mothers as the confirmed subject (.8 versus 1.6, $p<.05$);
- lower rates of preventive, protective, and placement services initiating (38.02 versus 60.02, $p<.05$).[374]

These findings indicate significant benefits of the Healthy Family program as a tool to lower rates of maltreatment recurrence. The Recurrence Reduction Opportunity (RRO) subgroup also produced most impressive results in the cost-benefit analysis:

For women in the RRO subgroup, investment in HFNY produced a net savings in government costs of $12,395 per family and a return of $3.16 for every dollar invested by the time the target child was 7 years old. This amounted to a 316% recovery of the initial $3,920 net HFNY cost invested.[375]

Obviously, impact of home visiting programs extends beyond monetizable benefits. Based on the New York trial findings, researchers expect both monetary and non-monetary savings to accrue following the initial investment in the program.[376] The seven-year follow-up in New York suggested that "HFA-based programs delivered by paraprofessionals can produce sustained effects on parenting that extend past the intended period of service."[377] The New York study also helped identify subgroups that would benefit the most from involvement in the HFA program.

The Healthy Families America home page cites favorable statistics on reduction in child maltreatment rates from comparative studies in Arizona, Hawaii, and Oregon.[378]

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[373] Ibid.
[374] Ibid. A *p* value of less than 0.1 indicates that the outcomes of the program probably would not have occurred on their own if the program had not been implemented.
[375] Ibid.
[376] Ibid.
[377] Ibid.
[378] *Healthy Families America Reduces Child Maltreatment*, available at www.healthyfamilies.org (accessed September 5, 2013).

Benefit-cost analyses of the Healthy Families America programs produced as inconsistent results as the studies of its effectiveness. In fact, in its updated inventory of evidence-based, research-based, and promising practices for child prevention services, the Washington State Institute for Public Policy suggested downgrading the HFA from the category of "evidence-based" to "research-based" as it does not meet the benefit-cost criteria for evidence-based programs; it cannot be characterized as cost-beneficial as the odds of a positive net present value are only 18 percent.[379] An earlier analysis performed by the WSIPP also indicated low odds of a positive net present value for Healthy Families: 26 percent.[380]

In Pennsylvania, three agencies currently use Healthy Families America: Erie County Family Center; Snyder, Union, Mifflin Child Development in Lewistown; and Maternity Care Coalition in Upper Darby.[381]

### *Early Head Start*

Head Start/Early Head Start was launched as part of the War on Poverty declared by President Johnson in his State of the Union Speech in January 1964. Head Start was designed as a comprehensive program for children of low-income families to meet their nutritional, health, emotional, and psychological needs and, eventually, to help break the cycle of poverty. The program must be culturally responsive to the communities served, and these communities must have investment in the program's success. Early Head Start was developed by the Head Start Bureau in 1994, and the first Early Head Start grants were given by President Clinton in September of 1995.

To receive federal funding, programs are required to make their plans using child outcomes, family and community data. They must annually report aggregate program level outcomes to the Federal Office of Head Start.

In Pennsylvania, funding is federal to local. The Office of Child Development and Early Learning (OCDEL) is considered a grantee funded for 128 slots. This is different from other federal grants where funds are passed through to the programs. OCDEL must adhere to all the performance requirements, as do other "local" grantees.[382] Statewide, 40 Early Head Start programs were funded in 2012, with a total funded enrollment of 4,452 slots for pregnant women, infants, and toddlers.[383]

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[379] Washington State Institute for Public Policy. *January 2014 Inventory of Evidence-Based, Research-Based, and Promising Practices For Prevention and Intervention Services for Children and Juveniles in Child Welfare, Juvenile Justice, and Mental Health Systems*, available at http://www.wsipp.wa.gov/ReportFile/1552/Wsipp_Updated-Inventory-of-Evidence-based-Research-based-and-Promising-Practices-for-Prevention-and-Intervention-Services-for-Children-and-Juveniles-in-the-Child-Welfare-Juvenile-Justice-and-Mental-Health-Systems_Inventory.pdf (accessed July 22, 2014).

[380] Lee, Stephanie et al. *Return on Investment: Evidence-based Options to Improve Statewide Outcomes: April 2012 Update*. Washington, Olympia, WA: Washington State Institute for Public Policy, April 2012, available at http://www.wsipp.wa.gov/ReportFile/1102/Wsipp_Return-on-Investment-Evidence-Based-Options-to-Improve-Statewide-Outcomes-April-2012-Update_Full-Report.pdf (accessed July 25, 2014).

[381] Information provided to the Joint State Government Commission by DPW on September 5, 2013.

[382] Information provided to the Joint State Government Commission by DPW on September 5, 2013.

[383] Data provided to the Joint State Government Commission by DPW on September 5, 2013.

As a comprehensive, flexible child development and parental education program, Early Head Start can be delivered through home visitation, center-based services to children and families, or a combination of both delivery modes. Parent-child activity groups are sometimes also part of the program.[384] Early Head Start provides children of low-income families with a variety of services, including medical, mental health, nutrition, and education. Low-income parents of children under the age of three can apply to participate in the program; often they are referred to it by pediatricians and other professionals.

The program is flexible, so families and children can receive different services depending on their needs, which, in turn, results in different program costs. The FRIENDS program directory estimates implementation cost at approximately $10,500 per family per year.[385]

The program goals include multiple outcomes. Child maltreatment reduction has recently been found to be one of them. In 2013, researchers at the Portland State University and the Harvard University found that low-income children who participated in Early Head Start were less likely to suffer abuse at home than their peers who were not part of the program.[386] The research team analyzed thirteen years of data covering 1,247 children and their children in six states. Half the families received Early Head Start services, and the other half did not. The researchers found that families and children who had received Early Head Start services were significantly less likely to be reported to child welfare agencies in the years after their enrollment in the program (up to the age fourteen) than the comparison group. This important measure of child abuse or neglect indicated a link between Early Head Start and preventing child maltreatment. Beth Green, Director of Early Childhood and Family Support Research at the Portland State University School of Social Work, said, "From these results, we think the program reduces risk factors. It sets families on a trajectory to greater stability and better parenting."[387]

Results achieved by Dr. Green and her colleagues indicate that "children who had participated in the EHS program were less likely to be physically or sexually abused and less likely to be abused or neglected a second time. Additionally, in the majority of the program sites, there was an overall pattern of fewer total child welfare encounters for EHS children compared to controls."[388]

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[384] FRIENDS National Resource Center for CBCAP. *Evidence-Based and Evidence-Informed Programs: Prevention Program Descriptions Classified by CBCAP Evidence-Based and Evidence-Informed Categories*. Chapel Hill, N.C., September 2009, available at http://friendsnrc.org/joomdocs/eb_prog_direct.pdf (accessed January 30, 2014).

[385] FRIENDS National Resource Center for CBCAP. *Evidence-Based and Evidence-Informed Programs: Prevention Program Descriptions Classified by CBCAP Evidence-Based and Evidence-Informed Categories*. Chapel Hill, N.C., September 2009, available at http://friendsnrc.org/joomdocs/eb_prog_direct.pdf (accessed January 30, 2014).

[386] *Study Shows Link between Early Head Start and Reductions in Child Abuse*, available at http://medicalxpress.com/news/2013-07-link-early-reductions-child-abuse.html (accessed May 13, 2014).

[387] Ibid.

[388] Green, B.L. et al. "The Effects of Early Head Start on Child Welfare System Involvement: A First Look at Longitudinal Child Maltreatment Outcomes." *Children and Youth Services Review* (2014), doi.10.1016/j.childyouth.2014.03.044.

According to this carefully designed study's findings, "children in EHS had 29% fewer substantiated reports involving abuse (physical and/or sexual) than did their peers in the control group."[389] The effects on maltreatment recurrence were also significant: "children in the control group were 2.71 times more likely (estimated hazard) of experiencing a second child welfare encounter earlier than the children in the EHS program … at nearly every age (especially if the second encounter occurred in the birth to three year range) control group children had a higher rate of child welfare encounters than program children."[390]

A somewhat unexpected finding was that children in the EHS group had more substantiated reports of neglect than their peers in the control group. As it seemed unlikely to them that the program increased child neglect, the authors offered an alternative explanation: surveillance bias. As the researchers surmised, "being under the watchful eye of EHS staff may trigger intervention by child welfare services with neglectful families, which in turn obscures the program's positive impacts by elevating the rate of neglect in the program group and not the control group."[391] Other scholars have also pointed out the difference in surveillance as a serious methodological challenge for prevention research.[392]

An important conclusion made by Dr. Green and her colleagues is that "increasing access to programs like EHS for high-risk children may reduce child maltreatment directly (through its effects on parents and children) or indirectly, by connecting families with needed services to help them provide safer, more stable and nurturing environments."[393] This two-prong impact should be kept in mind while analyzing and implementing other child maltreatment prevention programs as well.

The Portland State University study was the first one to show a link between Early Head Start and reductions in child abuse and neglect. Most of the other studies have not attempted to measure this outcome. Home Visiting Evidence of Effectiveness Review lists this outcome as "not measured" for Early Head Start-Home Visiting.[394] The FRIENDS' directory of evidence-based and evidence-informed programs, based on four EBP national registries, does not include this outcome either though it characterizes Early Head Start as well-supported program in general and indicates several CBCAP protective factors that the program seeks to enhance.[395] By building up protective factors such as knowledge of child and youth development, positive parenting practices, nurturing and attachment, behavior management and discipline as well as offering concrete

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[389] Ibid.
[390] Ibid.
[391] Ibid.
[392] See, e.g., Howard, Kimberly S. and Jeanne Brooks-Gunn. "The Role of Home-Visiting Programs in Preventing Child Abuse and Neglect." *The Future of Children*. Vol. 19. No. 2. Fall 2009, available at http://files.eric.ed.gov/fulltext/EJ856318.pdf (accessed June 25, 2014).
[393] Green, B.L. Op. cit.
[394] Avellar, S. et al. *Home Visiting Evidence of Effectiveness Review: Executive Summary.* Washington, D.C.: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, September 2013, available at http://homvee.acf.hhs.gov/HomVEE_Executive_Summary_2013.pdf#exec_summary (accessed May 5, 2013).
[395] FRIENDS National Resource Center for CBCAP. *Evidence-Based and Evidence-Informed Programs: Prevention Program Descriptions Classified by CBCAP Evidence-Based and Evidence-Informed Categories*. Chapel Hill, N.C., September 2009, available at http://friendsnrc.org/joomdocs/eb_prog_direct.pdf (accessed January 30, 2014).

supports to the family, Early Head Start is most likely to contribute to child maltreatment prevention, and it is good it has been recently confirmed by specific measurements.

