



Society for Child and Family Policy and Practice

# Child and Family Policy and Practice Review

Division 37 of the American Psychological Association

Volume 3, Number 2

Winter 2007

## Practice, Research, and Policy Agendas for Healthy Families America: A Program Designed to Prevent Child Maltreatment

**Editors:** Anne McDonald Culp, Ph.D., University of Central Florida, Orlando  
& Cynthia J. Schellenbach, Ph.D., Oakland University, Rochester

**Editor-in-Chief:** Patricia Y. Hashima, Ph.D., Clemson University

**Editorial Assistant:** Savannah L. Camp, Clemson University

### Introduction

**Anne McDonald Culp, Ph.D.**  
University of Central Florida, Orlando  
&

**Cynthia J. Schellenbach, Ph.D.**  
Oakland University, Rochester

The prevention of child maltreatment is a 2010 public health goal for the United States (U.S. Department of Health and Human Services, 2000). In addition, child maltreatment has been declared a "public health emergency" in the US for many of the past 15 years (U.S. Advisory Board on Child Abuse and Neglect, 1990). Yet the problem was identified fifty years ago, when Dr. C. Henry Kempe, a pediatrician, noticed the link between childhood injury and parenting practices. He and Dr. Brandt Steele started a Child Protection Team at the University of Colorado Medical Hospital in 1958; published "The Battered Child Syndrome" in 1965; and opened the National Center for the Prevention and Treatment of Child Abuse and Neglect in Denver in 1972 (International Society for Prevention of Child Abuse and Neglect, 2007). Dr. Kempe and many of his team relentlessly worked on identifying, treating and, ultimately, preventing child maltreatment. Shortly later, in 1978, Division 37 was founded. One of the Division's special interest areas has always been the prevention of child maltreatment.

At the same time that Division 37 was formed and Dr. Kempe founded the treatment center in Denver, the National Center for the Prevention of Child Abuse (NCPCA) was founded in Chicago, now called Prevent Child Abuse America

### Inside This Issue

#### Introduction

Anne McDonald Culp Ph.D., &  
Cynthia J. Schellenbach, Ph.D..... Page 1

#### Potential Lessons from Public Health And Health Promotion for the Prevention of Child Abuse

Joanne B. Martin, Ph.D. ....Page 3

#### Healthy Families America: The Link Between Infrastructure and Policy

Lori Friedman, M.P.H. &  
Bridget Gavaghan..... Page 5

#### The Role of Community in Facilitating Service Utilization

Deborah Daro, Ph.D.....Page 8

#### Across the Great Divide: Healthy Families America's Research to Practice Collaborative

Joseph Galano, Ph.D., &  
Cynthia Schellenbach Ph.D.....Page 11

#### HFA Research Update

Anne McDonald Culp, Ph.D., &  
Cynthia Schellenbach, Ph.D.....Page 15

#### Discourse of HFA: Practice, Research, and Policy Action Steps

John K. Holton, Ph.D.....Page 19

## ◆ Child and Family Policy and Practice Review

---

(PCAA). The goal of NCPAA thirty years ago and PCAA today, is to build awareness of child maltreatment, provide education, and inspire hope to everyone involved in the effort to prevent the abuse and neglect of our nation's children (Prevent Child Abuse America, 2007).

From the 1970's until now, many of us continue in our deeply committed efforts supporting new parents, identifying parents at risk for child abuse, and helping prevent any injuries to children by promoting safe and nurturing homes, with the goal of preventing all forms of child abuse.

Many professionals believed from the early 1970's that going to the parents' homes, rather than relying on the parents to come to classes at community centers or agencies would be an effective method of service delivery to help prevent child abuse. The ideas for many of the grass-roots programs were that the highly trained staff would support and strengthen parents who had not yet abused their children (mothers in their first pregnancy or with children who were infants or very young) by linking them to health and community services, teach and model appropriate parenting practices, and provide training regarding normal developmental stages of their children. In fact, enough data had been collected that by 1990, the U.S. Advisory Board on Child Abuse and Neglect (1991) recommended that home visitation would be one of the techniques used in reaching their goal of helping parents not abuse and neglect their children (Hahn, Mercy, Bilukha, & Briss, 2005; Russell, Brittner, & Woolard, 2007).

In 1992, Prevent Child Abuse America (2006) released a home visitation model known as Healthy Families America for model description based on Hawaii's Healthy Start model. During the past 15 years, much has been learned about HFA (this Review gives a synopsis) and about other home visitation models (i.e. Healthy Start; Duggan et al, 1999; Nurse Family Partnership; Olds et al, 1995).

This Review is a summary of HFA's current and best practices, research, and program policy goals. The articles were selected and excerpted from a special issue of the *Journal of Prevention & Intervention in the Community* (2007) edited by Joseph Galano.

This Review has six articles describing the major topics of HFA's practice, research and policy agendas. First, Dr. Joanne Martin summarizes the lessons learned from other national public health emergencies such as the tobacco control and seat belt injury prevention programs, and applies those lessons to the national emergency of child maltreatment by specifying the lessons that HFA has taken notice.

Lori Friedman and Bridget Gavaghan describe the HFA state system and the support the states receive from the national PCA office. They also ask us for our support in the policy arena with supporting congressional bills regarding child maltreatment.

Dr. Joseph Galano and Dr. Cynthia Schellenbach describe the importance of research and practice partnerships within communities. They give examples of successful HFA partnerships, the outcomes of those partnerships, and future plans to

sustain the partnerships for HFA sites.

Dr. Deborah Daro describes data from multiple HFA sites and delineates the role of community factors in facilitating service utilization, namely the number of home visits completed and by what set of parents.

We, Anne Culp and Cynthia Schellenbach, review selected states' research on the outcome effects of HFA, utilizing either randomized trials or quasi-experimental designs.

Lastly, Dr. John Holton outlines the practice, research and policy steps that must be taken immediately – steps taken by HFA and all child advocates who believe in reducing the levels of child maltreatment.

Interestingly, in 2006, the Division of Violence Prevention within the National Center for Injury Prevention and Control of the Centers for Disease Control (CDC, 2006) actively sought out and continues to work with partnerships to fulfill their goal of preventing childhood maltreatment. They want to empower parents and strengthen parenting practices by focusing a national effort on safe, stable, and nurturing relationships. With HFA as a home visitation model that promotes safe and nurturing homes, PCA is currently an official partner with the CDC in reaching the ultimate goal of reducing parents maltreating their children, which again, has been designated for many years, as a national public health emergency.

This particular Review has been written with the idea that the reader is interested in active advocacy efforts of children and families. The Review is designed to be used in any community, state or federal effort to get more money in helping combat child maltreatment. If you take this Review and couple it with the newly released Division 37 Advocacy Manual (American Psychological Association, Division 37, Task Force on Child and Family Advocacy Training, 2006), we will feel that you have the tools to move forward on behalf of children, helping the US communities take notice and action in support of early prevention intervention programming.

### References

American Psychological Association, Division 37, Task Force on Child and Family Advocacy Training (2006). *APA Division 37's guide to advocacy: Legislative support for children, youth, and families*. Washington, DC: Author. Retrieved August 10, 2007 from <http://www.apa.org/divisions/div37/resources.html>

Center for Disease Control (2006). *Child Maltreatment Prevention Partners' Meeting Follow-Up Report*. National Center for Injury Prevention and Control, Center for Disease Control, Atlanta, GA.

Duggan, A.K., McFarlane, E.C., Windham, A.M., Rohde, Salkever, D.S., Fuddy, L., Rosenbery, L.A., Buchbinder, S.B., Sia, C.J. (1999). Evaluation of Hawaii's Healthy Start Program. *The Future of Children*, 9, 66-90.

Hahn, R. Mercy, J., Bilukha, O., & Briss, P. (2005). Assessing home visitation programs to prevent child abuse: Taking silver and bronze along with the gold. *Child Abuse & Neglect*, 29, 215-218.

Healthy Family America (2006). The HFA model. Retrieved September 4, 2007 from [http://www.healthyfamiliesamerica.org/about\\_us/index.shtml](http://www.healthyfamiliesamerica.org/about_us/index.shtml)

International Society for Prevention of Child Abuse and Neglect (2007). *Remembering Henry Kempe*. Retrieved August 10, 2007 from [http://ispcan.org/anniversary/letter\\_Richard\\_Krugman.htm](http://ispcan.org/anniversary/letter_Richard_Krugman.htm)

National Center on Child Abuse and Neglect (1996). *The third national incidence study of child abuse and neglect*. Washington, DC: U.S. Government Printing Office.

Olds, D., Henderson, C. R., Kitzman, H. & Cole, R. (1995). Effects of prenatal and infancy home visitation on the surveillance of child maltreatment. *Pediatrics*, 95, 365-371.

Prevent Child Abuse America (2007). Retrieved August 10, 2007 from [http://www.preventchildabuse.org/about\\_us/index.shtml](http://www.preventchildabuse.org/about_us/index.shtml)

Russell, B. S., Brittner, P. A., & Woolard, J. L. (2007). The promise of primary prevention home visitation programs: A review of potential outcomes. *Journal of Prevention & Intervention in the Community*, 34, 129-148.

U.S. Advisory Board on Child Abuse and Neglect (1990). *Child abuse and neglect: Critical first steps in response to a national emergency*. Washington, DC: U.S. Government Printing Office.

U.S. Advisory Board on Child Abuse and Neglect (1991). *Creating caring communities: Blueprint for an effective federal policy on child abuse and neglect* (Rep. No. 9-1991). Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services. (2000). *Healthy People 2010* (2<sup>nd</sup> ed., Vols. 1-2). Washington, DC: U.S. Government Printing Office.

## Potential Lessons from Public Health And Health Promotion for the Prevention of Child Abuse

Joanne B. Martin, Dr.P.H., R.N., F.A.A.N  
Indiana University

While research evidence is accumulating gradually in their own field, practitioners can look to obvious successes in other fields for guidance and inspiration (Lancaster, 1992). Two of the great successes of the last third of the 20<sup>th</sup> century in North America--control of the tobacco epidemic and reduction in auto crashes--were declared by Centers for Disease Control and Prevention (CDC) to be among the ten greatest public health achievements of the twentieth century (CDC, 1999).

Smoking, dangerous driving and child abuse all involve complex behavioral patterns that occur outside the purview of health professionals and yield low rates of success with individual level intervention. In addition, there is strong public support for protecting children, despite the usual reluctance of policy makers to intrude on adult behaviors associated with smoking, driving and parenting. Therefore, what lessons from tobacco control and injury prevention might be applied to the field of child abuse prevention?

### Lessons for Child Abuse Prevention

In a nutshell, the successes of tobacco control and injury control demonstrate that effective campaigns can increase public awareness of the problem and generate support for enacting and enforcing laws. In turn, this can significantly change individual behaviors and reduce adverse outcomes. The following lessons with implications for prevention of child abuse and neglect are offered.

*Lesson 1: Investigate Varied Logic Models or Conceptual Frameworks to Identify New Opportunities for Effective Intervention.*

Haddon's Matrix, an epidemiological model of host, agent, and environment, in relation to the time sequence, was a conceptual breakthrough for preventing motor vehicle fatalities. A paradigm shift in primary prevention of child abuse came in 1991 when the U.S. Advisory Board on Child Abuse and Neglect recommended a universal system of voluntary newborn home visitation to avoid stigma by reaching mainstream families, while providing more intensive services for at-risk families (Krugman, 1993). Responding to the Advisory Board's recommendations, Prevent Child Abuse America officially launched a home visiting model in 1992 and called it Healthy Families America (HFA); other home visiting programs proliferated, as well (Schorr, 1997).

After careful review of evidence from 21 studies, the Task Force on Community Preventive Services concluded that home visitation had prevented child maltreatment among high risk

## ◆ Child and Family Policy and Practice Review

---

populations by 39 % (Bilukha, et al., 2005). However, important questions about timing, focus and intensity of home visiting remain (Gomby, Culross & Behrman, 1999). If home visiting is part of a comprehensive approach to preventing child maltreatment, what else could or should be included, and how should other components be coordinated with home visitation?

