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Exploring New Paradigms for Evaluation and Service Delivery:

The National Quality Improvement Center on Early Childhood

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This Issue and Why It Matters

This issue of *Zero to Three* focuses on the work of the federally funded National Quality Improvement Center on Early Childhood (QIC-EC) which supported four research and demonstration projects that tested new approaches to preventing child maltreatment of very young children. The authors are from the Children's Bureau, which funded the work; The Center for the Study of Social Policy (CSSP), the lead organization; four research and demonstration projects; and the cross-site evaluation team.

The Adverse Childhood Experience study (ACE; **www.cdc.gov/violenceprevention/acestudy/**) and other research has raised public awareness of the prevalence of adverse childhood experiences and the negative lifelong impact those experiences can have on physical, emotional, and social well-being. Child maltreatment data **www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2012** paint a grim picture for our nation's youngest children, revealing that:

- The majority of child abuse and neglect cases involve children less than 3 years old.
- Those less than 1 year old are at greatest risk, and in fact newborns are particularly likely to suffer maltreatment.
- Almost three quarters of child maltreatment fatalities take place among children less than 3 years old.
- Child maltreatment risk may be heightened among young children with special needs, and maltreatment can cause injury and disability.
- Studies show that one third to two thirds of child maltreatment cases involve substance use to some degree (Child Welfare Information Gateway, n.d.).

This has been the bleak story of the maltreatment of very young children for decades. Even as maltreatment reports are currently trending downward, its disproportionate and severe impact on the youngest children remains stubbornly consistent. From this bleak story a more hopeful one is emerging.

It's a story of identifying family strengths and partnering with families in enhancing and building on those strengths. It's a story of hope and possibility for even the most stressed families: those experiencing maternal substance abuse, those living in poverty and in communities with few resources, and those caring for infants and toddlers with chronic illness and developmental delay and disability. It's a story of focusing on flourishing: well-being for infants and toddlers and increased strength and capacity for their families.

Over a 5-year span the QIC-EC shaped a new way of conceptualizing the primary prevention of maltreatment. The CSSP lead the way, together with partners the National Alliance of Children's Trust and Prevention Funds and ZERO TO THREE. Each of the four grantees designed and evaluated a unique approach to primary prevention and is now disseminating lessons learned and recommendations for future work. The project evaluation team used a developmental evaluation approach to capture the project's process and outcomes. We're excited to share this story with you. We look forward to your questions, comments, and continued partnership in striving for the best possible outcomes for infants, toddlers, and their families. Feel free to contact us at the email addresses below.

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REFERENCE

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***The Journal of Zero to Three* has a new look!** We are pleased to present with this issue the updated design and hope you will find that the Journal is more engaging and easier to read. We welcome your feedback on both our design and content, and look forward to hearing from you.

Stefanie Powers, Editor
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CONTENTS

Exploring New Paradigms for Evaluation and Service Delivery:
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ALSO IN THIS ISSUE

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National Quality Improvement Center on Early Childhood

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ABSTRACT

The National Quality Improvement Center on Early Childhood (QIC-EC) funded four research and demonstration projects that tested child maltreatment prevention approaches. The projects were guided by several key perspectives: the importance of increasing protective factors in addition to decreasing risk factors in child maltreatment prevention efforts, improving adults' capabilities to increase the likelihood of optimal child development, developing effective collaborative partnerships for the successful provision of integrated services, and addressing multiple domains of the social ecology to effect positive child and family outcomes. Also, the QIC-EC's work highlighted the importance of focusing on well-being in maltreatment prevention efforts, exploring the relationship between culture and protective factors, and developing strengths-based parent assessment tools.