In Pennsylvania, Early Head Start programs overwhelmingly use the Parents as Teachers curriculum within the EHS model.[396] Some programs use Creative Curriculum for Infants and Toddlers as well as Healthy Babies Curriculum developed by the Florida State University.[397] The federal Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) is one of the funding sources for PAT, along with the OCYF funding. MIECHV grantees using Parents as Teachers include school districts, intermediate units, Head Start/Early Head Start agencies, county community services and children's prevention services. Pennsylvania has approximately 80 PAT-affiliate providers.[398]

### *Parent to Parent*

Parent to Parent of Pennsylvania is the largest mentoring program in the state for families who have children with disabilities or special health needs. Parents or caregivers are matched with a trained, volunteer peer supporters for purposes of emotional and informational support. One-on-one peer support is the model promoted by Parent to Parent USA.

Parent to Parent programs originated in most localities as grassroots organizations energized and directed by the parents who believe in the importance of one-on-one, parent to parent support. The first Parent to Parent program, Pilot Parents, was launched in 1971 in Omaha, Nebraska, by a mother of a young child with Down syndrome.[399] In collaboration with professionals, she developed a model for handling referrals and making matches; for recruiting, screening, and training veteran parents; and for providing follow-up support to each match. Later the Omaha Pilot Parents program, with the help of a federal grant, provided training and technical assistance to other parents and professionals who wished to replicate the model in their communities. In the 1980s, several statewide Parent to Parent programs were created to support the efforts of developing local programs. Currently, most of the Parent to Parent programs are cross-disability; they do not limit themselves to one particular medical condition. In 2011, there were 29 statewide Parent to Parent Alliance members that follow evidence-based practices endorsed by Parent to Parent USA.[400]

Parent to Parent programs provide an opportunity for parents who have children with disabilities to connect with and support each other. Because the newly referred parent and the veteran parent share so many common disability and family experiences, they can quickly establish an understanding, and emotional and informational support from the veteran parent is all the more

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[396] The Parents as Teachers program is described in detail in the Family Centers section of the report. See p. 37.
[397] Information provided to the Joint State Government Commission by DPW on June 10, 2014.
[398] Information provided to the Joint State Government Commission by DPW on September 5, 2013.
[399] Santelli, B. et al. "Parent-to-Parent Programs: A Resource for Parents and Professionals." *Journal of Early Intervention*, 1997. Vo. 21. No. 1. Pp.73-83, available online at http://www.beachcenter.org/Research/FullArticles/PDF/PP3_Parent_to_Parent_Programs_8_07.pdf (accessed May 14, 2014).
[400] P2P USA. *Program Support*, available at http://www.p2pusa.org/p2pusa/SitePages/p2p-program.aspx (accessed May 15, 2014).

meaningful. "For some parents, the more intimate, individualized support that is a natural part of a Parent to Parent match best meets their emotional and informational needs."[401]

Matches are made on as many similar factors as possible because the more the parents have in common, the easier it is for them to empathize with each other.

Prospective volunteer veteran parents receive training that covers orientation to the program, positive philosophy about people with disabilities, communication and listening skills, adjustment to the disability experience as well as community resources and the referral process.

A national study conducted to determine the effectiveness of Parent to Parent support for the referred parents indicated the following:

- Parent to Parent support increases parents' sense of being able to cope.
- Parent to Parent support increases parents' acceptance of the situation.
- Parent to Parent helps parents make progress on the need they present when they first contact a Parent to Parent program.
- Over 80 percent of parents find Parent to Parent support to be helpful.
- There is a strong relationship between the number of contacts a parent has with a veteran parent and how helpful the parent finds Parent to Parent support to be.[402]

Based upon the results of this three-year study, the research team recommended that Parent to Parent should be an essential component of a comprehensive family support system.[403]

Early intervention professionals can both benefit from and contribute to the development of Parent to Parent programs. Doctors, nurses, or social workers can refer parents to a local Parent to Parent program and help them establish connections with the nearest program.

The funding stream for this is program is federal to state and state. The main federal source of funding is the Community-Based Child Abuse Prevention (CBCAP) grant. Currently, the annualized CBCAP funding for the Parent to Parent program in Pennsylvania is $77,735.[404]

Parent to Parent of Pennsylvania is a statewide organization whose main mission is to link families of children with disabilities or special needs together for purposes of support and information exchange. The staff are located in five regional offices and four home-based offices across the state. In August 2012, a new Structured Query Language (SQL) database containing the names of over fifteen hundred peer supporters became available to the staff, which greatly streamlined the program.[405] The program director describes these peer supporters (or mentors) as

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[401] Santelli, B. et al. Op. cit.
[402] Santelli, B. et al. Op. cit.
[403] P2P USA. *Program Support*, available at http://www.p2pusa.org/p2pusa/SitePages/p2p-program.aspx (accessed May 15, 2014).
[404] Data provided to the Joint State Government Commission by DPW on November 21, 2013.
[405] *Parent to Parent Pennsylvania: Program Summary*. FY 2012-2013. July 1, 2012-June 30, 2013, available at http://www.parenttoparent.org/assets/Parent-to-Parent-of-PA-Program-Summary-FY-12-13.pdf (accessed May 16, 2014).

"the lifeline" of the program. Parent to Parent of Pennsylvania can match for physical disabilities, developmental disabilities, special health care needs, behavioral/mental health concerns, foster care or adoption, educational issues or other additional concerns that the family may need support for.[406] The match process includes the completion of an intake interview via telephone to gather information relevant to the child's condition, the family situation, and special consideration for making a match. Potential peer supporters are then identified through a database search process or, when necessary, via external sources, such as the Parent to Parent USA listserve. When a peer supporter is identified and agrees to support the applying family, the two families are linked. Matches are generally to be completed within 24-48 hours of the original request.[407] A follow-up call is made to both the caller and the peer supporter within one or two weeks to ensure the match has been successful.

The program goal for fiscal year 2012-2013 was to increase the number of matches made to 1,000 matches. Parent to Parent of Pennsylvania exceeded that goal: it reached a historical milestone by helping to provide support to 1,131 families, which is the most matches ever made in the history of the 17-year-old program and a 26.1 percent increase from fiscal year 2011-2012.[408] The program also completed and exceeded its goal to increase the number of matches made in the Early Intervention population ages 0 to 5: 603 families receiving Early Intervention Services were matched in FY 2012-2013, which was a 30.7 percent increase from FY 2011-2012.[409]

To assess caller satisfaction with their match or match/resource request, Parent to Program of Pennsylvania administers the caller outcome survey. The results of this survey conducted in the federal fiscal year 2012-2013 showed high levels of client satisfaction:

- 84 percent of callers learned about new resources.
- 91 percent of callers gained helpful tips on parenting/supporting their family member with a disability or special need.
- 81 percent of callers surveyed gained helpful tips on navigating service systems.
- 93 percent of callers surveyed experienced positive progress in their specific areas of concern.
- 93 percent of callers surveyed felt better connected to other families in similar circumstances.
- 95 percent of callers surveyed received what they hoped to from the call.[410]

[406] *Parent to Parent Pennsylvania: Program Summary*. FY 2012-2013. July 1, 2012-June 30, 2013, available at http://www.parenttoparent.org/assets/Parent-to-Parent-of-PA-Program-Summary-FY-12-13.pdf (accessed May 16, 2014).
[407] Ibid.
[408] Ibid.
[409] Ibid.
[410] Data provided to the Joint State Government Commission by DPW on November 21, 2013.

In addition to establishing peer support, Parent to Parent of Pennsylvania can link families to support groups and provide technical assistance upon request.

To invite families into the Parent to Parent network, the program makes presentations to parent groups and professionals; it also prepares exhibits for conferences and community fairs. Networking with other organizations at state, regional and local levels provides other outreach opportunities. A variety of printed materials such as rack cards in English and Spanish, outreach packets, peer support packets, and small display boards are used for education and public relation purposes.

Parent to Parent of Pennsylvania collaborates with leading state hospitals in administering parent support programs through which medical facilities help families whose child has been diagnosed with a certain condition establish contact with another family dealing with a similar problem for emotional support and information. Since 2011, it has collaborated with five hospitals and one Early Intervention agency to create the following affiliate matching programs:

- Penn State Hershey Children's Hospital NICU Parent Support Program,
- Pediatric Therapy Professionals (PTP) Family Connection,
- Children's Hospital of Philadelphia (CHOP) Trisomy 21 Parent Peer Program,
- DuBois Regional Medical Center NICU Parent Support Program,
- Geisinger Medical Center NICU Parent Support Program,
- York Hospital NICU Parent Support Program.

Hospital NICU programs connect families who currently have a baby in their Neonatal Intensive Care Unit (NICU) with other families who previously had a baby in the NICU. The Pediatric Family Professionals, Inc., an Infant/Toddler Early Intervention Provider, serving families in Allegheny, Armstrong-Indiana, Beaver, Butler, Lawrence and Mercer counties, collaborated with Parent to Parent Pennsylvania to create the PTP Family Connection program, which matches families who previously used the early intervention services with families new to the early intervention services. The Trisomy 21 Parent Peer program at the Children's Hospital of Philadelphia matches families of children with a diagnosis of Trisomy 21 (Down syndrome) with other families of children or adults with Trisomy 21 for emotional support and information.

Parent to Parent of Pennsylvania has a sister program - Hands & Voices Guide By Your Side (GYBS). GYBS matches families of children ages 0 to 3 who are deaf or hard of hearing to parent guides who also have a child who is deaf or hard of hearing. This program is run by the Pennsylvania Department of Health.