### ***Lesson 2: Use a Multi-disciplinary, Multi-sector Approach.***

Community interventions, media advocacy, public information campaigns and legislation combined to reduce tobacco use and improve motor vehicle safety. Ramey and Ramey (1993) suggest that achieving robust and lasting effects in preventing child abuse requires a multidimensional approach, addressing multiple domains. Home visiting programs should be an integral part of a comprehensive family support program and coordinated with community, statewide, and national program and policy components.

Results from a meta-analysis of evaluation outcomes across 56 family support programs, aimed at preventing child abuse, support this view. Most programs showed evidence of effectiveness in preventing child maltreatment and promoting family wellness, with an overall effect size of .41. (MacLeod & Nelson, 2000). In general, programs for at-risk families were more effective for families with infants, compared to families with older children. Improvements tended to last over time and even increase, unless families already had experienced child maltreatment.

Overall, multi-component programs were more effective than home visiting only programs. Moreover, they were equally effective serving low-income families or a mix of moderate and low-income families; whereas, home visiting programs were effective for a mix of moderate and low-income families.

If multi-component programs are more effective than home visiting only programs, how should policy-makers and community leaders proceed? Evidence suggests they should not expect home visiting programs to do everything. In fact, home visiting programs were less effective when too many components were added to the tasks of the home visitor (MacLeod & Nelson, 2000).

### ***Lesson 3: Normalize Desired Behaviors and Denormalize Undesirable Behaviors.***

Laws in 50 states demonstrate society's expectation that nonsmokers are to be protected from secondhand smoke, that children are to be transported safely, and that people should not be exposed to the risk of drunk drivers on their roads (Zwerling & Jones, 1999). When laws that mandate behavior are coupled with efforts to facilitate behavioral change, it creates a powerful impetus to establish new social norms. For example, laws requiring professionals and others to report suspected child maltreatment and the data that flowed from compliance with those laws set new societal expectations. Assuring confidentiality of the reporter and setting the threshold at suspected maltreatment facilitated reporting behaviors.

Laws requiring all parents to participate in home visiting,

however, would be viewed as inappropriate. Fortunately, health-related social norms can change without legal mandates. Recall examples of adopting family planning methods in the early decades of the last century, immunizing against polio in the 50's, changing childbirth practices in the 70's, and positioning infants on their back to sleep in the 90's. Whether consumer-driven or instigated by professionals, these examples of widespread change occurred because caring for children is a core value. Families overcame inertia, fear, and inconvenience after becoming convinced that the new approach would benefit their child.

Supporting parents of newborns could become a social norm. Offering support to all parents sends a message that parents deserve support because they are parents, not because they are problems. When offering and accepting support is normalized, at-risk parents will be more inclined to participate in home visiting and/or other programs.

### ***Lesson 4: Balance Efficacy, Feasibility, and Cultural Appropriateness***

Balancing efficacy and feasibility starts with requiring standards to be evidence-based, and not imposing standards until sufficient evidence is available. Variation occurred when states and local jurisdictions purposefully set their own motor vehicle safety standards. Feasibility could be determined in different settings and realistic expectations set before requiring every state to adopt new standards or laws.

HFA and other national home visiting programs admirably seek to reach more at-risk families in diverse communities, without jeopardizing quality or diluting effectiveness. However, requiring adherence to excessively precise process measures may prove to be a misguided attempt to control quality at the expense of needed adaptation to local culture and circumstances. Requiring home visiting programs to demonstrate adherence to each and every standard of practice could unnecessarily restrain professional discretion, innovation and adaptation and result in an overly regimented, stultified service strategy that can no longer respond to family needs.

When home visiting credentialing standards were revised, HFA applied this lesson. Recognizing that evidence to support an association between weekly home visits and desired outcomes is weak and few families are able and willing to participate at that level of intensity, HFA recently changed the standard. Now the revised credentialing standards require home visitors to *offer* weekly home visits, instead of mandating weekly home visits for the first six months after birth. If this change allows families to participate in home visiting longer, it might result in more positive outcomes. Home visiting programs strive to develop evidence-based standards. The problem is that most evidence is not based in practice (Green, 2006). As more evidence of effectiveness accumulates, the field of home visitation can look forward to being held accountable for meeting standards that reflect practice-based evidence.

## References

- Bilukha, O., Hahn, R., Crosby, A., Fullilove, M., Liberman, A., Moscicki, E., Snyder, S., Tuma, F., Corso, P., Schofield, A., Briss, P., & Task Force on Community Preventive Services. (2005). The effectiveness of early childhood home visitation in preventing violence: A systematic review. *American Journal of Preventive Medicine*, 28 (2S1), 11-39.
- Centers for Disease Control and Prevention (1999). Ten great public health achievements -- United States, 1900-1999. *Morbidity and Mortality Weekly Report*, 48, 241-243.
- Gomby, D., Culross, P., & Behrman, R. (1999). Home visiting: Recent program evaluations --- analysis and recommendations. *The Future of Children*, 9, 4-24.
- Green, L. (2006). Public health asks of systems science: To advance our evidence-based practice, can you help us get more practice-based evidence? *American Journal of Public Health*, 96, 406-409.
- Krugman, R. (1993). Universal home visiting: Recommendation from the U.S. Advisory Board on Child Abuse and Neglect. *The Future of Children*, 3, 184-191.
- Lancaster, B. (1992). Closing the gap between research and practice. *Health Education Quarterly*, 19, 408-411.
- MacLeod, J., & Nelson, G. (2000). Programs for the promotion of family wellness and the prevention of child maltreatment: A meta-analytic review. *Child Abuse & Neglect*, 24, 1127-1149.
- Ramey, C., & Ramey, S. (1993). Home visiting programs and the health and development of young children. *The Future of Children*, 3, 129-139.
- Schorr, L. (1997). *Common Purpose: Strengthening families and neighborhoods to rebuild America*. NY: Bantam Doubleday Dell Publishing Group, Inc.
- Zwerling, C., & Jones, M. (1999). Evaluation of the effectiveness of low blood alcohol concentration laws for younger drivers. *American Journal of Preventive Medicine*, 16 (suppl 1), 76-80.



**Joanne Martin Dr.P.H., R.N., F.A.A.N.** is Assistant Professor at Indiana University School of Nursing. Dr. Martin plays a leadership role in many different capacities at the state and national level. She is Director of Healthy Families Indiana Training and Technical Assistance Project and Director of the Institute for Action Research in Community Health. In 2005, she received a 2-year Harris Fellowship from ZERO TO THREE.

Currently, she is a co-principal investigator on a CDC funded research project to study the impact of a computerized parenting intervention within home visitation.

### Healthy Families America: The Link Between Infrastructure and Policy

**Lori Friedman, M.P.H.**  
Prevent Child Abuse America  
&  
**Bridget Gavaghan**  
Prevent Child Abuse America

It is an exciting time for the home visiting field – there has been a great deal of activity and momentum in our nation's capitol. Education Begins at Home (EBAH), proposed federal legislation that would provide funding to states to expand or establish quality home visiting programs, has received broad bipartisan support and opportunities to pass the bill are being seriously considered. Nancy Pelosi, Speaker of the House, hosted the National Summit on America's Children in May, 2007 where home visiting was identified time and again as an effective approach in helping families achieve successful outcomes. In September, 2006, the Education Reform Subcommittee of the House Education & Workforce Committee held a hearing titled Perspectives on Early Childhood Home Visitation Programs that was focused solely on home visitation; a first for the field.

This is when the work that has gone into developing the infrastructure, known within the Healthy Families America (HFA) network as state systems, is validated. In an era of fiscal constraints and increased accountability for social service programs, having a centralized and efficient infrastructure is critical. A well-functioning infrastructure helps a state reduce duplication of services, creates economies of scale, coordinates

## ◆ Child and Family Policy and Practice Review

---

resources, supports high-quality site development and promotes the self-sufficiency and growth of community-based programs. This article briefly describes the history of HFA state systems and the ways in which these systems have contributed to positive outcomes, particularly in the policy arena. Examples of how state level collaborations (some HFA-only and some comprised of representatives from multiple home visiting programs) have contributed to and are preparing for the opportunities on the horizon are provided.

### The Evolution of HFA State Systems

In 1992, promising results of a home visiting program called Hawaii Healthy Start prompted a strategic decision by Prevent Child Abuse America (PCA America) to replicate this program on the U.S. mainland. Implementation began with 25 sites scattered throughout the country. Increased funding from sources such as Temporary Assistance to Needy Families (TANF) and tobacco settlement funds in the mid-1990s enabled many states to implement multiple programs concurrently. By 1995, it became clear that skyrocketing program growth would quickly outstrip the capacity of the national office to provide training and technical assistance. States were encouraged to create a permanent infrastructure to support program growth. PCA America began assisting states in the creation of planning task forces that engaged state level administrators and policy makers in the growth of the Healthy Families America (HFA) program.

Over time, it was determined that 10 components tend to drive the organization of a state's HFA or home visiting infrastructure. These components ranged from governance and planning to training and technical assistance to policy and communication. This infrastructure, known as a state system, has evolved according to a state's resources, needs and political environment. Some have a system of coordination primarily around one or two key functions such as training or quality assurance. Others are comprehensive and entirely centralized to the point that funding streams are blended and a statewide coordinator oversees all systems-related activities. For more details on the history and benefits of state systems, please refer to an upcoming article

### Utilizing State Systems to Impact Public Policy

There are a variety of benefits to having this type of system in place, particularly as it relates to the policy arena and ensuring the availability of resources to support families. Due to the efforts of state level collaboration around issues related to children and families, states have been able to:

- Minimize budget cuts by engaging key decision-makers, informing them about the value of home visiting services and inviting them to see firsthand the benefits of family support programs (MA and VA).
- Expand funding to ensure that HFA was available to families in 150 communities throughout one state (AZ).
- Create an initiative to educate and encourage Healthy Families

program staff and participating families about the political process and the impact their votes can have in addressing community needs (IN).

- Secure HFA and other home visiting representation on state level committees, task forces, and review panels where prevention is discussed. As a result of this work, State Leaders have participated in legislative hearings and provided testimony on the value of home visitation (multiple states).

### State Level Collaborative Opportunities with EBAH

As HFA state systems mature, a natural progression is to look beyond HFA to build statewide home visitation partnerships around areas such as public policy and coordinated services. Georgia, Kansas, Michigan, and New York are just a few of the states that are beginning to leverage EBAH to foster and strengthen collaborations and to elevate the issue of home visitation with state policymakers. With EBAH as the rallying point, state-level collaborations that include representatives from an array of home visitation programs and other stakeholders in the early childhood and child abuse prevention fields are working to:

- Improve understanding of home visitation programs;
- Create cross-program cooperation and learning;
- Create a common message that emphasizes home visitation as a research-based and cost-effective way to ensure children are healthy and ready to learn;
- Enhance quality of home visitation services in their state;
- Improve understanding of home visitation as an important part of the continuum of services to children and families; and
- Advocate for and help others advocate for state and federal policies that support early childhood home visitation.

This work in anticipation of the eventual passage of EBAH is positioning the collaborators to access the state formula grants when it is enacted, as well as providing guidance to state officials to determine how EBAH funds could best be used to meet the needs of the state.

In addition to providing a sustainable funding source for home visitation services, EBAH would provide the mechanism for each state to build a comprehensive early childhood home visitation system. Rather than funding a particular home visitation model, the bill requires states to assess the needs of their communities, identify gaps in services, and determine what home visitation program or suite of programs would best address those needs. West Virginia and New Jersey are examples of states that are not waiting for EBAH to pass to go through this planning process, and as such are well positioned to make the case for additional funding, either through EBAH or through other sources.