### *Children's Trust Fund*

The Pennsylvania Children's Trust Fund (PA CTF) was established pursuant to Act 151 of 1988, the Children's Trust Fund Act. Its purpose is to provide funding for community-based child

abuse and neglect prevention program, with the specific emphasis on primary prevention programs that focus on the prevention of abuse before it occurs.[411]

The Children's Trust Fund is led by the 15-member Board of Directors and administered by the Office of Child Development and Early Learning (ODCEL). The PA CTF Board consists of three members of the Pennsylvania House of Representatives, three members of the Pennsylvania Senate and nine citizens appointed by the Governor. The Deputy Secretary for the OCDEL serves as the Executive Director of the CTF.

Funds are generated from a $10 surcharge on all applications for marriage licenses and divorce complaints. Gifts, donations, interest, and sometimes federal funds provide additional sources of revenue.[412] Recently, PA CTF established the nonprofit supporting organization, Friends of the Children's Trust Fund, with the purpose to raise additional funds through philanthropy and promote awareness of CTF by publicizing the program and its mission.[413]

Since its inception in December 1988, the Pennsylvania Children's Trust Fund has awarded more than $34 million dollars to 275 organizations statewide.[414]

PA CTF awards grants to a variety of organizations such as intermediate units, family support centers, women's and children's shelters, and others. The list of current grantees, for years 2011-2014, 2012-2015, and 2013-2016 is as follows:

| **Pennsylvania Children's Trust Fund (PA CTF)<br>Years 2011-2014, 2012-2015, and 2013-2016**[415] | Subsidy |
|---|---|
| Allegheny Intermediate Unit in Allegheny County | $120,000 |
| ARIN Intermediate Unit in Indiana County | $120,000 |
| Beginnings Inc. in Cambria County | $120,000 |
| Bethany Christian Services of the Greater Delaware Valley in Montgomery County | $120,000 |
| Carson's Valley Children's Aid in Montgomery County | $120,000 |
| Catholic Social Services in Philadelphia County | $120,000 |
| Children's Aid Society in Clearfield (Clearfield County) | $120,000 |
| Columbia County Family Center | $117,677 |
| Community Action Partnership for Somerset County | $120,000 |
| Community Action Southwest in Washington County | $120,000 |
| Congreso de Latinos Unidos in Philadelphia County | $120,000 |
| Employment Opportunity & Training Center of Northeastern Pennsylvania<br>operator of the Scranton Area Family Center in Lackawanna County | $120,000 |
| Einstein Healthcare Network in Philadelphia County | $119,999 |
| Every Child Inc. in Allegheny County | $111,771 |
| Family First Health Corporation in York County | $105,100 |
| Family Pathways in Butler County | $120,000 |
| Family Services Association of Bucks County | $120,000 |
| Family Services of Western Pennsylvania in Allegheny County | $120,000 |

[411] *Children's Trust Fund*, available at http://www.dpw.state.pa.us/dporganization/officeofchilddevelopmentandearlylearning/childrenstrustfund/index.htm (accessed April 25, 2014).
[412] Ibid.
[413] Ibid.
[414] Friends of the Pennsylvania Children's Trust Fund, available at http://www.pactf.org (accessed May 19, 2014).
[415] Information provided to the Joint State Government Commission by DPW on September 5, 2013. The list of the latest grantees is available at http:/www.pactf.org/ (accessed April 25, 2014)

| Pennsylvania Children's Trust Fund (PA CTF)<br>Years 2011-2014, 2012-2015, and 2013-2016[415] | Subsidy |
|---|---|
| Fulton County Partnership Inc. | $120,000 |
| Good Samaritan Health Services Foundation in Lebanon County | $120,000 |
| Institute for Safe Families Inc. in Philadelphia County | $120,000 |
| Jim Thorpe Area School District in Carbon County | $120,000 |
| Lancaster Lebanon Intermediate Unit 13 in Lebanon County | $120,000 |
| Maternal and Child Health Consortium of Chester County | $120,000 |
| Maternity Care Coalition in Philadelphia County | $120,000 |
| Pathways PA in Delaware County | $120,000 |
| Pottstown Family Center in Montgomery County | $120,000 |
| Pressley Ridge in Cumberland County | $120,000 |
| Resources for Human Development, Inc. in Philadelphia County | $120,000 |
| Turning Points for Children in Philadelphia County | $120,000 |
| Union City Family Support Center in Erie County | $120,000 |
| Union Snyder Community Action Agency in Snyder County | $120,000 |
| Visiting Nurse Association of St. Luke's in Lehigh County | $120,000 |
| Women's Center & Shelter of Greater Pittsburgh in Allegheny County | $120,000 |
| Young Women's Christian Association (YWCA) of York in York County | $71,639 |

Specific programs provide a variety of services to young parents and pregnant teens. Most of them combine education, counseling, home visits and regular group activities; they also link their clients to other community-based supports and services, if needed. Some programs are targeted to specific at-risk populations such as women who are incarcerated or are just returning from prison or parents who have recently undergone substance abuse treatment.

Lately, the Children's Trust Fund has requested that organizations applying for its grants use evidence-based programs. Most of these programs pursue the outcomes that face validity with CBCAP protective factors such as knowledge of parenting and child and youth development, behavior management and discipline, parental resilience, nurturing and attachment, and social connections. Programs most commonly used by the PA CTF grant recipients include Parents as Teachers, Nurse-Family Partnership, Incredible Years, Magic, Nurturing Parents, Strengthening Families, and others.[416] Several of these programs are described in earlier sections of the report. Of the remaining ones, Nurturing Parenting and Incredible Years are used by multiple agencies.

*Nurturing Parenting*

The Nurturing Parenting Programs (NPP) are family-based programs aimed at the prevention of child maltreatment. The program was originally developed for families who have been identified by child welfare agencies for past abuse and neglect or who are considered to be at high risk for child abuse and neglect. The goals of NPP are to

- Increase parents' sense of self-worth, personal empowerment, empathy, bonding, and attachment.
- Increase the use of alternative strategies to harsh and abusive disciplinary practices.
- Increase parents' knowledge of age-appropriate developmental expectations.
- Reduce abuse and neglect rates.[417]

[416] Information provided to the Joint State Government Commission by DPW on September 5, 2013.
[417] *NREPP SAMHSA's National Registry of Evidence-based Programs and Practices: Nurturing Parenting Programs,* available at http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=171 (accessed May 22, 2014).

As the goals indicate, the NPP approach is to teach age-specific parenting skills along with the need for a parent to nurture oneself. Nurturing Parenting is a universal parent education/support program that can be delivered in a group-based setting or through individual home visits. "The program focuses on developing nurturing skills as alternatives to punitive parenting practices."[418] Parents receive information on nurturing, discipline, child development, and communication. Teaching strategies include discussions, skills practice, and role modeling. A variety of curricula are available for parents and children ages birth to 18, with some adaptations for special populations.

The Nurturing Parenting Program was developed in the early 1980s, spearheaded by a two-year national project funded by the National Institute of Mental Health. National implementation began in 1985. "Over the past 30 years, about 14,000 agencies have implemented NPP worldwide, reaching an estimated 1.1 million families."[419] NPPs are currently being implemented by all fifty states. Dr. Stephen J. Bavolek and other program developers based their approach on the belief that "of all primary prevention strategies tested, parenting education for adults and adolescents before they become parents is often identified as the strategy most likely to prevent initial injuries to children."[420] The program developers perceived its ultimate objectives as stopping the intergenerational cycle of child abuse in the families by building nurturing parenting skills and reducing the rate of recidivism in families receiving social services, along with s few concomitant goals.[421]

Existing research includes measurements of child abuse and neglect prevention. Several studies of families referred to NPP by the state welfare agency because of allegations of child abuse and/or neglect found significant positive changes in parenting and child-rearing attitudes and behaviors. Specifically, parents participating in the NPP developed more appropriate developmental expectations of children, an increased empathic awareness of their needs, more appropriate attitudes toward the use of corporal punishment, an increase in acquired knowledge related to behavior management concepts and techniques, and a decrease in parent-child role reversal behaviors.[422] Studies found encouraging outcomes in the rate of recidivism of child maltreatment; recidivism was identified by determining whether participants were involved in any abuse and neglect incidents after completing the NPP treatment program. One study found that a high dosage of treatment (at least 14 NPP sessions) reduced child abuse and neglect recidivism by 73 percent. Another study indicated the recidivism rate for the NPP participants was only 7.36 percent, when only seven of the 95 adults who completed the program were charged with additional counts of child abuse and neglect after their participation in the program.[423]

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[418] FRIENDS National Resource Center for CBCAP. *Evidence-Based and Evidence-Informed Programs: Prevention Program Descriptions Classified by CBCAP Evidence-Based and Evidence-Informed Categories*. Chapel Hill, N.C., September 2009, available at http://friendsnrc.org/joomdocs/eb_prog_direct.pdf (accessed January 30, 2014).

[419] *NREPP SAMHSA's National Registry of Evidence-based Programs and Practices: Nurturing Parenting Programs,* available at http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=171 (accessed May 22, 2014).

[420] Bavolek, Stephen J. *The Nurturing Parenting Programs: Juvenile Justice Bulletin.* Washington, D.C.: U.S. Department of Justice. Office of Justice Programs. Office of Juvenile Justice and Delinquency Prevention. November 2000 available at https://www.ncjrs.gov/pdfiles1/ojjdp/172848.pdf (accessed May 22, 2014).

[421] Ibid.

[422] Ibid.

[423] *NREPP SAMHSA's National Registry of Evidence-based Programs and Practices: Nurturing Parenting Programs,* available at http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=171 (accessed May 22, 2014).