### State Example – West Virginia's Partners in Community Outreach

The work being done in West Virginia is an exciting ex-

ample of how federal legislation coupled with strong partnerships is building momentum for the home visitation field. Partners in Community Outreach is a coalition of “research-based In-Home Family Educations programs” operating in the state that includes Healthy Families America, Maternal Infant Health Outreach Workers, and Parents as Teachers. As a result of the coalition’s work, the West Virginia Legislature passed a resolution in 2005 to study the need for expansion and funding of home visitation programs. Partners in Community Outreach prepared findings and recommendations to support the Legislature’s work on this issue. Recommendations include the establishment of a statewide system of In-Home Family education to provide high quality home visiting services, and a state appropriation to expand existing programs and developing programs in unserved areas. As a result of the study’s findings, the Governor put an additional \$250,000 in his FY 2008 budget for In-Home Family Education, which was approved. Partners in Community Outreach is now developing core competencies in eight focus areas for a career ladder for home visitors to develop their knowledge and skills.

#### State Example – New Jersey’s Comprehensive Home Visiting System

Like West Virginia, New Jersey’s planning for a comprehensive state system of home visitation has demonstrated the value of home visitation and need for additional resources while positioning the state for quick implementation of EBAH once the legislation is enacted. In 2004, the Joint Working Group of the Prevention Subcommittee of the NJ Task Force on Child Abuse and Neglect and the Governor’s Juvenile Justice and Delinquency Prevention Committee prepared a white paper outlining the benefits of home visitation. The white paper provides a research overview, recommends criteria a program must meet to receive funding, and identifies home visitation programs in New Jersey that currently meet those standards. In 2006, the Joint Working Group released a model for a comprehensive home visiting system in which there would be a central point of intake, a uniform system for data collection and analysis, coordinated referrals, cross-training and linkages to other services.

#### Planning for the Future

Early childhood home visitation programs are receiving a great deal of attention from federal elected officials and national policy experts, due in large part to the Education Begins at Home Act. States that have gone through the process of developing the infrastructure for an HFA state system are well positioned to leverage EBAH to form collaborative public policy efforts at the state and federal levels; coordinate services with other home visitation programs; and build statewide partnerships to strengthen and expand home visitation services.

#### References

- Friedman, L., & Schreiber, L. (2007). Healthy Families America State Systems Development: An Emerging Practice to Ensure Program Growth and Sustainability. *Journal of Prevention & Intervention in the Community*, 34, 67-86.
- Joint Workgroup of The New Jersey Task Force on Child Abuse and Neglect and The Governor’s Juvenile Justice and Delinquency Prevention Committee (November 2004). *Home Visitation Programs in New Jersey: A Promising Approach for Preventing Child Abuse and Neglect*. Retrieved July, 17 2007 from: <http://www.preventchildabuse.nj.org/documents/referenceroom/White%20Paper%20on%20Home%20Visiting.pdf>
- New Jersey Task Force on Child Abuse and Neglect (May 2006). *Comprehensive Home Visiting System*. Retrieved July 17, 2007 from: [http://www.preventchildabuse.nj.org/documents/referenceroom/Home%20Visiting%20Flow%20Chart8-21%20\(4\).jpg](http://www.preventchildabuse.nj.org/documents/referenceroom/Home%20Visiting%20Flow%20Chart8-21%20(4).jpg).
- Partners in Community Outreach (December 2005). *In Home Family Education: Supporting Healthy Child Development in the First Years of Life*. Retrieved July 17, 2007: [http://www.teamwv.org/Media/pageone\\_stuff/report.pdf](http://www.teamwv.org/Media/pageone_stuff/report.pdf).
- Pelosi, N. (2007). *National Summit on America’s Children: Legislative Priorities Addressing the Needs of Young Children in the 110th Congress*. Retrieved July 17, 2007 from <http://speaker.gov/issues?id=0032>
- Prevent Child Abuse America (2001). *Framework for Healthy Families America state systems development*. Chicago: Prevent Child Abuse America.
- U.S. House of Representatives (2006). *Perspectives on Early Childhood Home Visitation Programs*. Retrieved July 17, 2007 from [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109\\_house\\_hearings&docid=f:30056.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_house_hearings&docid=f:30056.pdf)

#### Authors’ Note

Correspondence concerning this article should be addressed to Lori Friedman, Senior Prevention Analyst or Bridget Gavigan, Director of Public Policy, Prevent Child Abuse America, 500 North Michigan Avenue, Suite 200, Chicago, Illinois 60611. E-mail: [lfriedman@preventchildabuse.org](mailto:lfriedman@preventchildabuse.org) or [bgavigan@preventchildabuse.org](mailto:bgavigan@preventchildabuse.org). Additional information and resources pertaining to Healthy Families America can be found on the website located at [www.healthyfamiliesamerica.org](http://www.healthyfamiliesamerica.org).



**Lori Friedman, M.P.H.**, is the Senior Prevention Analyst for Prevent Child Abuse America. She is currently working on a CDC-funded project to enhance the ability of their chapter network members to use evidence in decision-making and to build capacity to conduct evaluations of their work.



**Bridget Gavaghan** is the Director of Public Policy for Prevent Child Abuse America. Bridget provides public policy and advocacy leadership to Prevent Child Abuse America, including mobilizing support for the organization's policy priorities, nurturing collaborations with partner organizations, and increasing the advocacy capacity of the Prevent Child Abuse and Healthy Families America networks.

2001), early child behavior problems (Linares et al., 2001), and later deviance (Simons et al., 2002).

In addition to influencing parent-child interactions, community values and local service resources also may contribute to the interest and willingness of parents to seek out formal and informal supports. We explored this relationship in the context of a multi-component research effort that examined the decision-making process new parents undergo in considering voluntary prevention services (Daro, McCurdy & Nelson, 2005). Guided by an integrated theory of parent participation (McCurdy & Daro, 2001), this research posited that a number of factors at both the individual, provider, agency and community levels contribute to a parent's decision to consider, access, and remain engaged in voluntary support programs. Further, this decision making process reflects a multitude of sequential choices on the part of participants regarding the relative benefits and costs associated with initial and ongoing service utilization. This paper focuses on the unique role community factors play in influencing these decisions as demonstrated by a sample of Healthy Families America (HFA) participants.

### Methods

The present study focuses on the service retention decisions of a sample of new parents offered intensive home visitation services by one of nine HFA program sites. In keeping with the study's overarching theoretical assumptions, our analytic model examined the relative importance of individual, programmatic and community factors in explaining a participant's number of home visits. A complete description of the study's research design, measures and analytic methods has been reported elsewhere (Daro, McCurdy & Nelson, 2005; Daro, et al, 2007) and, therefore, are only briefly summarized here.

Participant characteristics entered in the model included race/ethnicity; the number of socio-economic risk factors; other risk and protective factors such as infant health issues, general parenting concerns, and the size and support for the program within the participant's personal network; and the participant's belief that the program had altered their attitudes and skills.

The analytic model also included two measures of the participant's relationship with her home visitor – an eight item scale that summarized the extent to which the participant felt the home visitor respected her family's beliefs and culture and encouraged the utilization of community services and a standardized measure (i.e., the Helping Relationship Inventory) that addressed both the structural components of the service interaction and interpersonal elements of service delivery (Poulin & Young, 1997; Young & Poulin, 1998).

A participant's "community" was defined as the U.S. Census block group in which she lived. Although this definition of neighborhood is statistical and may not correspond to a participant's notion of community, this unit of analysis is commonly used in examining community impacts in part because it ensures uniformity of definition and reliable access to a wide

## The Role of Community in Facilitating Service Utilization

**Deborah Daro, Ph.D.**  
Chapin Hall Center for Children,  
University of Chicago <sup>1</sup>

Community context and neighborhood resources have long been considered key factors in determining a child's relative risk for maltreatment. The beliefs and attitudes of neighbors and family members as well as the availability and quality of local health care and family support services can serve as either powerful protective factors or potent risk factors, particularly for families with limited financial resources or child care skills. In explaining the absence of substantial positive impacts from interventions that seek to change individual attitudes or behaviors, several analysts point to the inevitable limitations of any strategy that leaves families or youth living in chaotic, often dangerous, environments and dealing with poorly defined and implemented local service systems. It is not surprising, therefore, that efforts to enhance community capacity or "to alter the context in which parents rear their children" have emerged as promising strategies for improving outcomes with respect child maltreatment (Daro, 2000), juvenile delinquency (Brody et al.,

range of descriptive variables (Brooks-Gunn, Duncan, & Aber, 1997; Coulton, Korbin, Su, & Chow, 1995). In defining the level of social organization for each block group, we developed two measures. First, we summarized seven descriptive characteristics available through the U.S. Census such as the proportion of residents living in poverty, the proportion of households headed by single woman, and the proportion of rental housing into a construct we identified as “community distress”. Second, drawing on the work of Coulton, Korbin and their colleagues (1995), we also computed the dependency ratio for each census block group (e.g., the number of individuals under age 18 or over age 65 divided by the number of individuals between ages 19 and 64).

The study’s participant sample was drawn from a larger pool of new parents recruited for a more general examination of participant enrollment and retention (Daro, McCurdy & Nelson, 2005). Subjects in this study were limited to those who had received at least one home visit and who represented a unique block group. The sample was limited to those who had received a home visits in keeping with our theoretical assumption that community factors would have greatest influence on retention as opposed to initial enrollment decisions. In those cases in which a given block group had multiple study participants, the participant who enrolled first in the study was retained for this analysis. This decision was made to insure that the variable values across individual subjects were statistically independent. These limitations produced a participant sample of 182 new parents.

Standard OLS multiple regression techniques were used to examine the unique contribution of community characteristics on the number of home visits a participant received over a 12-month period. The independent variables were entered in four blocks – demographic characteristics, presenting problems and strengths, program experiences and community characteristics. Community characteristics were entered last to assess the portion of additional variance explained by community attributes after accounting for all other factors in the model.

Substantial variation existed in the characteristics of the sample participants and communities in which they lived as reported elsewhere (Daro, McCurdy & Nelson, 2005; Daro, et al, in press). Although greater variation was observed in the racial composition and socio-economic status of the participants across the nine program sites than within each site, many participants resided in contiguous block groups that differed in terms of distress levels and concentration of children. This variation provided a rich and robust test of our assumptions regarding the impacts of community characteristics on families with different socio-demographic characteristics, presenting problems, and service experiences.

### Results

The final model indicates that all variables, taken together, explained 21% ( $p < .001$ ) of the total variance in the number of home visits provided this HFA participant sample. As we anticipated, the community characteristics block increased ex-

plained variance by 8% ( $p < .001$ ) over the variance accounted for by the participants’ demographic characteristics, initial risk and protective factors, and program experiences.

In the final model, race was the only demographic variable to achieve a significant ( $p < .05$ ) effect. African American participants received fewer home visits than non-African American participants, a relationship that remained constant even when we independently compared the performance of African American participants to the two other major ethnic groups (e.g., Hispanics and Whites) represented in the sample.

Two presenting concerns significantly influenced the number of visits. Participants giving birth to infants presenting at least one indicator of risk (e.g., low birth weight, placed in a special nursery following birth, etc.) received a greater number of home visits than participants giving birth to infants with no presenting risk factors. Participants who reported a greater number of parenting and personal concerns at three months following enrollment received a greater number of home visits than participants with fewer concerns. In addition, there was a trend ( $p < .07$ ) for participants with larger informal support networks to receive fewer home visits than those with smaller networks.

Of the program experiences posited to impact participation, only the relationship with the home visitor achieved significance ( $p < .01$ ). Participants assessing the relationship with their home visitor as more positive received more visits than those with less positive relationships. A trend did emerge such that participants received more visits if their informal network support system were perceived as supportive of HFA services ( $p < .11$ ).

In terms of our community variables, only the measure of community distress had a significant impact on the number of home visits participants received. Contrary to our initial assumption, residents in communities with the greatest level of distress received more, not fewer home visits.