NPP has found its place on the FRIENDS' list of evidence-based and evidence-informed prevention programs as a "promising" program.[424]

Implementation costs per family are approximately $300-$600 for group series and approximately $2,000 for home visitation.[425]

*Incredible Years*

Another parent training program developed in early 1980s and used by several CTF grants recipients in Pennsylvania is called Incredible years. Developed by Carolyn Webster-Stratton, it is a parent education/support program and skills-based program for children 2-12 years old. The Parent Training Intervention focuses on improving parenting practices, particularly related to positive discipline and communication. It also encourages parents' involvement in children's education. Incredible Years has a Teacher Training Intervention module designed to strengthen teachers' classroom management strategies and improve children's cooperation with peers and teachers. The child training curriculum is centered on children's social and emotional competencies. The program includes an interactive parent-child component.[426]

Incredible Years is well supported by research, with studies offering "strong evidence related to identified child abuse and neglect prevention protective factors."[427]

Implementation of Incredible Years requires a certified group leader. Potential group leaders can come from several disciplines such as counseling, social work, psychology, psychiatry, nursing and education and are expected to have training in child development and behavior management. They should undergo an authorized training and certification process. Training costs are $400-$500 per leader.[428]

Implementation costs are $1,500 per series for program materials, with the cost for the child program slightly higher due to the price of puppets. Ongoing costs are estimated at

- $500 annually for each leader to receive consultation,
- $476 for each parent in parent groups,
- $775 for each child in child treatment groups,
- $15 for each child receiving the Dinosaur Curriculum in school,
- $30 for each teacher receiving the teacher training.[429]

[424] FRIENDS National Resource Center for CBCAP. *Evidence-Based and Evidence-Informed Programs: Prevention Program Descriptions Classified by CBCAP Evidence-Based and Evidence-Informed Categories*. Chapel Hill, N.C., September 2009, available at http://friendsnrc.org/joomdocs/eb_prog_direct.pdf (accessed January 30, 2014).
[425] Ibid.
[426] FRIENDS National Resource Center for CBCAP. *Evidence-Based and Evidence-Informed Programs: Prevention Program Descriptions Classified by CBCAP Evidence-Based and Evidence-Informed Categories*. Chapel Hill, N.C., September 2009, available at http://friendsnrc.org/joomdocs/eb_prog_direct.pdf (accessed January 30, 2014).
[427] Ibid.
[428] Ibid.
[429] Ibid.

Curricula are implemented with child and parent groups over a period of 18 to 28 weeks. The Classroom/Dinosaur program for children implemented by teachers is 30 to 60 lessons a year.

*MOMobile*

While most of the PA CTF grant recipients rely on the evidence-based programs used nationwide and even worldwide such as the Nurse-Family Partnership, Parents as Teachers, and Incredible Years, some are informed by locally developed research. An example of a successful program of this kind is MOMobile. Through the MOMobile program, Maternity Care Coalition (MCC) provides support and education to pregnant women, new parents, and their families in Philadelphia and Delaware Counties. The program also links women to necessary community resources. Established in 1999, the Delaware County MOMobile is a community-based outreach and family support service. Traveling in brightly colored MOMobile vans, experienced, well-trained community health worker advocates form trusting relationships with pregnant women and their families. Advocates work with families in their own homes. There are six MOMobile sites located throughout Philadelphia and Delaware Counties. Several sites have specialty programs designed to meet the needs of their communities.

The following core activities ensure achievement of MOMobile program goals:

- Conduct outreach to identify and enroll pregnant and newly parenting women.
- Provide support to clients through home visiting, telephone contact, and office visits.
- Ensure families are well educated using a maternal and child health home visiting curriculum.
- Ensure access to health care, public benefits, and social service programs.
- Provide access to emergency supplies such as food, clothing, cribs, diapers, and formula.
- Encourage community support and involvement in MOMobile services.[430]

Maternity Care Coalition serves populations who are considered to be at high risk for several medical issues as well as child abuse and neglect such as low-income women suffering from postpartum depression and incarcerated pregnant women and new mothers who need assistance with reentry.

The 2011-14 CTF grant awarded to Maternity Care Coalition is intended for the Delaware County MOMobile Teen Parenting Program. A Teen Advocate will provide targeted, home-based case management, along with individual and group parenting education, to pregnant and newly parenting teenagers and young women in Delaware County and Southwest Philadelphia. Particular emphasis will be placed on targeting young women who have dropped out of school or who are disengaged from existing community-based services."[431]

[430] *MCC – Maternity Care Coalition: Strengthening Families, Inspiring Change*, available at http://maternitycarecolition.org/professionals/services-for-families/momobile (accessed May 28, 2014).
[431] Information provided to the Joint State Government Commission by DPW on September 5, 2013.

Different kinds of child maltreatment require different prevention strategies. Neglect may often be eliminated or mitigated by assisting families in obtaining safe and affordable housing, health care, mental health, and substance abuse treatment services. Physical and emotional abuse may be prevented by educating parents on the child's development and emotional needs and on acceptable kinds of discipline, by making respite care and crisis intervention available to those who need it, by increasing parental resilience, and by helping them to establish a community support system. It is clear that none of these measures will stop child sexual abuse; it requires a different approach.

A number of general prevention strategies are applicable to sexual abuse prevention though they are used differently. Education and proper reporting are as important in sexual abuse prevention as when dealing with other forms of child maltreatment. Teaching parents and primary caretakers as well as professionals working with children to recognize signs and symptoms of child sexual abuse and to respond properly, and increasing general public awareness are of paramount importance. With sexual abuse, educating children themselves is also useful. For education to be successful, programs need to address the different people involved.

### *Models of Prevention and Types of Child Sexual Abuse Prevention Programs*

Child sexual abuse prevention programs can be based on several models of prevention. As with other forms of child maltreatment, the public health approach has brought up significant changes in prevention work: "the field of public health has been integral in changing the focus of anti-sexual violence prevention work from treating a person after they have been victimized to preventing violence from happening at all."[432]

The public health model, widely used in developing prevention programs across the country, classifies prevention efforts as primary, secondary, and tertiary. With regard to sexual abuse prevention, universal primary prevention efforts target large groups, and selective primary prevention efforts are directed to those who are at risk for victimization or those who are potential perpetrators. The main components of primary prevention of child sexual abuse include teaching people about healthy relationships, about identifying a situation that could become abusive, and about protective policies child care organizations can implement; teaching people what to do if they suspect the risk of child sexual abuse; and working to change social structures and norms that support the occurrence of child sexual abuse. [433] Secondary prevention of child sexual abuse aims to reduce the potential short-term harm resulting from child sexual abuse, mostly by improving

[432] National Sexual Violence Resource Center. *Child Sexual Abuse Prevention*, available at http://www/nsvrc.org/print/publications/child-sexual-abuse-prevention-information-packet (accessed September 5, 2012).
[433] Ibid.

how individuals and social services respond to survivors of abuse. This includes "ensuring that survivors have access to services such as advocacy, health care, and/or legal support."[434] Secondary prevention of child abuse involves teaching possible responders such as doctors, teachers, and parents how to screen for child sexual abuse and what to do if they suspect that abuse has occurred; increasing awareness about social services available to abuse survivors; and reducing the stigma associated with child sexual abuse.[435] Tertiary prevention of child sexual abuse consists of preventing further harm to a person already involved in a sexual abuse incident. Its two chief components include working with perpetrators to prevent them from reoffending, and working with victims to prevent long-term problems.[436]

The social-ecological model of prevention examines the multiple systems that surround each act of violence. It emphasizes the idea that child sexual abuse prevention, similar to other types of violence prevention, requires "changing norms, climate, and culture."[437] Many factors at the level of the individual, relationships, community, and society can increase or decrease the risk that individual sexual violence and sexual exploitation will occur. Further, several settings influence the degree of harm resulting from child sexual abuse once it has happened. Various micro- and macrosystems can contribute to the occurrence of sexual violence but can also be used to facilitate prevention efforts. According to the social-ecological model, "the burden of prevention should be distributed among community members, organizations, and social structures."[438]

National organizations such as the National Sexual Violence Resource Center (NSVRC) offer plentiful materials on development and implementation of abuse prevention programs designed for different population groups. There are several types of programs that are commonly used to educate and engage adults in preventing child sexual abuse: teacher-training components of school-based programs for children and school-based education/orientation sessions for parents and guardians; stand-alone parent education programs, either community-based or as part of home-visitation programs for families considered to be at high risk of abuse; training for professionals who are mandated reporters such as teachers and other school personnel, health care workers, law enforcement officers, and state agency employees working with children; public education campaigns addressed to broader audiences and aimed at raising awareness about the problem and assisting the public in identifying signs of child abuse; media campaigns as a special kind of public education campaigns; and social marketing campaigns that draw upon research and behavior change theory to develop strategies.[439]

Sexual abuse prevention programs that teach children self-protective skills are the most popular kind of program in the category of interventions designed to make children less vulnerable to abuse.[440] Sexual abuse prevention programs designed for children have traditionally applied a

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[434] Ibid.
[435] Ibid.
[436] Ibid.
[437] Ibid.
[438] Ibid.
[439] National Sexual Violence Resource Center. *Child Sexual Abuse Prevention: Programs for Adults,* available at http://www.nsvrc.org (accessed September 5, 2012).
[440] Noor, Ismail and Robert A. Caldwell. *The Costs of Child Abuse vs. Child Abuse Prevention: A Multi-year Follow-up in Michigan*, available at https://www.msu.edu/~bob/cost2005.pdf (accessed December 6, 2013).

risk reduction approach – "one that educates children about child sexual abuse and provides them with skills to repel and report abuse."[441] A variety of prevention programs are available for a wide range of children, from those very young to teenagers. Child abuse prevention programs for children have three main goals: to teach children to recognize sexual abuse, to give them the skills to avoid abuse, and to encourage them to report abuse in case they experience it.[442] According to studies of various prevention programs, the most effective among them include children as physically active participants; combine the techniques of modeling, group discussion, and role-playing/rehearsal; tend to last for longer periods of time than less effective programs; are broken into multiple sessions; and involve parents in prevention efforts.[443] Though teaching children about risk and risk reduction is important, experts and advocates recognize that risk reduction will not stop sexual violence. Children cannot be expected to protect themselves from sexual abuse. Therefore, prevention programs designed for children are only one of the many components of a successful community effort to prevent child abuse. Ultimately, "changing the behavior of adults and communities, rather than the behavior of children, is the ideal way to prevent sexual child abuse."[444]

### *Investigation of Occurrence and Prevention of Recurring Abuse*

If the abuse has already occurred, and the issue is investigation and prevention of further abuse, local child-abuse prevention teams may play a major part in achieving this goal. Most experts agree that a crucial factor in child abuse prevention is cooperation between law-enforcement and welfare agencies, such as Children and Youth Services. Child-abuse prevention teams that have been created in several localities appear to be a promising tool in combating child abuse. One of the most comprehensive, well-organized teams operates in Lancaster County. The team is comprised of prosecutors, detectives, Children and Youth Services, the Lancaster County Children's Alliance, Lancaster General Hospital, and others.[445] Collaborative efforts of law enforcement officers, social workers and medical professionals ensure that a child victim receives the necessary help and a child predator or abuser is stopped from re-victimizing the same child or hurting another young individual.

Children's advocacy centers have been increasingly recognized as an effective tool of sexual abuse tertiary prevention. These centers bring together doctors, nurses, social workers, prosecutors, and police in order to provide an essential program of treatment for child victims. An outgrowth of the Task Force on Child Abuse report, Act 28 of 2014 provided for the establishment of child advocacy centers and for their funding as well as funding for training of mandated reporters of suspected child abuse. The source of funding is an increase from ten dollars ($10) to twenty dollars ($20) in the cost for a copy of a birth certificate. The newly added section of the Administrative Code emphasizes that "children's advocacy centers not only treat child victims,

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[441] National Sexual Violence Resource Center. *Child Sexual Abuse Prevention: Programs for Children*. *Building an Evidence-Informed Approach*, available at http://www.nsvrc.org (accessed September 5, 2012).
[441] Ibid.
[442] Ibid.
[443] Ibid.
[444] Ibid.
[445] Hambright, Brett. *County Praised for Work on Abuse*, available at http://lancasteronline.com/article/local/747667_County-praised-for-work-on-abuse.html (accessed October 2, 2012).

but assist in preventing and detecting child abuse and provide, through forensic interviewing and other techniques employed by the multidisciplinary investigative teams, the most effective way to bring perpetrators of child sexual abuse to justice."[446]

Requirements of the multidisciplinary investigative team, as well as the multidisciplinary review team, are detailed in the recent amendments to the Child Protective Services Law (Title 23, Chapter 63).[447] Multidisciplinary investigative teams will be used to coordinate child abuse investigations between county agencies and law enforcement.

To strengthen the investigation and prosecution of child abuse, Pennsylvania has introduced a nationally recognized forensic interview and multidisciplinary team (MDT) training program ChildFirst. ChildFirst is the forensic interview training program of the National Child Protection Training Center currently in partnership with CornerHouse, a child abuse training facility in Minnesota. "The program is specifically designed for investigative teams of law enforcement officers, social workers, prosecutors, child protective attorneys, and mandated reporters of abuse who must provide investigating professionals with essential information."[448] In 2009, the Pennsylvania Children and Youth Solicitors Association in collaboration with the Pennsylvania District Attorney's Association made the financial commitment to bring ChildFirst to the Commonwealth.[449] In 2012, ChildFirst PA partnered with the Pennsylvania State Police for the use of their Training Academy in Hershey and their training sites across the state. At present, approximately one half of Pennsylvania counties have completed the ChildFirst training.[450]

### *Primary and Secondary Prevention*

The development of multidisciplinary investigative teams, child advocacy centers and ChildFirst training program is expected to facilitate tertiary sexual abuse prevention. Primary and secondary prevention, that have increasingly become the focus of child protection experts, involve, however, a different, comprehensive approach.

A key to success in child abuse prevention is a consorted effort that engages entire communities in a multi-level strategy in which adults take responsibility and action to protect children from abuse.

Involving the larger community in protecting child from sexual abuse is especially important for a number of reasons. One of them is that parents are not the most common perpetrators of sexual abuse; mothers hardly ever are, so traditional parenting programs such as the Nurse-Family Partnership and Triple P cannot be expected to be effective in sexual abuse prevention even though they have significant impact on reducing physical abuse or neglect and deserve continued support.[451] Carefully designed education campaigns targeting teachers and other

[446] Act of Apr. 9, 1929 (P.L.177, No.175), § 2301-B(2); 71 P.S. § 614.1(2).
[447] 23 Pa.C.S. § 6365.
[448] ChildFirst Pennsylvania, available at http://www.childfirstpa.com (accessed June 17, 2014).
[449] Ibid.
[450] Ibid.
[451] Telephone interview with Dr. Jennie G. Noll, Director of Research and Education, Network on Child Protection &Well-being, the Pennsylvania State University on January 24, 2014.

professionals working with children as well as campaigns addressed to the general public can both play an important part in protecting children. When the communities are more aware of child sexual abuse and when people who suspect it are empowered to act, children's safety is increased.[452] An important perspective on child sexual abuse is to view it in conjunction with long-term problems. Being sexually abused as a child puts a person at increased risks for obesity, teen pregnancy and a number of other detrimental long-term consequences. Preventing such distant consequences is one of the tasks in dealing with child sexual abuse.[453] Timely intervention with appropriate treatment of physical and mental health problems such as post-traumatic stress disorder can eliminate or mitigate costly long-term consequences and break intergenerational transmission. In regards to sexual abuse, secondary and tertiary prevention can play a big part in reducing child abuse rates and have more impact than general primary prevention efforts.[454]

### *Intergenerational Impact of Child Sexual Abuse and Possible Preventive Measures*

Child sexual abuse has significant intergenerational impact. Child abuse often recurs from generation to generation. Children born to mothers who were sexually victimized in childhood are more likely than the national average to end up in child protection. It has been noted that sexual abuse "affects processes in parents that confer risks to offspring. It is estimated that 30% of mothers with histories of abuse go on to abuse their offspring or recreate environments where abuse persists across generations."[455] When victims of child sexual abuse become mothers, they may have difficulties building healthy relationships with their children. Often mothers who had been victimized as children do not recognize danger, or they have no capacity to act. Parenting programs targeted to women who experienced sexual abuse in their own childhood need to take into account unique factors that affect them. These women must be taught how to protect their children. Most of them want to protect, but they need tools to do it. Parenting programs specifically tailored for them can help achieve this goal.[456]

A multigenerational study of women who experienced childhood sexual abuse empirically demonstrated that offspring of such mothers "were more likely to be born preterm, have a teenage mother, and be involved in protective services."[457] The prospective results of the study "demonstrate the inordinate prevalence of various forms of adversity and risk for maldevelopment operating in the lives of offspring born to mothers who experienced sexual child abuse. They also provide a snapshot of the *cumulative* risk to these offspring, the potential for continued victimization and adversity, and a powerful illustration of the amount of burden that children born

[452] Ibid.
[453] Ibid.
[454] Ibid.
[455] Noll, Jennie G. and Penelope K. Trickett. *Health & Wellbeing of Sexually Abused Females & Offspring: 25 and 27 Yr. Followup*, available at https://www.collectiveip.com/grants/NIH:8727798 (submitted to the Joint State Government Commission on January 23, 2014).
[456] Telephone interview with Dr. Jennie G. Noll, Director of Research and Education, Network on Child Protection &Well-being, the Pennsylvania State University on January 24, 2014.
[457] Noll, Jennie G. et al. "The Cumulative Burden Borne by Offspring Whose Mothers Were Sexually Abused as Children: Descriptive Results from a Multigenerational Study." *Journal of Interpersonal Violence*. Vol. 24, No. 3, March 2009. P. 424.

into adversity are required to bear."[458] Based on the results of their study, the authors assert that "intervention programs for child abuse survivors should be characterized as "selective primary prevention efforts" that would likely curtail the large public health burden of the various sequelae of childhood abuse as well as the impact on the next generation who are placed at-risk because of these various sequelae."[459] Considering differential funding priorities, the authors contend that "such efforts would likely show increased efficacy over primary prevention programs designed for nonabused individuals at lower risk for maldevelopment."[460]

One of the clear predictors of the intergenerational child abuse is teen pregnancy. In the long-term perspective, reducing or eliminating teen pregnancy may significantly reduce child abuse, including sexual. There seems to be a general consensus among experts about this conclusion.[461] Researchers surmise that "effective teen pregnancy prevention programmes could shift the population of children born to mothers who are at high risk of contact with child protective services."[462] An innovative data linkage project in California established that a much higher percentage of children born to teenage mothers were subsequently identified as possible victims of maltreatment compared with children born to mothers over the age of thirty: 25.4 percent versus 9.5 percent.[463] This leads some researchers to conjecture that "even modest declines in teen birth rates may prove more impactful as a method for lowering the prevalence of child maltreatment" than home-visiting programs for young mothers such as the NFP, that have been proven to produce positive results.[464]

A recent study of teen childbirths in maltreated and non-maltreated females has found that "maltreated females were twice as likely to experience teen childbirth after controlling for demographic compounds and known risk factors," with birth rates being highest for sexually abused and neglected females.[465] The authors came to the conclusion that "sexual abuse and neglect are unique predictors of subsequent teen childbirth."[466] Having established that sexual abuse and neglect were independent predictors of subsequent teen childbirth over and above demographic characteristics and other risk factors, the researchers suggest that "partnerships between protective service providers and teen childbirth prevention strategists hold the best promise for further reducing the U.S. teen birth rate."[467]

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[458] Ibid. P. 442.
[459] Ibid.
[460] Ibid.
[461] Suspected Child Abuse and Neglect (SCAN) Advisory Board meeting on December 12, 2013.
Telephone interview with Dr. Jennie G. Noll, Director of Research and Education, Network on Child Protection &Well-being, the Pennsylvania State University on January 24, 2014.
[462] Putnam-Hornstein, Emily. "A Public Health Approach to Child Maltreatment Surveillance: Evidence from a Data Linkage Project in the United States." *Child Abuse Review*. 2011. Vol. 20. Pp. 256-273, published online in Wiley Online Library (wileyonlinelibrary.com) DOI: 10.1002/car.1191.
[463] Ibid.
[464] Ibid.
[465] Noll, Jennie G. and Chad E. Shenk. "Teen Birth Rates in Sexually Abused and Neglected Females." *Pediatrics.* Vol. 13, No. 4, April 2013, also available online at http://pediatrics.aappublications.org/content/131/4/e1181.full.html (accessed June 13, 2014).
[466] Ibid.
[467] Ibid.