### Discussion

Despite its universal outreach, a certain efficiency appears to exist among HFA programs in how home visiting services are distributed, with the greatest number of home visits being accepted by new parents with the highest-risk infants, the fewest social supports, and who live in the most distressed communities. Our analysis suggests that key factors in achieving this efficiency may be both the targeting of high risk communities as well as the nature of the provider-participant relationship. Specifically, HFA’s universal outreach to new parents living in neighborhoods with moderate to high levels of distress may bring a welcomed service opportunity to families who struggle with finding the few available resources that may exist in their local community. By introducing the option of ongoing assistance, the HFA approach does not require new parents to self-identify as being in need of support. This type of normalization of the helping process has been advocated by others as an essential component for enhancing the success of prevention and early intervention efforts (Melton & Barry, 1994).

## ◆ Child and Family Policy and Practice Review

---

Successfully enrolling residents living in high risk communities may hinge on the home visitor's ability to engage families in the case planning process and the family's ability to respond to these types of incentives. In our model, those participants who rated their relationship with their worker as involving more active participation in the case planning process received more home visits. This strategy of actively engaging a participant in defining her needs and determining her case plan may increase the likelihood she will keep scheduled appointments. Participants who have a more passive relationship with their home visitor may remain on a program's caseload, but may not be highly motivated to help insure that an actual home visits occurs.

A common assumption in assessing community-based services is that such services are offered to residents who share a similar neighborhood context and geographic location and are, therefore, more "place-based" than large public social service or health providers. Indeed, the majority of HFA programs around the country explicitly target their services to a specific census tract or neighborhood. Our data suggest, however, that this assumption may mask wide variation in the neighborhood realities for families served by a single program. Once HFA programs move out of large urban areas, it is not uncommon for them to serve a set of communities that often differ from each other in terms of socio-economic status and human resources. Rather than viewing a program as serving a specific community, HFA program managers and providers need to plan for serving several communities within their target area. To better engage this range of families, HFA programs need to acquire knowledge of the varying neighborhood conditions and resources, and an ability to adapt staffing patterns and service delivery procedures to the unique community where the participant resides.

Our earlier work in examining retention rates among HFA participants led us to suggest that the agencies most successful in retaining families and delivering the greatest number of home visits were embedded in community support agencies and tended to employ a high proportion of experienced workers who placed high value on involving families in the service planning process (Daro et al., 2003). The findings in this study further accentuate the importance of the provider-parent relationship noted by others (Kormacher, 1998). Programs hoping to engage similar participants should offer specific training aimed at ways for visitors to *guide* service planning and delivery, and to avoid strategies that tend to prescribe service delivery.

### Conclusions

Participants do seek out, enroll and remain in voluntary services in part because of their own characteristics and preferences. However, these choices also are influenced by their program experiences and relationships with their home visitor. In addition, community context does matter but not in the direction we had assumed. Once enrolled, new parents living in the most distressed communities are far more likely to receive

a greater number of visits than those in less distressed areas. Certain features of the HFA service model may facilitate its implementation within high risk communities and contribute to its ability to achieve strong service levels in areas that can be inhospitable to social service interventions. These features include the delivery of services within a participant's home, the ability to assess and respond to a broad range of parenting and personal concerns, and the use of home visitors who encourage participants to be active participants in the service planning process.

### Footnote

<sup>1</sup> The research summarized in this article represents a collaboration of several HFA sites and members of the HFA Research Network. Contributors to this work include the following: Karen McCurdy, Human Development and Family Studies, University of Rhode Island; Lydia Falconnier, School of Social Work, University of Illinois at Chicago; Carolyn Winje, Chapin Hall Center for Children, University of Chicago; Elizabeth Anisfeld, Best Beginnings, Columbia University College of Physicians & Surgeons, Department of Pediatrics; Aphra Katzev, Bates Family Study Center, Oregon State University; Ann Keim, Cooperative Extension, University of Wisconsin; Craig LeCroy, School of Social Work, University of Arizona; William McGuigan, Human Development & Family Studies, Penn State University; Carnot Nelson, Department of Psychology, University of South Florida

### References

- Brody, G.H., Ge, X., Conger, R., Gibbons, F.X., Murry, V.M., Gerrard, M., & Simons, R.L. (2001). The influence of neighborhood disadvantage, collective socialization, and parenting on African-American children's affiliation with deviant peers. *Child Development, 72*, 1231-1246.
- Brooks-Gunn, J., Duncan, G., & Aber, J. L. (1997). *Neighborhood poverty. Volume II: Policy implications in studying neighborhoods*. New York: Russell Sage Foundation.
- Coulton, C. J., Korbin, J. E., Su, M., & Chow, J. (1995). Community level factors and child maltreatment rates. *Child Development, 66*, 1262-1276.
- Daro, D., McCurdy, K., Falconnier, L., Winje, C., Anisfeld, E., Katzev, A., et al. (2007). The role of community in facilitating service utilization. *Journal of Prevention & Intervention in the Community, 34*, 181-203.
- Daro, D. (2000). Child abuse prevention: New directions and challenges. In: Hansen, D. (Ed.). *Motivation and Child Maltreatment Vol. 46 of the Nebraska Symposium on Motivation*. University of Nebraska, Lincoln, 161-220.
- Daro, D., McCurdy, K., Falconnier, L., & Stojanovic, D. (2003). Sustaining new parents in home

visitation services: Key participant and program factors. *Child Abuse & Neglect*, 27, 1101-1125.

Daro, D., McCurdy, K., & Nelson, C (2005). *Engagement and retention in voluntary new parent support programs*.

Chicago: Chapin Hall Center for Children at the University of Chicago.

Korfmacher, J. (1998, February/March). Examining the service provider in early intervention. *Zero to Three*, 17-22.

McCurdy, K., & Daro, D. (2001). Parent involvement in family support programs: An integrated theory. *Family Relations*, 50, 113-121.

Melton, G. & Barry, F. (Eds.). (1994). *Protecting children from abuse and neglect: Foundations for a new national strategy*. New York: Guilford Press.

Poulin, J., & Young, T. (1997). Development of a helping relationship inventory for social work practice. *Research on Social Work Practice*, 7, 463-489.

Simons, R.L., Lin, K.H., Gordon, L.C., Brody, G.H., Murry, V., & Conger, R.D. (2002). Community differences in the association between parenting practice and child conduct problems. *Journal of Marriage and Family*, 64, 331-345.

Young, T., & Poulin, J. (1998). The Helping Relationship Inventory: A clinical appraisal. *Families in Society: The Journal of Contemporary Human Services*, 79, 123-133.



**Deborah Daro, Ph.D.** is an Associate Professor and Research Fellow at the Chapin Hall Center for Children at the University of Chicago. Prior to joining Chapin Hall, Dr. Daro served as the Director of the National Center on Child Abuse Prevention Research, where she contributed to the development of Health Families America (HFA). Her current work examines reform strategies that embed individualized, targeted prevention efforts within

more universal efforts to alter normative standards and community context. Dr. Daro holds a Ph.D. in Social Welfare and a Masters degree in City and Regional Planning from the University of California at Berkeley.

## Across the Great Divide: Healthy Families America's Research to Practice Collaborative

**Joseph Galano, Ph.D**

College of William and Mary

&

**Cynthia J. Schellenbach, Ph.D**

Oakland University, Rochester

Integrating prevention science with field-based practice is challenging. Too often, university-based researchers and professional evaluators are on one side of the great divide, while practitioners in the field are on the other side. This division exists in every field of prevention. For instance, in 1998, the Institute of Medicine produced a report that summarized the gap between science and effective treatment of substance abuse disorders (Lamb, Greenlick, & McCartney, 1998). Despite great strides in research, the substance abuse treatment system in 1998 was indistinguishable from the one in place in 1975 (Sorenson, Guydish, Rawson, & Zweben, 2003). The implication is that during that 23-year period, while researchers were discovering better ways to treat substance abusers, our jails and cemeteries were filling up with people failed by a delivery system that did not effectively disseminate known, evidence-based treatments. Following the report, the National Institute of Drug Abuse launched an initiative designed to blend research and practice, significantly benefiting both researchers and practitioners.

The field of child abuse and neglect prevention has also struggled to bridge the gap between science and practice. In 1999, the David and Lucile Packard Foundation conducted the most comprehensive national study of home visiting programs and identified several critical shortcomings. The study's authors (Gomby, Culross, & Behrman, 1999) made it clear that home visiting programs and their national organizations should bring together researchers and practitioners to assess fidelity to the model and to understand and strengthen implementation and quality of services. Prevent Child Abuse America was uniquely poised to accept this challenge, having spent the five years prior to the Packard study creating an infrastructure—the Healthy Families America Research Network, a national coalition of researchers and practitioners – that had independently arrived at the same conclusion.

Kahn (1993) recognized that the Network also presented a rare and valuable opportunity to learn how to build researcher-practitioner collaboratives. This paper is a self-reflection on what has happened over the past ten years in order to learn from that experience, an opportunity to share with colleagues engaged in researcher-practitioner partnerships, and a plan for sustaining and growing the HFA Network.

## ◆ Child and Family Policy and Practice Review

---

### **The Urgency of the Problem**

Before describing the evolution of the research collaborative, it is important to underscore the scope of the problem of child abuse and neglect in America. Despite strides in understanding, treating, and preventing child abuse and neglect, it remains one of the most significant public health problems in the United States. In 2000, nearly 2 million reports involving 2.7 million children were referred for investigation (USDHHS, 2003). Of these children, approximately 879,000 were found to be victims of maltreatment. The impact on our nation is profound. Survivors inherit a deplorable long-term legacy that includes mental retardation, intellectual and social deficiencies, major adult health problems, and increased risks for school failure, delinquency, and violent behavior (Cicchetti & Toth, 2000; National Research Council and Institute of Medicine, 2000; Felitti, et al., 1998).

### **The Evolution of the Research Collaborative: From Phase I (Researcher) to Phase II (Researcher-Practitioner)**

In 1994, PCA America launched the HFA Research network to bring together two groups of researchers: academic researchers and community-based evaluators of HFA programs. These groups maintained the long-term goal of strengthening researcher-practitioner collaboration at the local, state, and national levels. The two major goals in Phase I were to improve the quantity and quality of HFA evaluated programs and to create a common database describing HFA programs, participants, and outcomes. By bringing together those conducting the most sophisticated program evaluations and those conducting quasi- and non-experimental designs in action settings, the Network fostered a deeper understanding of the experience among its members, allowing the Research Network to provide guidance for others embarking on similar research collaborations (Daro & Harding, 1999).

#### *HFA Research Network Phase I (1994-1999)*

From 1994-1999, 50 researchers from 25 states were active members. They were employed in state agencies, universities, and evaluation firms, and they spanned the fields of child maltreatment, public health, and early childhood programs. Diverse educational backgrounds including psychology, public health, child development, and social work ensured that no one theoretical orientation would dominate research questions or evaluation strategies, but they also presented barriers to working together.

Phase I processes. During the early years of the Network, PCA America helped to direct and nurture the Research Network, funded by the Robert Wood Johnson corporation and Gerber. Nationally recognized experts in child abuse, home visiting, and early childhood development participated in annual Network meetings. Committees were developed to work on the major goals that had been established (e.g. risk assessment, national database, outcomes and measurement issues, and research questions). Phase I was immensely successful in establishing a national researcher collaborative network by

transforming the network from a group of individual researchers to a collaborative that quickly developed a sense of shared mission. From the beginning, the network was characterized by joint ownership and collaborative leadership.

Phase I outcomes. Most importantly, Phase I produced a significant increase in the quality and quantity of HFA evaluated programs and the development of a national program information system. Approximately 17 evaluations were completed and 18 additional studies were in progress. Most importantly, Phase I saw the completion of a 3-year, 30-state review that informed the initial development of the computerized Program Information Management System and the Participant-Tracking components (PIMS I and II). These components were designed to supply information about HFA site resources, target communities, funding sources, and collaborating agencies; to track participant characteristics; and to evaluate the level and quality of services participants receive. PIMS established standard data elements, allowing HFA to collect more consistent evidence about program fidelity and program effectiveness across the nation.

Several critical challenges were identified internally as the funding for Phase I was about to end. How could network members coordinate the publication of findings? How could joint research projects be promoted and funded? How could HFA findings be best communicated among network members and the field at large?

#### *HFA Research Practice Network (RPN) Phase II (2000-2004)*

The impetus for Phase II activities came from both internal and external sources. After five years of researchers and evaluators working closely together, it was clear that this group was not capable of closing the research-to-practice gap alone. Examinations of programs in substance abuse treatment, education, social service, community development, and virtually every other field reveal similar gaps (Schorr, 1997). For example, Lamb, Greenlick, and McCarty (1998) conducted a national study for the Institute of Medicine (IOM) focusing on the research-to-practice gap in the drug and alcohol abuse arena and identified strategies that can be used to close the gap. These strategies focused on mutual challenges: researchers learning more about complex organizational and community-level challenges required for successful dissemination, and practitioners learning more about research and training.

HFA also recognized the gap and the need to broaden the partnerships involved in promoting the HFA model. In 1999, the HFA Research Network consisted of 50 researchers in 33 states. A grant provided by the Packard Foundation allowed 25 of the original 50 researchers to join together with 15 practitioners from across the country as full partners in order to understand and grapple with contemporary research-to-practice issues and community concerns. The Research Practitioner Council (RPC) was created and the HFA Research Network was transformed into the Research Practice Network. Phase II objectives were to create a forum that would reflect and integrate research-practice issues. Moreover, with funding from

the Packard and Gerber Foundations (\$1 million and \$300,000 grants, respectively), HFA responded to the recommendation made by the Packard Report (Gomby, Culross, & Behrman, 1999) for a “dedicated effort led by the field to improve the quality and implementation of existing home visiting programs. . .” (p. 24). PCA America and RPC accepted that challenge.

**Phase II process.** Building meaningful bridges between scientists and practitioners is a formidable challenge. Historically, there have been far too few research-to-practice links, and each group has been socialized within a culture that contributes to misunderstanding. The goals of the RPC were derived, in part, from an awareness of the limitations of past research paradigms in the social and behavioral sciences, specifically: (a) the tendency to dichotomize research and practice, and devalue practitioners and “real world” researchers, (b) under-appreciation for the importance of integrating local knowledge with externally initiated intervention and research, and (c) inadequate concern about sustaining social interventions when external funding runs out. In fact, with science advancing so rapidly, it is understandably challenging for practitioners to stay abreast of scientific developments and their implications for evidence-based practice. It may be even more challenging for researchers to become fully aware of the administrative support needed to effectively integrate innovations into existing service delivery systems and to appreciate the complexities of the organizational change process. Having practitioners in the mix helps assure that the researchers formulate research/evaluation questions that are important to practitioners and reflective of what is happening on the ground.

Much of the RPC’s first year was spent learning enough about the “other group” to allow an equality of collaboration. The research agenda was decided in collaboration and guided by the needs of both the practice and research communities. Collaborative activities included exchanging resources and building two-way learning relationships. As the RPC moved into the tangible work of designing and implementing a national implementation study, the complementary expertise of both sets of partners and the complementary nature of the work became increasingly apparent. The fact that the work groups had to integrate issues relevant to practitioners with issues that could also contribute to prevention science required real bi-directional interactions and knowledge exchange. An outcome of the dialogue was an increasingly ecological understanding of the etiology of child maltreatment, one that emphasized parent-child interaction and the broader contexts of community and culture. Over time, the work of collaboration led to relationships based on mutual trust, respect for diversity in thinking, a willingness to collaborate in conducting and publishing research, increased ownership of research and evaluation findings, and an increased likelihood of acting on research and evaluation findings.

**Phase II outcomes.** The HFA Research Practice Network embarked on a 4-year national implementation study (Harding, Reid, Oshana, & Holton, 2004) aimed at informing the field about site characteristics, family retention, service intensity,

service content, and staff retention. It was the focal point of Phase II and required an enormous investment of time and resources, resulting in the largest collaborative study of home visiting programs ever conducted. The study’s architects included researchers and practitioners from 14 states, employing data from nine states and over 100 sites. Their three major objectives were fostering research-practice collaboration, implementing an evidence-based quality improvement strategy, and applying the knowledge gained throughout HFA and beyond (Harding, Reid, Oshana, & Holton, 2004). This study provided the first comprehensive description of national implementation and identified factors associated with successful implementation. The RPC worked with HFA/PCA America to disseminate findings and to develop recommendations to guide future research and practice. A summary of the findings and lessons learned have been disseminated to HFA programs and are available on the HFA website.

An ongoing focus of Phase II was continuing to improve the quantity and quality of evaluations of HFA programs. Both the number of evaluations, their size and scope (process and outcome) grew considerably. There were 25 evaluations conducted during the 4-year Phase II period compared to the 17 of Phase I. Moreover, most of the evaluations conducted during Phase II were state-level or multi-site evaluations. The synthesis of outcome findings (Harding, Galano, Martin, Huntington, and Schellenbach, 2007) were based on 242 sites from 17 states and over 100 field-based evaluations. The fact that so many network members were able to partner with practitioners, policy makers, and organizational leaders to generate scholarly publications reflects the success of Phases I and II in building critical bridges that did not exist before.

### **A Plan for Sustaining the Research-to-Practice Council**

Research to practice collaboration is an ongoing, long-term, and evolving process. The progress made during the first ten years of the RPN is heartening. However, sustained progress requires more permanent structure and support. The circumstances that contribute to child abuse and neglect are longstanding. Meaningful solutions necessitate that PCA America and the RPN stay the course and implement a long-term plan. Over the next five to ten years, there are a number of important steps that the HFA Research Center should take to institutionalize the research-to-practice collaborations that have been established and to increase the rate at which prevention science is incorporated into child abuse and neglect prevention efforts in our communities. John Holton’s paper in this review deals broadly with the next steps for HFA and the Research Practitioner collaborative. In addition, Galano and Schellenbach (2007) elaborate on the following recommendations:

1. Establish a long-term leadership and a formal structure to sustain and grow the researcher-practitioner partnerships within the HFA RPN.
2. Strengthen and expand the researcher-practitioner partnerships and develop strong collaborations with

## ◆ Child and Family Policy and Practice Review

---

policymakers and funding sources at the national, state, and local levels.

3. Develop broad partnerships, joint ownerships, and collaborative leadership. Sorenson and colleagues (2003) provide exemplary work in this domain.
4. Promote the use of evidence-based and effective prevention and intervention approaches within the community.
5. Better integrate the work of RPN with HFA's dissemination and training to insure widespread adoption of evidence-based practices

### Conclusion

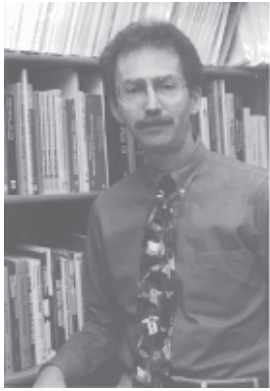
Today, the prevention science and prevention practice divide is better understood, as are the bridges to decrease the gap. Researchers, practitioners, and policy-makers recognize that effective community-based prevention efforts can improve outcomes for children and families. Yet, our science has generally not focused on understanding community-based efforts, and our policies have often lagged behind. PCA America's multi-state, researcher-practitioner collaborative is not an end in itself, but a means to conducting and utilizing research that can improve child abuse and neglect prevention programs. The lessons learned from creating and sustaining this resource should not be lost. Now, we urgently need leadership and funding at the national level to enable regional and national prevention agencies, practitioners, scientists and evaluators to achieve their collective potential. Our nation's children deserve no less.

### Author's Note

Correspondence should be addressed to Joseph Galano, Department of Psychology, College of William and Mary, P.O. Box 8795, Williamsburg, VA 23187-8795; jxgala@wm.edu. The authors would like to express their gratitude to the Robert Wood Johnson, Packard, and Gerber Foundations for their support of the RPN and acknowledge those individuals who came together from across the country, bound only by their collective commitment to contribute to the knowledge base on child abuse and neglect prevention.

### References

- Cicchetti, D., & Toth, S.L. (2000). Child maltreatment in the early years of life. In J.D. Osofsky & H.E. Fitzgerald (Eds.), *WAIMH Handbook of Infant Mental Health, Vol. 4: Infant mental health in groups at high risk* (pp 255-294). New York: Cambridge University Press.
- Daro, D. A., & Harding, K. A. (1999). Healthy Families America: Using research to enhance practice. *The Future of Children, 9*, 152-176.
- Galano, J., & Schellenbach, C. (2007). The Healthy Families America Research Practice Network: A unique partnership to integrate prevention science and practice. *Journal of Prevention & Intervention in the Community, 34*, 39-66.
- Gomby, D. S., Culross, P. L., & Behrman, R. E. (1999). Home visiting: Recent program evaluations – Analysis and recommendations. *The Future of Children, 9*, 4-26.
- Harding, K., Galano, J., Martin, J., Huntington, L., & Schellenbach, C. (2007). Healthy Families America effectiveness: A comprehensive review of outcomes. *Journal of Prevention & Intervention in the Community, 34*, 149-180.
- Harding, K., Reid, R., Oshana, D., & Holton, J. (2004). *Initial results of the National healthy Families America implementation study: A report submitted to the David and Lucille Packard Foundation*. Chicago, IL: Prevent Child Abuse America.
- Kahn, R. (1993). *An experiment in scientific organization: The MacArthur Foundation program in mental health and human development*. Chicago: The MacArthur Foundation.
- Lamb, S., Greenlick, M. R., & McCarty, D. (Eds.). (1998). *Bridging the gap between practice and research: Forging partnerships with community-based drug and alcohol treatment*. Washington, DC: National Academy Press.
- Shonkoff, J.P., & Phillips, D.A. (Eds.). (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.
- Schorr, L. (1997). *Common purpose*. New York: Simon & Schuster.
- Sorensen, J. L., Rawson, R. A., Guydish, J., & Zweben, J. E. (Eds.). (2003). *Drug abuse treatment through collaboration: Practice and research participants that work*. Washington, DC: American Psychological Association.
- Trickett, P., & McBride-Chang, C. (1995). The developmental impact of different forms of child abuse and neglect. *Developmental Review, 15*, 311-337.
- U.S. Advisory Board on Child Abuse and Neglect (1990). *Child abuse and neglect: Critical first steps in responding to a national emergency* (1<sup>st</sup> Report). Washington, DC: U.S. Government Printing Office.
- U.S. Department of Health and Human Services. (2003). *Child Maltreatment 2001*. Washington, DC: U.S. Government



**Joseph Galano, Ph.D.** is an Associate Professor of Psychology at the College of William and Mary and a core faculty member in the Virginia Consortium Program in Clinical Psychology. He is committed to applying psychology and working directly with communities to address social problems and to improve the human condition. He is a fellow in the Society for Community Research and Action (APA Division 27). In recognition of his career accomplishments, APA

honored him with the 1996 Distinguished Contribution to Practice in Community Psychology award.

Dr. Galano has worked at the local, state, and national levels to prevent child abuse and neglect. He has consulted with Hampton, Virginia's Healthy Families Partnership for over fifteen years. Hampton was twice designated City of the Year for its proactive approach to solving social problems. Since 1995, he has worked with Prevent Child Abuse Virginia to develop Virginia's statewide child abuse prevention initiative, Healthy Families Virginia. He was a member of the steering committee that developed the Blue Ribbon Plan to Prevent Child Abuse and Neglect in Virginia and currently serves on Healthy Families Virginia's Advisory Council. Since 1992 he has been a member of the Healthy Families America (HFA) Research Practice Network and is a member of the HFA State Leaders Network.



**Cynthia J. Schellenbach, PhD** is an Associate Professor of Sociology at Oakland University, Rochester, Michigan. She is currently the co-author of publications on the innovative work on Healthy Families America, a national network of child abuse prevention programs utilizing the home visitation model. With colleague, Joseph Galano at the College of William and Mary in Virginia, she has published work on the Healthy Families America Research Practice Network: A Unique Partnership to Integrate

prevention Science and Practice. In addition, she has collaborated on the publication of the outcome of the first national implementation study of the Healthy Families America Network. She has co-edited several books including *Violence in the Family and the Community and Investing in Children, Youth, Families, and Communities: Strengths-based Research and Practice*. She has served as president of the Division 37 of APA. She is currently serving on the National Task Force on Prevention of Child Maltreatment of the APA as well as the

Planning Committee for the PCA National Conference on the Prevention of Child Maltreatment. She has been an active leader in child abuse prevention research at the local, state, and national levels.