Since the 1990s, teen pregnancy in the United States has declined 42 percent, and the teen birth rate is down 52 percent.[468] However, "teen pregnancy, abortion and birth rates in the United States for teens age 15 to 19 remain among the highest in the industrialized world."[469] According to the National Conference of State Legislatures' estimate, three in ten girls will be pregnant at least once before their twentieth birthday, and one of five teen mothers will have a second child during her teen years.[470] These statistics are disturbing because pregnancy and parenthood are associated with a host of social, economic, and medical issues affecting adolescent mothers, their offspring, and society. Further steps to curtail teen pregnancy are, obviously, needed. Child abuse prevention is one of the compelling reasons for continued efforts to achieve this goal. Targeting teen pregnancy preventive measures to specific populations, such as those adolescent women who were themselves victims of sexual abuse in their childhood, along with other high-risk groups like homeless teens and those in or aging out of foster care, and tailoring prevention and intervention programs based on their specific needs may be an efficacious way to make further progress in both teen pregnancy and child abuse prevention.

### *Enhancing Public Awareness: Darkness to Light*

Growing realization of the importance to involve the larger community in protecting children from sexual abuse led to the creation of several programs aimed at increasing public awareness about child abuse. One of the leading organizations that has spearheaded this effort nationwide and is quickly spreading in Pennsylvania is Darkness to Light.

Darkness to Light (D2L) is a nationwide nonprofit organization created to fight child sexual abuse. Its purpose is to educate adults about ways to recognize child sexual abuse and react to it responsibly as well as to prevent it from happening in the future. Darkness to Light uses media campaign to increase awareness about child abuse among the general public. It has developed a training curriculum, "Stewards of Children," targeted to parents, responsible adults, and youth-serving organizations such as day care centers, after-school programs, sports leagues, children's clubs, and church groups.

In June 2012, the Pennsylvania State Alliance of YMCAs adopted Darkness to Light as a statewide initiative under the YMCA's Social Responsibility area of focus. The State Alliance received a $50,000 grant from the Redwoods Foundation specifically for Darkness to Light. Combined with the $25,000 in seed money that was required, the State Alliance had the resources for training facilitators and providing training and information materials.[471] The purpose of the D2L program "Steward of Children" offered by YMCAs across Pennsylvania is "to empower and mobilize adults to take action and prevent child sexual abuse."[472]

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[468] National Conference of State Legislatures. *Teen Pregnancy Prevention*, available at http://ncsl.org/research/health/teen-pregnancy-prevention.aspx 9accessed January 27, 2014).
[469] Ibid.
[470] Ibid.
[471] Information provided to the Joint State Government Commission by Mr. David John, Executive Director of the Pennsylvania State Alliance of YMCAs, on June 25, 2014.
[472] Long, Howard W., III and Cameron Frantz. *Pennsylvania State Alliance of YMCAs Testimony Presented to the House Republican Policy Committee on May 1, 2014*.

"Stewards of Children" is designed to increase knowledge, improve attitudes, and change behavior to protect children. The training covers a five-step plan:

(1) Learn the Facts (1 in 10 children are sexually abused, and over 90 percent know their abuser);

(2) Minimize Opportunity (eliminate or reduce isolated, one-on-one situations to decrease risk for abuse);

(3) Talk About It (have open conversations with children about their bodies, sex, and boundaries);

(4) Recognize the Signs (know the signs of abuse to protect children from further harm);

(5) React Responsibly (understand how to respond to suspicions or reports of child abuse).[473]

The State Alliance has trained over forty facilitators by May 2014 and has made a commitment to train all adult full-time and part-time employees in the YMCAs across the Commonwealth in the next five years.[474]

Not only does the Pennsylvania State Alliance intend to train all YMCA employees, but it would like to be a leader in the fight against child sexual abuse and facilitate the change in the entire community. As research has shown that training five percent of the population is the critical point of positive change in the community, the State Alliance has set a goal of training over 586,000 adult residents throughout the state in the next five years. To achieve this goal, the organization is planning to work with the 68 corporate YMCAs across the state to initiate this program for their communities in collaboration with local community partners, including schools, volunteer groups, and local governments.[475]

Recently, the national Darkness to Light organization selected the State Alliance to offer free online "Stewards of Children" training through December 2015. This will enable all Ys in the Commonwealth to educate their staff, volunteers, and community partners. The Darkness to Light organization received a national grant to expand training, and because the PA State Alliance of YMCAs had taken on its program as a statewide initiative, it was selected for this special opportunity.[476] It should bring the Pennsylvania Ys closer to achieving their ambitious goal in increasing knowledge about child sexual abuse and changing attitudes and behaviors to enhance child protection.

[473] Ibid.
[474] Ibid.
[475] Ibid.
[476] Information provided to the Joint State Government Commission by Mr. David John, Executive Director of the Pennsylvania State Alliance of YMCAs, on June 25, 2014.

As has been mentioned earlier, assessing the effectiveness of prevention programs is a challenging task. It is even more so in regards to sexual abuse prevention, "due to the complexity, inherent secrecy, significant underreporting, and difficulty in accurate data collection."[477] Efficacy of child abuse prevention programs is typically evaluated by measuring increases in participants' knowledge, alterations in attitudes, and changes in child-protective behaviors. Darkness to Light's "Stewards of Children" training has met these criteria. Several studies, performed between 2003 and 2011, have indicated it increases knowledge, improves participants' attitudes, and changes their behavior over the long term.[478] Participants' surveys showed that after the training, they were more likely to

- Discuss issues of sexual abuse with a child or another adult,
- Pay attention to potential signs of child abuse,
- Drop in unexpectedly to ensure that a child is safe in the care of another adult.[479]

All these behaviors can be helpful preventive measures.

While the bulk of Darkness to Light training in Pennsylvania is provided by the YMCAs, it is also offered by several rape crisis centers, sometimes in conjunction with a local YMCA, Pennsylvania Family Support Alliance, or another organization. For example, Centre County Women's Resource Center offers "Stewards of Children" training, along with another prevention training program for adults, at various locations, including hotels, area agencies, and school districts.[480] In Bucks County, the Network of Victim Assistance (NOVA) has also used Darkness to Light's "Stewards of Children" sexual assault awareness/prevention program and has found it effective.[481] In Bucks County, victims service agency and child advocacy center exist under the same umbrella, so they often combine their training and prevention efforts.[482]

Funding for public awareness/prevention training and education programs run by rape crisis centers comes from a variety of sources, including the Pennsylvania Coalition Against Rape (PCAR), the Pennsylvania Coalition Against Domestic Violence (PCADV), grants from the United Way and other private organizations. Child abuse is not a primary issue for either PCAR or PCADV. However, both agencies are involved in state-wide education and prevention initiatives aimed at increasing children's safety and enhancing public awareness of child sexual abuse.

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[477] Darkness to Light: End Child Sexual Abuse. *Evidence and Efficacy of Stewards of Children Prevention Training*, available at http://www.d2l.org/site/c.4dICIJOkGcISE/b.6143167/k.81F8/Evidence_and_Efficacy_of_Stewards_of_Children_Prevention_Training.htm (accessed June 12, 2014).

[478] Ibid.

[479] Ibid.

[480] Telephone interview with Ms. Jody K. Althouse, Director of Outreach & Education at the Center County Women's Resource Center, on January 31, 2014.

[481] Telephone interview with Ms. Mandy Mundy, Director of Education and Training at NOVA, on February 7, 2014.

[482] Ibid.

In response to an inquiry made by the Joint State Government Commission in writing this report, Ms. Alexa Livelsberger, the PCAR Children's Advocacy Coordinator, provided the following list of state-wide initiatives child abuse and neglect prevention programming facilitated and/or funded by PCAR:

- Child Abuse and Mandated Reporting
  - A training-of-trainers curriculum approved by the Pennsylvania Department of Education to fulfill training requirements of mandated reporters in accordance with Act 126 requirements.
  - The training-of-trainers is two days and is offered to Pennsylvania rape crisis centers staff.
  - The curriculum can then be delivered in one- or three-hour formats for school personnel or alternate formats for community members.

- The Parent Involvement Project
  - A curriculum for engaging parents/caregivers in child sexual abuse prevention
  - Parent/caregiver sessions are two hours each for four total sessions.
  - Sessions include topics of boundaries, bystanders, healthy relationships, and healthy sexuality.
  - There are take-home opportunities for parents/caregivers to continue practice outside of the session.

- The Situational Prevention Model
  - Considers possible situational factors that may increase the risk of sexual violence (characteristics/location of the setting, relevant policies/regulations, routine activities of individuals using the setting).
  - Involves two-part process:
    (1) Assessment of an organization/program is performed to determine situational risks that increase the chances that child sexual abuse could occur.
    (2) Risks are then linked to prevention or risk reduction strategies to create a safer environment for children and adolescents.
  - Is piloted in both Pennsylvania and Oregon.

All these programs include an evaluation component.[483]

Prevention and training are not on the list of services that rape crisis centers are required to provide as part of their subcontract with PCAR.[484] Some of them, however, expressed a wish to offer prevention education and outreach as well as child advocacy as additional services.[485]

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[483] E-mail to the Joint State Government Commission from Ms. Alexa Livelsberger, PCAR Children's Advocacy Coordinator, received on January 2, 2014.
[484] *Funding Formula Options for the Pennsylvania Coalition Against Rape: Report to the Pennsylvania General Assembly Per Act 87 of 2012. January 13, 2013*, available at http://www.dpw.state.pa.us/cs/groups/webcontent/documents/reports/p_025503.pdf (accessed September 18, 2014).
[485] Ibid.

During fiscal year 2012-2013, the PCAR Children's Advocacy Coordinator conducted webinars, such as "Growing Resiliency: Meeting the Needs of Children Surviving Incest," "Mandated Reporting of Suspected Child Abuse," and "Children Need Us All Rural Webinar." Together with the PCAR Education and Resource Coordinator, she co-facilitated Create Safe Communities for Children and conducted training sessions on child abuse and reporting suspected child abuse to victim services centers' staff.[486]

Similar to PCAR, the Pennsylvania Coalition Against Domestic Violence (PCADV) devotes part of its attention to training and technical assistance activities aimed at child abuse prevention. Training covers topics such as intersection of domestic violence and child abuse, child safety planning and enhancing safety for victims of domestic violence and their children. PCDAV's legal assistance to battered women in obtaining custody of their children and providing for the children's safety while visiting their fathers may also be considered an abuse prevention measure.[487]

[486] Information provided to the Joint State Government Commission by Ms. Alexa Livelsberger, PCAR Children's Advocacy Coordinator.

[487] *Pennsylvania Coalition Against Domestic Violence Final Report July 1, 2012-June 30, 2013*. *35 Years on a Mission: Pennsylvania Coalition Against Domestic Violence 2010/2011 Annual Report*, available at http://www.pcdav.org (accessed September 19, 2014).

# RECOMMENDATIONS

Successful child maltreatment prevention involves a holistic approach. Reducing poverty, increasing support for families, and advancing education would all contribute to reductions in child abuse and neglect.

Specific approaches addressing known risks can also play a significant role. In recent years, agencies in Pennsylvania have been utilizing a number of evidence-based programs and practices that can be expected to continue bringing good results.

The following recommendations can lead to further development of child abuse prevention efforts, to more effective program implementation, and to better outcomes:

(1) Focus funding on primary and secondary prevention.

(2) Implement programs according to their original designs. Accurate and faithful implementation of a program, retaining all of its original proven components is a key to success. Cutting corners to save costs is counterproductive.

(3) Target programs carefully: the program must be matched to the population that needs its services.[488]

(4) Allocate more resources and more research to well-established programs, especially to answer the questions of how to engage families and how to improve delivery methods for better success.

(5) Select programs carefully, with the focus on measurable results. In program selection, it is important not to rely solely on the program site or the information provided by its administrators, but instead to base the decisions on independent studies and well-established national clearing houses.

(6) Examine the impact of program participation on subsequent incidents of child maltreatment and other outcomes and continuously apply the results of such examination to program utilization and improvement.

[488] An extensive cost-benefit RAND study strongly states that "at least from the perspective of government savings, appropriate targeting is crucial." Karoly, Lynn A. et al. *Investing in Our Children: What We Know and Don't Know About the Costs and Benefits of Early Childhood Interventions.* Santa Monica, CA; Washington, D.C.: RAND, 1998. P. 91.

(7) Develop new intervention strategies for families for whom conventional approaches appear to bring minimal benefit.

(8) Have clear expectations and distinguish between short-, medium-, and long-term outcomes sought by a particular program or policy.

(9) Continue research aimed at creating and evaluating new approaches to prevention.

(10) Enhance training for mandatory reporters. Mandatory training must go hand-in-hand with mandatory reporting (for PCPs, family physicians, pediatricians, mental health providers, and some specialists). Consider whether a child abuse recognition course should be required when physicians and nurses apply for their license.

(11) Teach providers how to screen for corporal punishment and for domestic violence.

(12) Reorganize preventive services on the basis of reassessment of risk factors, establish a more unified approach to injury intervention and prevention as a potentially more successful and efficient means of improving child safety.

(13) Reduce the number of teen pregnancies.

(14) Reduce the number of unwanted/unplanned child pregnancies.

(15) Promote spacing the births.

(16) Prevent reproductive coercion.

(17) Teach parents positive child rearing and management skills through parent training or behavioral intervention as needed.

(18) Provide social support to parents and families to relieve the effects of chronic and situational stress.[489]

(19) Conduct massive education campaigns with clear, crisp messaging.

(20) Focus on positive messages, reframe statements in public health campaigns in a positive way, towards more positive parenting.

(21) Improve fatalities and near-fatalities review.

[489] Parenting education and social support can be combined in multi-component programs run by Family Centers and early child home visitation programs such as the NFP. Both of these have been successful in Pennsylvania and deserve further support and development.

(22) Strengthen tertiary prevention - prevent re-abuse.

(23) Improve program monitoring, evaluation, and coordination by the state.

(24) Concentrate program implementation, evaluation and monitoring, as well as training, in the hands of those state agencies and other organizations that are primarily focused on children and have already demonstrated success such as OCYF, PFSA, SCAN and the Pennsylvania State Alliance of YMCAs. Keeping such leading agencies in control ensures high quality and consistency in program implementation.

(25) Ensure better accountability. Require the tracking of all child abuse prevention funds, especially in agencies that receive such funding although they are not solely focused on child-oriented services.

(26) Consider designating a portion of the fee charged by the PA State Police for a criminal background check ($10) and by the Department of Public Welfare for its child abuse history check ($10) toward evidence-based child abuse and neglect prevention services/programs.

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**THE GENERAL ASSEMBLY OF PENNSYLVANIA**

# HOUSE RESOLUTION

## No. 163 Session of 2013

INTRODUCED BY HARHART, WATSON, TOOHIL, ROCK, TOEPEL, HEFFLEY, YOUNGBLOOD, LONGIETTI, MILLARD, MUNDY, PICKETT, MAJOR, DENLINGER, MARSICO, READSHAW, FABRIZIO, V. BROWN, KORTZ, O'NEILL, MACKENZIE, HARPER, QUINN, KAUFFMAN, MILLER, BOBACK, GINGRICH, PEIFER, GILLEN, STEVENSON, WHEATLEY, ROEBUCK, DEASY, MOUL, KULA AND BISHOP, MARCH 15, 2013

REFERRED TO COMMITEE ON CHILDREN AND YOUTH, MARCH 15, 2013

A RESOLUTION

Directing the Joint State Government Commission to identify existing evidence-based child abuse and neglect prevention programs in this Commonwealth and nationwide, evaluate the effectiveness and relative cost of these programs and identify opportunities to integrate child abuse and neglect prevention methods and approaches into Commonwealth programs and policy.

WHEREAS, The General Assembly recognizes that child abuse and neglect are persistent problems in this Commonwealth; and

WHEREAS, The Task Force on Child Protection was created by the General Assembly to thoroughly review State laws and procedures governing child protection and the reporting of child abuse; and

WHEREAS, The task force issued its report and recommendations on November 27, 2012; and

WHEREAS, The task force recommended that evidence-based child abuse and neglect prevention programs be encouraged and financially supported where feasible, and that the numerous

models of successful prevention programs throughout this Commonwealth and nationwide be more fully considered to determine whether they are adaptable to diverse communities throughout this Commonwealth; therefore be it

RESOLVED, That the House of Representatives direct the Joint State Government Commission to identify existing successful evidence-based child abuse and neglect prevention programs operating in this Commonwealth and nationwide; and be it further

RESOLVED, That the Joint State Government Commission evaluate the effectiveness and relative cost of these programs; and be it further

RESOLVED, That the Joint State Government Commission identify opportunities to integrate child abuse and neglect prevention methods and approaches into Commonwealth programs and the policy of Commonwealth agencies where feasible; and be it further

RESOLVED, That the Joint State Government Commission, in consultation with the Legislative Budget and Finance Committee as necessary, identify all existing Federal, State and county funding streams currently provided for child abuse and neglect prevention and provide recommendations on how to create incentives for the adoption and implementation of evidence-based child abuse and neglect prevention programs; and be it further

RESOLVED, That the Joint State Government Commission prepare a report of its findings and transmit copies of the report to the chairperson and minority chairperson of the Children and Youth Committee and the chairperson and minority chairperson of the Judiciary Committee of the House of Representatives no later than 18 months after the adoption of this resolution.

# APPENDIX 2

## *Child Protection Legislation Enacted in 2013-2014*

| ACT | BILL NUMBER | SUBJECT MATTER OF ENACTED PROVISIONS |
|---|---|---|
| 2013 Act No. 105 | 2013 House Bill No. 321 | ● Indecent contact<br>● Sexual abuse of children<br>● Sentencing enhancement for offenses involving sexual abuse of children |
| 2013 Act No. 107 | 2013 House Bill No. 414 | ● Custody: consideration of child abuse and involvement with child protective services or general protective services; cooperation among entities<br>● Release of information in confidential reports<br>● Availability of information regarding reports of a child in need of general protective services<br>● Inspection of court files and records<br>● Law enforcement records |
| 2013 Act No. 108 | 2013 House Bill No. 726 | ● Definitions, including, but not limited to, bodily injury, founded report, indicated report, serious physical neglect, sexual abuse or exploitation, and child abuse<br>● Exclusions from child abuse<br>● Notice regarding the disposition of a founded or indicated report<br>● Amendment or expunction of information<br>● Investigation of reports<br>● Evidence in court proceedings |
| 2013 Act No. 109 | 2013 House Bill No. 1201 | ● Non-disclosure of the name of a minor who is a victim of sexual or physical abuse<br>● Report by a district attorney to a health care professional: amendment of the definition of state board |
| 2013 Act No. 117 | 2013 Senate Bill No. 23 | ● Definitions of perpetrator and person responsible for the child's welfare<br>● Expunction of information of a perpetrator who was under 18 when the child abuse was committed |
| 2013 Act No. 118 | 2013 Senate Bill No. 28 | ● Simple assault<br>● Aggravated assault<br>● False reports of child abuse<br>● Intimidation, retaliation, or obstruction in child abuse cases |