## HFA Research Update

**Anne McDonald Culp, Ph.D.**  
University of Central Florida, Orlando

&

**Cynthia J. Schellenbach, Ph.D.**  
Oakland University, Rochester

In this article, we summarize the outcome results of selected HFA sites which utilized randomized designs or quasi-experimental designs in evaluation. These sites also collected program fidelity data to assess compliance to the current model or to design the best working model. All sites had a strong commitment to both process and outcome evaluation. Most outcome measures are in the domains of child health and development, parenting skills and attitudes, and rates of child maltreatment.

Given the constraints of the current review, we are unable to provide the detailed explanation each study deserves or to report every study in several other states (see Harding et al, 2007). Each of the studies reported here is fully referenced for the reader to find the scientific detail, the data analyses, the strength of effects, and the mediator and moderator variables that influence the strength of the findings.

The format of this particular article is one that can be shared with parents, legislators, and community partners and leaders.

*Arizona: Healthy Families Arizona (HFAz; Krysik & LaCroy, 2007; LeCroy, Ashford, Krysik, & Milligan, 1996; LeCroy & Whitaker, 2005)*

Over the past fifteen years, HFAz has been committed to gathering formative evaluation in order to assess and strengthen the implementation of their model. In addition to data analysis on strengthening the model, they implemented a quasi-experimental outcome study comparing 800 intervention mothers to 302 at-risk families of similar demographic background, high rates of poverty, and risk rates of child abuse. Significant differences were found on child maltreatment rates, stress level reductions and child immunizations. The intervention mothers, although screened at higher stress and higher risk for child maltreatment than the comparison mothers, had significantly lower rates of child maltreatment (2.8%) than the comparison group (5.2%).

Mothers also differed in the types of substantiated incidents: the comparison group had a greater proportion of incidents classified by CPS as high-risk physical abuse than did the

## ◆ Child and Family Policy and Practice Review

---

HFAz group, including one child death. The HFAz participant group, in contrast, had a greater proportion of incidents classified as neglect than the comparison group and no child deaths.

A between-group comparison was also conducted measuring parental stress. Over multiple years, HFAz parents have consistently shown significant improvements on the stress levels from entry into the program to 6, 12, and 18 months. Significant improvements have been noted in five areas of stress: mothers' sense of competence, parental attachment, social support, parental efficacy, and perceived health. Significant decreases have been noted in five areas of stress: depression, feeling restricted in their parental role, parental distress, social isolation and difficult parent/child interactions. The HFAz group showed significant improvements on 10 of the 11 parental stress subscales, the comparison group did not. In fact, in the period from 3 weeks after birth to 6 months, data from the independent comparison group showed a significant negative progression on the same 10 of 11 subscales while the HFAz group showed significant improvements on each of these scales.

A third area of positive outcome was in the area of immunizations. By 2004, the HFAz immunization completion rate was 91%, 14 percentage points higher than the state rate of 77%.

The findings and publications on strengthening the HFAz model and its implementation have had positive implications for research. In 2005, HFAz launched their first randomized trial which is in being implemented at this time. The planned longitudinal, controlled study will not only provide information on program effectiveness, but will allow the piloting of a number of new measures in domains that are not currently addressed in the ongoing evaluation. This experience should inform and lead to improvements in measurement for the ongoing evaluation, and ultimately, improved services and outcomes for participating families.

Kentucky/Ohio: Every Child Succeeds (ECS; Ammerman, et al. 2007; Donovan, Ammerman, et al, 2007)

ECS is a multisite home visitation program in southwestern Ohio and Northern Kentucky, and targets first-time, high risk mothers. Enrollment occurs either prenatally or within three months of birth, with home visits provided by child development specialist/trained professionals (82%), nurses (12%), or paraprofessionals (6%). In a case-control design, 1665 of the ECS families were compared to 4995 families who did not receive home visiting. Researchers reported that the control families were 2.5 times more likely to die in infancy compared with infants whose families were visited. Black infants were at least as likely to benefit from home visiting as were nonblack infants. Early intervention home visiting programs reduce the risk of death within the infant's first year of life.

In addition, using a quasi-experimental design in which the outcomes of all home visitation mothers were compared to benchmarked objectives in order to document results. Bench-

marks were determined by published findings from similar samples where available. At the end of intervention, ECS mothers reported having beliefs and attitudes consistent with nurturing and effective parenting (99%); meeting the emotional needs of their children (93%), and having realistic expectations for behavior and development (87%). In addition, home environments contained stimulating learning materials (98%), conducive to learning (97%), and had high maternal involvement (97%). In addition, 51% of the mothers with elevated levels of depression at enrollment reported lower scores on depression at 9 months.

Further work by Ammerman and associates, as is true in the work in Arizona, show strong support for working closely with home visitors in identifying maternal depression, substance abuse, and domestic violence early so that more intensive interventions can take place immediately. ECS, has tested augmented modules to the intervention model that seem promising. A pre-post evaluation was carried out with 26 depressed first-time mothers in home visitation who exhibited histories of interpersonal trauma (73%), suicide attempts (35%), and hospitalizations (50%). The augmented model was administered by a trained social worker over 17 weekly sessions, two of which were conducted with the home visitor present. Results indicated that 69% of mothers no longer met criteria for major depression at the end of treatment; an additional 15% were partially remitted.

Additional findings included decreased self-reported functional impairment, increased self-reported acceptance of and emotional closeness to the child, increased rate of home visiting during treatment period, and overall satisfaction with the program by mothers and home visitors. A detailed case study describing the clinical procedures of IH-CBT can be found in Ammerman et al (2007).

It has become increasingly evident that there are a number of social and clinical issues that potentially undermine home visitation effectiveness: mothers with depression (Ammerman, Putnam, Altaye et al., 2005), history of trauma (Stevens et al., 2002), and mental illness and alcohol abuse (Margie and Phillips 1999; LeCroy & Whitaker, 2005). Future research must identify ways of adapting or augmenting standard home visitation curricula to meet the needs of a sizable group of affected families, and to train the home visitors to identify the clinical issues and refer to their supervisors for supplemental intervention.

New York: (Mitchell-Herzfeld, Izzo, Greene, Lee, & Lowenfels, 2005; Dumont, Mitchell-Herzfeld, Greene, Lee, & Lowenfels, in press; Mitchell-Herzfeld, Rodriguez, & Walden, 2007)

Utilizing a sample of 579 intervention parents and 594 control families and paraprofessionals as the home visitors, these researchers conducted a randomized trial across three sites in New York. The evaluation has demonstrated that Healthy Families New York (HFNY) helps to lower the incidence of low birth weight babies, sustain access to health care,

and reduce abusive and neglectful parenting practices.

HFNY mothers were less than half as likely to have low birth weight babies as control group mothers (Mitchell-Herzfeld et al., 2005). HFNY mothers and children showed sustained access to health care when compared with control families. The children were more likely to have health insurance and less likely to go without needed medical care; the mothers were more likely to have health insurance and to have primary care providers (Dumont et al., in press).

HFNY mothers self reported less child abuse and neglect and negative parenting practices than control mothers. They reported marginally less neglect at Age 1 and 2 years; reported committing fewer acts of very serious physical abuse, minor physical aggression, psychological aggression, and harsh parenting at Age 1, and fewer acts of serious physical abuse at Age 2 (Dumont et al., in press).

HFNY was particularly effective in reducing child abuse and negative parenting practices for certain groups of mothers. Compared to their counterparts in the control group, first-time mothers under age 19 who were offered HFNY early in pregnancy were markedly less likely to report engaging in minor physical aggression and harsh parenting when their children were at age 2 (Dumont et al., in press); at age 3, they were reported as less likely to be *observed* using harsh parenting (Mitchell-Herzfeld et al., 2007). In addition, mothers in the HFNY group who had marked depressive symptoms and/or a limited sense of control over their lives were only about a quarter as likely to report committing acts of serious abuse or neglect as similar mothers in the control group (Dumont et al., 2006a).

HFNY helped to promote positive parenting behaviors that have been identified in previous research to be predictive of children's adjustment. For example, at age 3, mothers assigned to the HFNY group were *observed* providing more cognitive stimulation with their children and engaging in more sensitive structuring (e.g., showing empathy, setting appropriate limits, offering reassurance) with their children than were mothers assigned to the control group (Mitchell-Herzfeld et al., 2007).

Oklahoma: Community-Based Family Resource Program (CBFRP; Culp et al. 2004; Culp et al. 2007).

In a quasi-experimental design, 156 first-time mothers who were provided home-based early intervention weekly prenatally through the infants' first birthdays were compared to 107 control mothers matched demographically from similar at-risk counties. The home visitors were specialists with college degrees in child development, were well supervised, and demonstrated strong program fidelity in that the process data showed high curriculum compliance.

Compared to a control group of mothers, the CBFRP mothers used significantly more community services, had safer homes, had more appropriate developmental expectations, had better understanding of noncorporal punishment, and had behaviors that were more accepting and respectful to their infants.

In addition, the CBFRP mothers were more likely to use

birth control, thus had fewer pregnancies since birth of their first child; reported smoking fewer cigarettes; knew more about effects of smoking on their child's health; and were more likely to use health department services.

Further analyses (Culp, et al, 2003) showed that within a randomly selected set of 40 intervention and control mothers, the intervention made a difference in mothers' speech to their infants at one year of age. The mothers and children were videotaped during play for 10 minutes and were asked to play with their infant as they normally would at home. Word-for-word transcripts of the language used by each mother and infant pair during the complete 10-minute play interaction were transcribed.

Compared to the controls, the CBFRP mothers spoke more often to their infants, and when they spoke, the mothers spoke about what the infants were doing at the time; they were in "joint attention". In addition, the intervention mothers had a higher number and higher percentage of teaching utterances. The intervention mothers had direct teaching episodes, described activities and toys, and asked questions to their infants more often than control mothers. Most importantly, the infants of the intervention mothers spoke more often than the controls at one year of age, and the phonetic content of their utterances were more complex than the control infants.

Virginia: The Hampton Healthy Families Partnership (HFP; Galano and Huntington, 1999; 2007; Galano and Schellenbach, 2007)

HFP reduced pregnancy risk status, birth complications, repeat teen pregnancies, and immunization coverage, as well as increased parent-child interaction and the quality of the home environment among participants compared to control parents. Most recently, Hampton out-performed all of the comparison regions and communities on infant mortality and child maltreatment. Analyses of trends in infant mortality demonstrated that all of the communities experienced a reduction in infant mortality between 1991 and 2000. Hampton experienced the largest per year decline. Hampton's rate of change indicated that the infant mortality rate fell by nearly one infant death per 1,000 infants per year, while the rates for Hampton Roads and Greater Richmond decreased by .23 and .32 infant deaths per 1,000 per year, respectively.

The analyses of trends in substantiated cases of abuse and neglect for children born in Hampton, Hampton Roads, and Greater Richmond between 1991 and 2000 indicated that Hampton experienced considerable success in reducing child abuse and neglect. The trend of declining child abuse and neglect was significant only for Hampton and not for either Hampton Roads or Greater Richmond.

### References

- Ammerman, R. T., Putnam, F. W., Stevens, J., Holleb, L. J., Novak, A. L., & Van Ginkel, J. B. (2005). In-home cognitive behavior therapy for depression: An adapted treatment for first time mothers in home visitation. *Best*

## ◆ Child and Family Policy and Practice Review

---

*Practices in Mental Health, 1*, 1-14.

- Ammerman, R., Putnam, F. W., Kopke, J. E., Gannon, T.A., Short, J. A., Van Ginkel, J. B., Clark, M. J., Carrozza, M. A., Spector, A. R. (2007). Development and implementation of a quality assurance infrastructure in a multisite home visitation program in Ohio and Kentucky. *Journal of Prevention & Intervention in the Community, 34*, 89-108.
- Culp, A. M., Culp, R. E., Anderson, J. W., & Carter, S. (2007). Health and safety intervention with first-time mothers. *Health Education Research, 22*, 285-294.
- Culp, A. M., Culp, R. E., Howell, C. S., Hechtner-Galvin, T., Saathoff-Wells, T. S., & Marr, P. (2004). First-time mothers in home visitation services utilizing child development specialists. *Infant Mental Health Journal, 25*, 1-15.
- Culp, A. M., Howell, C., Horton, C., Culp, R. E., Palermo, F., & Ward, K. (April, 2003). *Positive intervention effects with first-time mothers: Maternal speech behaviors with one year old infants*. Poster presented at the meeting of the Society for Research in Child Development, Tampa, FL.
- Donovan, E. F., Ammerman, R. T., Besl, J., Atherton, H., Khoury, J. C., Altaye, M., Putnam, F. W., & Van Ginkel, J. B. (2007). Intensive Home Visiting in Associated Decreased Risk of Infant Death. *Pediatrics, 119*, 1145-1151.
- DuMont, K. A., Mitchell-Herzfeld, S., Greene, R., Lee, E., Lowenfels, A., Rodriguez, M., & Dorabawila, V. (in press). Healthy Families New York (HFNY) Randomized Trial: Effects on early child abuse and neglect. *Child Abuse & Neglect*.
- Galano, J., & Huntington, L. (1999). *Evaluation of the Hampton, Virginia, Healthy Families Partnership: 1992-1998*. Center for Public Policy Research, The Thomas Jefferson Program in Public Policy, The College of William and Mary, Williamsburg, VA.
- Galano, J. & Huntington, L. (2007). *2007 Hampton Healthy Families Partnership Benchmark Study: Measuring community-wide impact*. Prepared by the Applied Social Psychology Research Institute, College of William and Mary, Williamsburg, VA.
- Galano, J., & Schellenbach, C. (2007). The Healthy Families America Research Practice Network: A unique partnership to integrate prevention science and practice. *Journal of Prevention & Intervention in the Community, 34*, 1/2, 39-66.
- Harding, K., Galano, J., Martin, J., Huntington, L., & Schellenbach, C. (2007). Healthy Families America effectiveness: A comprehensive review of outcomes. *Journal of Prevention & Intervention in the Community, 34*, 149-180.
- Krysiak, J., & LeCroy, C. W. (2007). The evaluation of Healthy Families Arizona: A multi-site home visitation program. *Journal of Prevention & Intervention in the Community, 34*, 109-128.
- LeCroy, C., Ashford, J., Krysiak, J., & Milligan, K. (1996). *Healthy Families Arizona: Evaluation Report for Tucson, Prescott, and Casa Grande sites, 1992-1994*. Phoenix: Arizona Department of Economic Security.
- LeCroy, C., & Whitaker, K. (2005). Improving the quality of home visitation: An exploratory study of difficult situations. *Child Abuse & Neglect, 29*, 1003-1013.
- Margie, N. G., & Phillips, D. A. (Eds.). (1999). *Revisiting home visiting: Summary of a workshop*. Washington DC: National Academy Press.
- Mitchell-Herzfeld, S., Izzo, C., Greene, R., Lee, E., & Lowenfels, A. (2005). *Evaluation of Healthy Families New York (HFNY): First Year Program Impacts*. Report to the Governor and Legislature. Rensselaer, NY: New York State Office of Children and Family Services.
- Stevens, J., Ammerman, R. T., Putnam, F. G., & Van Ginkel, J. (2002). Depression and trauma history in first time mothers receiving home visitation. *Journal of Community Psychology, 30*, 551-564.
-



**Anne McDonald Culp, Ph.D.** is a Professor and Chair of the Department of Child, Family and Community Sciences at the University of Central Florida. She is past president of Division 37 this year, having served in several capacities on the board for the last ten years. Since 1995, she has served on the Council for the National Center for Child Abuse Prevention Research. Recently, she received the 2007

Pavl Toussing Leadership Award from the Oklahoma Association for Infant Mental Health. Her current research is focused on: the effects of home visitation programs with first-time parents and their infants; and the parenting characteristics associated with early school success with Head Start and PreK populations. Dr. Culp holds a Ph.D. in Development and Child Psychology from the University of Kansas and a Masters degree in Applied Development Psychology from the University of Colorado.

## Discourse on HFA: Practice, Research, and Policy Action Steps

**John K. Holton, Ph.D.**  
Prevent Child Abuse America  
Chicago, Illinois

Child maltreatment (CM) occurs most frequently inside the family home.<sup>1</sup> CM is a complex event involving relationships that minimally transcend time, alter conceptions of place, and shatter familial and societal building blocks of trust, responsibility, and the meaning of love. As an individually learned and socially reinforced behavior, CM is a relic that often mars a child's developmental experience. Unfortunately, each year in the United States nearly a million children acquire an undeserved developmental legacy when neglected or abused physically, sexually, and emotionally.

To combat CM, prevention advocates propose public health approaches that are based on societal solutions rather than individual treatments. (see Martin, this review). In a public health approach, judgmental, stigmatizing, and criminalizing attributes of CM perpetrators are of lesser importance than emphasizing the social consequences of concealing, minimizing, or ignoring the problem. Adopting appropriate and effective change agents for caregivers, their families, and communities have led preventionists to adopt psychological theories--social learning and social ecology in particular--as the basis for program development. Home visitation incorporates both a public health approach and psychological tools to foster a con-

tribution in preventing child maltreatment. To reach caregivers, home visitation can be viewed as a portable "classroom". Literally, the importance of home visitation to prevent child abuse and neglect is in its location.

Arguably, other than our bodies, our "home" is the most important *context* for children. Home visiting as a strategy to prevent child maltreatment aims to make the family residence and its surrounding ecology of community institutions, systems and culture safe, nurturing and protective environments for the child.

In the early 1990s, the federal government was given a set of recommendations to confront CM, at that time described as a "national emergency" by the U.S. Advisory Board on Child Abuse and Neglect (1990, 1991, 1996). A central recommendation from the Advisory Board emphasized home visitation for all new families. Perhaps programmatically envisioned to be similar to Head Start, home visitation programs, federally supported, would reach parents most in need or described differently, had an imbalance of risk over available protective conditions. For reasons unknown, the federal government did not fund the recommendation. In the absence of federal funding, and with no clear signal that prevention of child maltreatment would become a national public health goal (as it became in 2000 and 2010 [National Center, 2001; U.S. Department of Health and Human Services, 2000]), Prevent Child Abuse America (known as the National Committee to Prevent Child Abuse) mobilized its resources to design a home visiting program that is known today as Healthy Families America (HFA). In operation for more than a decade, much learning about the mechanisms of home visiting via the HFA model can be shared. However, a brief background on the progeny of this model is in order.

HFA owes its beginnings to several sources, none more important than the Hawaii Family Stress Center, which instituted a home visitation service envisioned by the pediatrician C. Henry Kempe. To support parents, Kempe devised an assessment tool (Kempe & Kempe, 1976; Korfmacher, 2000; Orkow, 1985) to guide home visits by a well trained and supervised staff (Kempe, 1976a). The Hawaii Family Stress Center further developed Kempe's ideas which led to "Healthy Start," a home visitation program initiated in 1975 (Holton & Harding, 2007; Duggan et al, 1999). In time the practice spread across the state and by the early 1980s had come to the attention of mainland states.

Encouraged by the interest of several states to implement prevention programs and coupled with the promising results from others conducting research trials of home visitation (Olds, Henderson, Chamberlin, & Tatelbaum, 1986), PCA America took steps to promote a model fashioned after Healthy Start. From its perspective, Healthy Start provided a practice model for assessing and engaging parents, conducting home visits with new parents, addressing needs, concerns, and problems, and lastly, connecting the family to other accessible resources to limit, at a minimum, the possibility of isolation. The practice of home visitation as a service delivery concept was reviewed

## ◆ Child and Family Policy and Practice Review

---

and from the examination of available research literatures, twelve “critical elements” or best practices were derived and documented (Healthy Families America, 2006). Based on using best practices for conducting home visits, based on grounding the practice with the interests of communities, and based on available research at the time, Healthy Start became PCA America’s Healthy Families America (HFA). HFA adopted three goals—improving child health, improving parenting effectiveness, and preventing child abuse and neglect—and was presented to the public as a model to support “overburdened” families.

Armed with evidence to support home visitation services to meet the challenges of child maltreatment, PCA America’s immediate challenge was to transform itself from an organization that used media to change *attitudes* to one that used direct services to change *behaviors*. PCA America began to deploy its staff and professional contact resources to introduce, promote, and sustain a single program. PCA America took a course of action most familiar—collaboration and consultation—and assembled teams of experts in public health and applied research, adult educational training, and social service practice, as well as influential community and state leaders who wanted to take action.

Collectively, these teams representing influential community/institutional leaders, technical assistance providers and trainers, and researchers/evaluators became a foundation for implementing PCA America’s home visiting program. As implemented, HFA aims to change parental behaviors that contribute to caregiving risks. Secondly, by working in concert with communities desiring HFA, alliances and collaborations among agencies within the community promotes continuous support for the newborn’s first 5 years of life. Achieving the goal specific to child maltreatment prevention would depend in part on changing or enhancing individual behaviors. For example, parents who possess protective factors for child well-being, notably psycho-social readiness, knowledge and competence, are less likely to maltreat their children (Schumaker, Smith Slep, & Heyman, 2001; Egeland, Sroufe, & Erikson, 1983).

### *Future for HFA*

PCA America’s investment in HFA is unlike any in its prevention history. Working alongside its chapters and community organizations in social services, child welfare, public health and/or maternal and child health, as well as not-for-profit organizations, HFA’s national reach is considerable. Since HFA began, it has provided free home visitation services on a voluntary basis to tens of thousands of families across the United States. Funded primarily by state budgets from federal funding for welfare reform and the cigarette settlement largesse in the 1990s, HFA is arguably the most recognized direct service prevention program promoted by PCA America.

Given this recognition and our high energy level, here is a list of next steps to lead us into a successful future. Many of these steps will be taken by HFA and can be accomplished by all advocates of prevention practices:

1. HFA will continue to be an organic, learning laboratory within communities. Not only is HFA learning new ways to respond to the needs of its families, such as sustaining their interest in providing the best environment and learning experiences for children, but it is also learning more about the conditions that hinder protective interventions. HFA provides a needed real time laboratory of social and health interventions to better determine the effectiveness of home visitation and its delivery system, content, and quality. HFA provides an opportunity to understand more about the effect of certification and quality assurance. HFA’s singular strength—its adaptability to the varied terrains of populations and neighborhoods—allows HFA to compare outcomes across differences and similarities of childrearing experiences. Similar to other public health initiatives with feedback loops for program improvement and quality assurance, HFA’s dissemination of evaluations and research using the credentialing process make it a fluid work-in-progress (Oshana, Harding, Friedman, & Holton, 2005). HFA researchers can study how local adaptations, such as differences in community, host agency, and service provider characteristics; target population (risk factors); and services provided (based on community capacities) influence outcomes.

For instance, the City of Hampton (VA) has shown community-wide impacts following the implementation of HFA (Galano & Huntington, 2002). Although most evaluative attention is focused on HFA’s direct services to individual children and families, its ecological underpinnings and its systems approach to implementation have lead to community-wide change.

2. HFA will continue to credential sites (an accreditation process) knowing that the ongoing task of assessing the model may change the credentialing criteria. HFA will collect empirical evidence from credentialed v. non-credentialed sites to find out if the model *as implemented* translates into greater benefits to families.