| ACT | BILL NUMBER | SUBJECT MATTER OF ENACTED PROVISIONS |
|---|---|---|
| 2013 Act No. 119 | 2013 Senate Bill No. 30 | ● Definition of child-care services<br>● Immunity from civil and criminal liability for a person, hospital, institution, school, facility, agency, or agency employee acting in good faith and making a report of suspected child abuse or referral for general protective services, cooperating or consulting with an investigation, testifying in a proceeding, or engaging in other specified authorized actions<br>● Immunity from civil and criminal liability for an official or employee of DPW or a county agency who refers a report of suspected child abuse for general protective services to law enforcement authorities or who provides authorized services<br>● Contents of the statewide database of protective services<br>● Hearings regarding the amendment or expunction of information |
| 2013 Act No. 120 | 2013 Senate Bill No. 34 | Amendment of the Professional Educator Discipline Act: definitions; certification requirements; Professional Standards and Practices Commission; complaints and department investigations; mandatory reporting; discipline for criminal offenses; imposition of discipline on additional grounds or founded reports; reciprocal discipline; duties of school entities; department action after investigation; hearing; proposed report by hearing officer; appeal; reinstatement; immunity from liability; confidentiality; Commission proceedings and procedures; subpoenas; disposition of fees and fines collected |
| 2013 Act No. 123 | 2013 Senate Bill No. 1116 | ● Multidisciplinary investigative teams<br>● Response to reports and investigations |
| 2014 Act No. 4 | 2013 Senate Bill No. 29 | ● Mandatory reporting of suspected child abuse of a child under one year of age who is born and identified as being affected by illegal substance abuse by the child's mother, withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder<br>● Safety or risk assessment<br>● County agency duties |
| 2014 Act No. 27 | 2013 House Bill No. 89 | Funding of children's advocacy centers through grants to the Pa. Commission on Crime and Delinquency from the Drug Abuse Resistance Education (DARE) Fund |
| 2014 Act No. 28 | 2013 House Bill No. 316 | ● Children's advocacy centers<br>● Funding for training of mandated reporters of suspected child abuse and child abuse related costs<br>● Funding for children's advocacy centers and multidisciplinary investigative teams<br>● Child Advocacy Center Advisory Committee within the Pa. Commission on Crime and Delinquency |

| ACT | BILL NUMBER | SUBJECT MATTER OF ENACTED PROVISIONS |
|---|---|---|
| 2014 Act No. 29 | 2013 Senate Bill No. 24 | ● Electronic reporting regarding suspected child abuse<br>● Reporting the suspicion that a child died as a result of child abuse to the appropriate coroner or medical examiner<br>● Contents of statewide database of protective services<br>● Statewide toll-free telephone number<br>● Reports of children in need of general services and reports made by electronic technologies<br>● Reports by county agencies and law enforcement<br>● Reports by DPW and referral to a county agency<br>● Reports by DPW and referral to law enforcement<br>● Procedures regarding disposition of complaints for suspected child abuse: joint referrals; jurisdictional overlap; referral for services or investigation; records of pending reports; cases involving other states<br>● Investigations<br>● Access to and use of information in the statewide database<br>● Clearances<br>● Information in the statewide database<br>● Maintenance and expunction of information<br>● Release of information in confidential reports<br>● Cooperation of other agencies<br>● Assessment regarding general protective services |
| 2014 Act No. 31 | 2013 House Bill No. 431 | Education and training: licensing boards and specific persons required to meet child abuse recognition and reporting training requirements |
| 2014 Act No. 32 | 2013 House Bill No. 436 | ● Mandated reporters of suspected child abuse<br>● Privileged communications<br>● Failure to report a case of suspected child abuse or make a referral to the appropriate authorities |
| 2014 Act No. 33 | 2013 Senate Bill No. 21 | ● Mandated reporters of suspected child abuse<br>● Basis to report suspected child abuse or cause a report to be made<br>● Persons encouraged to report suspected child abuse<br>● Reporting procedures<br>● Photographs, medical tests, and X-rays regarding suspected child abuse<br>● Taking a child into protective custody<br>● Education and training |
| 2014 Act No. 34 | 2013 Senate Bill No. 33 | Protection from employment discharge or discrimination for acting in good faith in making a report of suspected child abuse or causing such a report to be made |

| ACT | BILL NUMBER | SUBJECT MATTER OF ENACTED PROVISIONS |
|---|---|---|
| 2014 Act No. 44 | 2013 Senate Bill No. 31 | ● Definitions of bodily injury, founded report, general protective services, indicated report for school employee (repealed), individual residing in the same home as the child (repealed), near fatality, school, and school employee<br>● Persons required to report child abuse<br>● Investigating performance of a county agency<br>● Student in public and private schools (subchapter repealed)<br>● Services for the prevention, investigation, and treatment of child abuse |
| 2014 Act No. 45 | 2013 House Bill No. 434 | ● Definitions of founded report for school employee (repealed), serious physical neglect and subject of the report<br>● Statewide database of protective services<br>● Founded and unfounded reports<br>● Amendment or expunction of information<br>● Prospective child-care personnel<br>● Family day-care home residents<br>● Other persons having contact with children<br>● Cooperation with other agencies<br>● Reports to the Governor and General Assembly<br>● Students in public and private schools (subchapter repealed)<br>● Background checks for employees in schools (subchapter repealed) |
| 2014 Act No. 56 | 2013 House Bill No. 112 | Amendment of the Crimes Code, including, but not limited to, provisions regarding sexual assault by a sports official, volunteer, or employee of a nonprofit association |
| 2014 Act No. 151 | 2013 House Bill No. 90 | Administrative subpoenas |
| 2014 Act No. 153 | 2013 House Bill No. 435 | Amendment of the Child Protective Services Law: foster parents as mandated reporters of suspected child abuse; reporting procedures and the release of information (applicability of the Mental Health Procedures Act); confidentiality of reports; release of information in confidential reports; employees having contact with children; adoptive and foster parents; information to be submitted for clearances; documentation; grounds for denying employment or participation in a program, activity or service; dismissal; provisional employees for limited periods; information relating to certified or registered day-care home residents; volunteers having contact with children; continued employment or participation in a program, activity or service; certification compliance; penalties; study to analyze and make recommendations regarding employment bans |

| ACT | BILL NUMBER | SUBJECT MATTER OF ENACTED PROVISIONS |
|---|---|---|
| 2014 Act No. 176 | 2013 Senate Bill No. 27 | Exchange of information regarding a case of suspected child abuse: certified medical practitioners |

## *Child Protection Legislation Introduced But Not Enacted*

Numerous bills, which were based directly on the work of the Commission or on which the Commission was directly consulted during the legislative process, were introduced during the 2013-14 legislative session of the General Assembly of Pennsylvania but were not enacted into law.

| HOUSE BILL NUMBER | SUBJECT MATTER |
|---|---|
| 19 | Child exploitation awareness education |
| 328 | Notification regarding a child abuse investigation |
| 350 | ● Aggravated assault<br>● Serious bodily injury to a child |
| 378 | New training regarding child abuse for police officers and the minor judiciary |
| 404 | Intimidation or retaliation in child abuse cases |
| 429 | ● Persons permitted to report suspected child abuse<br>● Discrimination against a person filing a report |
| 430 | ● Advanced communication technologies<br>● Persons required to report suspected child abuse<br>● Report by a mandated reporter<br>● Permissive report of suspected child abuse<br>● Contents of a report<br>● Photographs, medical tests, and X-rays of a child subject to a report<br>● Statewide toll-free telephone number<br>● Reports by county agencies and law enforcement<br>● Reports by DPW and referral to county agencies<br>● Reports by DPW and referral to law enforcement<br>● Procedures regarding disposition of complaints for suspected child abuse: joint referrals; ability of law enforcement to receive reports; jurisdictional overlap; referral for services or investigation; records of pending reports; cases involving other states<br>● Investigations<br>● Access to and use of information in the statewide central register<br>● Education and training |
| 432 | Child abuse recognition and reporting training for certain operators of entities caring for children, certain employees caring for children, certain caregivers in family day care homes, and foster parents |

| HOUSE BILL NUMBER | SUBJECT MATTER |
|---|---|
| 433 | ● Notice of the determination that a report is founded, indicated or unfounded<br>● Amendment or expunction of information in the statewide database<br>● Investigation of reports: review of indicated reports; final determination; notice generally; notice to the mandated reporter<br>● Evidence in court proceedings: child victims and witnesses |
| 476 | ● False reports of suspected child abuse against an institution<br>● Contents of the statewide central register<br>● Amendment and expunction of information |
| 673 | Persons required to report suspected child abuse and penalties for failure to report or refer |
| 725 | Training for child protective services workers regarding the recognition of drug and alcohol abuse and addiction, warning signs of drug and alcohol problems, and methods of referral for assessment and treatment of addiction |
| 930 | Amendment of the Professional Educator Discipline Act: definitions; certification requirements; Professional Standards and Practices Commission; membership and qualifications; powers and duties; organization and meetings of the Commission; expenses; Commission staff, complaints and department investigations, mandatory reporting, discipline for criminal offenses; imposition of discipline on additional grounds; imposition of discipline on founded and indicated reports; reciprocal discipline; unavailability of certain defense and mitigating factor; confidentiality; duties of school entities; department action after investigation; hearing; proposed report by hearing officer; appeal; reinstatement; unauthorized release of information; immunity from liability; Commission proceedings and procedures; subpoenas; disposition of fees and fines collected |
| 1045 | False reports of child abuse |

| SENATE BILL NUMBER | SUBJECT MATTER |
|---|---|
| 20 | ● Amendment of definitions, including, but not limited to, bodily injury, founded report, indicated report, serious physical neglect, and child abuse:<br>● Exclusions from child abuse |
| 22 | Penalties for failure to report or refer an incident of suspected child abuse |
| 25 | ● Electronic reporting regarding suspected child abuse<br>● Reporting the suspicion that a child died as a result of child abuse to the appropriate coroner or medical examiner<br>● Investigations<br>● Report reception<br>● Disposition of reports of suspected child abuse<br>● Cooperation with county agencies<br>● Release of information in confidential reports |
| 26 | Statewide three-digit toll-free telephone number and monitoring by DPW |
| 32 | ● School district's duty to notify the county when a child enrolls in a home school program or cyber charter school, is truant, or fails to register for school after attaining compulsory school age<br>● Safety and risk assessments |
| 46 | Employment at school entities and their independent contractors with direct contact with children |
| 352 | Newborns who receive a diagnosis of fetal alcohol syndrome or test positive for an illegal controlled substance |
| 353 | Newborns who test positive for an illegal controlled substance |
| 498 | Training for child protective services workers regarding drug and alcohol abuse and addiction, warning signs of drug and alcohol problems, and methods of referral for assessment and treatment of addiction |
| 517 | Home education program affidavit requirements |
| 518 | Endangering the welfare of a child by leaving the child alone with a registered sex offender |
| 1233 | Endangering the welfare of a child and conviction of DUI/DWI in which the child is a passenger in the vehicle |
| 1272 | Release of information by an investigating county agency |