3. HFA will combat poverty. Since we are in a position to evaluate the environmental contributors to child maltreatment (Belsky, 1980; Garbarino & Kostelny, 1994), we study the larger contextual influences such as poverty or “concentrated disadvantage” of the families. Home visitation services would suggest a readiness to combat poverty as the comprehensive community initiatives of the 1980s and '90s had done (Auspos & Kubisch, 2004). HFA will continue to design studies, given funding, to counteract concentrated disadvantage and its community accomplices, namely violence on the street and in the home.

4. HFA will continue to implement sophisticated research designs by advocating for research funding in prevention programs. We need ongoing documentation in myriad formats—some likely to be more expensive than others but all necessary: randomized trials (Rosen, Manor, Engelhard, & Zucker, 2006), ethnographic interviews (Stack & Burton, 1994), and community surveys (Giachello et al., 2003). The original rationale for creating a flexible model, namely, the uniqueness of each community surrounding HFA sites (see Daro, this review), should

be a central focus in process and outcome evaluation to understand how contextual factors impact program effectiveness. We will put forth greater efforts in understanding the risks to children and caregivers from their neighborhood context (Meyer, Armstrong-Cohen, & Batista, 2005).

While several states have experimentally designed outcomes studies (Culp & Schellenbach, this review) we must continue to set up research studies which evaluate the model (process) and which measure the effects of implementing the model on the behavior of the parents and children (outcome). We must continue to study the factors that influence how we intervene and to explain outcomes in child health and parenting practices. The studies are expensive and we need to get additional research dollars.

5. HFA and other advocates must get extremely active in their advocacy efforts with state and federal funders. We must send our message that we have data to show our serious and successful attempts at providing safe and nurturing homes. We always need more data, more studies. These advocacy meetings should yield more private, state, and federal monies be put in the arena of child maltreatment prevention.

HFA began as a program to help parents and caregivers support their children's growth and development. Acknowledging that more needs to be done to improve the HFA model—strengthening its operational infrastructure, training, and evaluation — is a signal of its commitment to direct service programs that support every child's right to grow into adulthood without the trauma of abuse and neglect are needed. Child abuse prevention occurs when deleterious behaviors are diverted, changed, or transformed. Finding the best means to accomplish prevention requires help from all quarters beginning with caregivers and their families. The latter, as repositories of their children's hopes, generally seek and respond to overtures of support and assistance. How parents are helped by their communities and the society at-large underscores or undermines the future of all children.

HFA or other home visiting programs are not the proverbial silver bullet to slay the vampire of CM, but it is an efficacious approach to reduce the likelihood of injury to children less than five years of age. So, let us all commit to the effort in preventing child maltreatment and get active with legislators and funders by getting our voices heard and the money we need to accomplish our goals.

#### Footnote

<sup>1</sup> As a pattern of behavior between adult caregiver and dependent child, CM features documental episodes of violence, absence of care, nurturing, or supervision; belittling and ignoring, and/or sexual exploitation for adult gratification. In recent years, states have characterized potential threats of injury as CM when caregivers engage in "clandestine laboratory synthesis" to produce drugs such as methamphetamine.

#### References

- Auspos, P., & Kubisch, A. C. (2004). *Building knowledge about community change: Moving beyond evaluation*. New York: Aspen Institute.
- Belsky, J. (1980). Child maltreatment: An ecological integration. *American Psychologist, 35*, 320-335.
- Duggan, A.K., McFarlane, E.C., Windham, A.M., Rohde, Salkever, D.S., Fuddy, L., Rosenberg, L.A., Buchbinder, S.B., & Sia, C.J. (1999). Evaluation of Hawaii's Healthy Start Program. *The Future of Children, 9*, 66-90.
- Egeland, B., Sroufe, L. A., & Erikson, M. F. (1983). The developmental consequences of different patterns of maltreatment. *Child Abuse & Neglect, 7*, 459-169.
- Garbarino, J., & Kostelny, K. (1994). Child maltreatment as a community problem. *Child Abuse & Neglect, 16*, 455-464.
- Giachello, A.L., Arrom, J.O., Davis, M., Sayad, J.V., Ramirez, D., Nandi, C., Ramos, C. & Chicago Southeast Diabetes Community Action Coalition (2003). Reducing diabetes health disparities through community-based participatory action research: The Chicago southeast diabetes community action coalition. *Public Health Reports, 118*, 309-323.
- Healthy Families America (2006). Retrieved July 29, 2007 from [http://www.healthyfamiliesamerica.org/downloads/critical\\_elements\\_rationale.pdf](http://www.healthyfamiliesamerica.org/downloads/critical_elements_rationale.pdf)
- Holton, J. K., & Harding, K. (2007). Healthy Families America: Ruminations on implementing a home visitation program to prevent child maltreatment. *Journal of Prevention & Intervention in the Community, 34*, 13-38.
- Kempe, C. H. (1976a). Approaches to preventing child abuse: The health visitor concept. *American Journal of Diseases of Children, 130*, 941-947.
- Kempe, R. S., & Kempe, C. H. (1976b). Child abuse. In J. Bruner, M. Cole, & B. Lloyd (Eds.). *The developing child series*. Cambridge, MA: Harvard University Press.
- Korfmacher, J. (2000). The Kempe family stress inventory: A review. *Child Abuse and Neglect, 24*, 129-140.
- Meyer, D., Armstrong-Cohen, A., & Batista, M. (2005). How a community-based organization and an academic health center are creating an effective partnership for training and service. *Academic Medicine, 80*, 1-7.

National Center on Child Abuse and Neglect. (1996). *The*

## ◆ Child and Family Policy and Practice Review

---

*third national incidence study of child abuse and neglect.* Washington, DC: U.S. Government Printing Office.

National Center for Health Statistics. (2001). *Healthy People 2000 Final Review.* Hyattsville, MD: Public Health Service.

Olds, D. L., Henderson, C. R., Chamberlin, R., & Tatelbaum, R. (1986). Preventing child abuse and neglect: A randomized trial of nurse home visitation. *Pediatrics*, 78, 65-78.

Orkow, B. (1985). Implementation of a family stress checklist. *Child Abuse & Neglect*, 9, 405-410.

Oshana, D., Harding, K., Friedman, L., & Holton, J. (2005). Letter to the Editor. *Child Abuse & Neglect*, 29, 219-228.

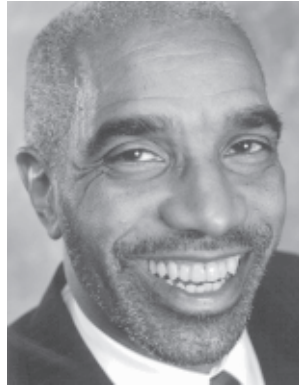
Rosen, L., Manor, O., Engelhard, D., & Zucker, D. (2006). In defense of the randomized controlled trial for health promotion research. *American Journal of Public Health*, 96, 1181-1186.

Schumaker, J., Smith Slep, A., & Heyman, R. E. (2001). Risk factors for child neglect. *Aggression and Violent Behavior*, 6, 231-254.

U.S. Advisory Board on Child Abuse and Neglect (1990). *Child abuse and neglect: Critical first steps in response to a national emergency.* Washington, DC: U.S. Government Printing Office.

U.S. Advisory Board on Child Abuse and Neglect (1991). *Creating caring communities: Blueprint for an effective federal policy on child abuse and neglect* (Rep. No. 9-1991). Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services (2000). *Healthy people 2010* (2<sup>nd</sup> ed., Vols. 1-2). Washington, DC: U.S. Government Printing Office.



**John Kingsley Holton, Ph.D.** is the Vice-President for Research at Prevent Child Abuse (PCA) America. Prior to his position at PCA America, he has conducted research for the Harvard School of Public Health and served as a consultant on public health practice, urban education, crime and delinquency, and child maltreatment at all levels of government in the United States.

Holton is a well published author and has presented to professionals and practitioners in five continents. He is an adjunct professor at the University of Chicago, School of Social Service Administration and has served on the faculties of DePaul University and the Illinois School of Professional Psychology. Holton is a member of the American Professional Society on the Abuse of Children, American Public Health Association, Open Minds, Inc., Target Group, Inc. and he also serves on the editorial board for *Family Violence & Sexual Assault Bulletin*. He chairs the City of Chicago anti-poverty committee and holds board memberships with the Tulane University School of Social Work (Porter-Cason Institute for Family Practice), Northwestern University Law School (Children and Family Justice Center), Jane Addams Juvenile Court Foundation and propriety organizations, Target Group, Inc. and Open Minds, Inc.

**REGISTER NOW!**

**SUMMIT ON VIOLENCE AND ABUSE IN RELATIONSHIPS:  
CONNECTING AGENDAS AND FORGING NEW DIRECTIONS**

**February 28-29, 2008  
Bethesda, MD**

Alan Kazdin, PhD, President-Elect of APA, has selected this summit as part of his presidential initiative. Topics include: Intimate Partner Violence; Child Maltreatment; Children Exposed to Violence and Abuse; Elder Abuse; Gender-Based Issues; Cultural Issues; Ethnic Minorities; Substance Abuse; and related themes. The focus will be on what we know, what we need to know, and where do we need to go with respect to research, intervention, and prevention. The program will consist of a number of plenary speakers and break-out groups to discuss relevant topics.

**Conference Schedule**

February 28: Opening Plenary, Poster Session, Networking Reception

February 29: Summit Programming

**Coordinators**

Jackie White, PhD, President-Elect, Society for the Psychology of Women (Division 35)

Bob Geffner, PhD, President-Elect, Trauma Psychology (Division 56)

**Preliminary Keynote Presenters**

Arun Gandhi, Mary Koss, PhD, Jacquelyn Campbell, PhD, RN, and David Finkelhor, PhD

In addition to the two lead divisions (Divisions 35 and 56) sponsoring the conference, preliminary co-sponsors of this summit are: Robert Wood Johnson Foundation, Centers for Disease Control, International Society for Research on Aggression, and the University of Kentucky's Center for Research on Violence Against Women. The following APA divisions and organizations are serving as collaborators:

- Society for Personality and Social Psychology (Division 8)
- Society for the Psychological Study of Social Issues (Division 9)
- Society of Counseling Psychology (Division 17)
- Rehabilitation Psychology (Division 22)
- Society for Community Research and Action: Division of Community Psychology (Division 27)
- Psychopharmacology and Substance Abuse (Division 28)
- Society for Child and Family Policy and Practice (Division 37)
- Psychoanalysis (Division 39)
- American-Psychology-Law Society (Division 41)
- Family Psychology (Division 43)
- Society for the Psychological Study of Ethnic Minority Issues (Division 45)
- Society for the Study of Peace, Conflict, and Violence (Division 48)
- Addictions (Division 50)
- Society for the Psychological Study of Men and Masculinity (Division 51)
- Interdivisional Task Force on Child Maltreatment Prevention  
National Center on Domestic Violence, Trauma and Mental Health

For additional information and to register for this summit, go to [www.APAviolence.summit.org](http://www.APAviolence.summit.org) or call (512) 845-9059

## Membership Application

### APA Division 37: Society for Child and Family Policy and Practice

I am interested in joining APA Division 37.

Name \_\_\_\_\_

Address \_\_\_\_\_

Membership Status in APA (circle one)    Fellow    Associate    Member    Student    Affiliate

APA Member Number, if applicable (8-digit number on mailing label) \_\_\_\_\_

Fees for Div37 Membership only:     \$35.00 for Members/Affiliates     \$15.00 for Students

I would like to join Div37's Section 1: Child Maltreatment (Note: Membership/affiliation in Div37 is encouraged but not required to join Section 1)

Fees for Section 1: Child Maltreatment Membership only:     \$30.00 for Members/Affiliates     \$20.00 for Students

Fees for Membership in both Div37 and Section 1:     \$65.00 for Members/Affiliates     \$35 for Students

**Please send Application and Membership Fee (U.S. only) made payable to APA Division 37 to:  
Division 37 Administrative Office  
American Psychological Association  
750 First Street, NE  
Washington, D.C. 20002-4242**

Division 37 Administrative Office  
American Psychological Association  
750 First Street, NE  
Washington, D. C. 20002-4242

# Please Recycle