The National Quality Improvement Center on Early Childhood (QIC-EC) was established to meet the nation's urgent need to identify and test innovative approaches for reducing the likelihood of abuse and neglect of children from birth to 5 years old. Children in this age group are subject to the highest rates of child maltreatment (U.S. Department of Health and Human Services, 2012) and are at the greatest risk of a variety of immediate and enduring physical, cognitive, language, social–emotional, and psychological problems (Felitti, 2002; Shonkoff & Garner, 2012; Wiggins, Fenichel, & Mann, 2007). Burgeoning research over the last decade in the neurobiological, behavioral, and social sciences has demonstrated the early years of life also offer the greatest opportunity for preventing or mitigating harm from trauma and setting the course for optimal development (Brazelton & Greenspan, 2000; National Research Council & Institute of Medicine, 2000; National Scientific Council on the Developing Child, 2010a; Shonkoff, 2009; Thompson, 2001). These research advances "are catalyzing an important paradigm shift in our understanding of health and disease across the lifespan" (Shonkoff & Garner, 2012, p. 232), including an increased focus on a strengths-based approach to prevention work with children and families as an alternative to a deficits-based model (Blundo, 2001; Leadbeater, Schellenbach, Maton, & Dodgen, 2004).

A Prevention–Promotion Framework

The Center for the Study of Social Policy (CSSP) was funded through a cooperative agreement with the Children's Bureau (2008–2013) to address critical issues about preventing child maltreatment along with two partner organizations—the National Alliance of Children's Trust and Prevention Funds and ZERO TO THREE: National Center for Infants, Toddlers, and Families. Originally called the "National Quality Improvement Center for Preventing the Abuse and Neglect of Young Children", changing the name to the National Quality Improvement Center on Early Childhood called attention to "the gradual—and still partial—shift in the field of child maltreatment" (Paxson & Haskins, 2009, p. 4) toward the prevention–promotion framework that guided the work of the QIC-EC. This framework identified that (a) addressing child maltreatment before it occurs (primary prevention) must be placed within the context of increasing parent capabilities that will promote optimal child development and (b) preventing child maltreatment must also incorporate a focus on both increasing protective factors (see Jargon Buster on p. 60) and decreasing risk factors. Stagner and Lansing (2009) supported this idea of strengths-based primary prevention efforts:

> *Whereas the traditional response aims to prevent a recurrence of maltreatment once it has already taken place…the new framework focuses on strengthening protective factors and building family and social networks to reinforce the ability of parents to care for their children. …Rather than seeking to minimize harm to the child (only), it aims to maximize potential—to strengthen the capacity of parents and communities to care for their children in ways that promote well-being. (p.19)*

KNOWLEDGE DEVELOPMENT, DISSEMINATION, AND INTEGRATION

The goals of the QIC-EC were to expand the knowledge base within the child maltreatment prevention field, disseminate relevant information and data, and promote the integration of lessons learned into practice and policy. Knowledge development centered on selecting and funding four research and demonstration projects from among 41 highly competitive proposals (see Table 1). The research and demonstration projects targeted families of young children (birth to 24 months old) with diverse risk factors for child maltreatment. Each innovative project tested and rigorously evaluated a different evidence-based or evidence-informed approach that supported parents in building the protective factors articulated in the Strengthening Families Protective Factors Framework™, plus one additional factor. A systems-oriented cross-site evaluation was conducted to understand similarities and differences in the four sites' approaches and to identify how norms, infrastructures, policies, and partnerships influenced the implementation and outcomes of their interventions. Both qualitative and quantitative methods were used to build evidence about implementation of a protective factors framework for preventing child maltreatment.

Knowledge development for the field was also supported by funding five advanced-level doctoral student fellows whose dissertation research was focused on primary prevention or promoting child and family well-being in families with young children who are at high risk for abuse, neglect, or abandonment. All fellows successfully completed and defended their dissertations within their 2-year funding period and were awarded doctoral degrees in the fields of child development, social work, or social welfare.

Knowledge dissemination and integration were achieved by facilitating collaborative information-sharing and problem-solving via a number of channels; one of these was a national QIC-EC Learning Network. The QIC-EC Learning Network served as an active mechanism for exchange of information between the QIC-EC and a multidisciplinary group of organizations and individuals who share the commitment to the prevention of child maltreatment and promotion of well-being in young children. More than 100 organizations were represented in the Learning Network. Other dissemination and integration channels included: presentations and facilitated discussions at national conferences; the QIC-EC website; press releases; national prevention partner meetings; Strengthening Families national partner meetings; expert panels that explored relevant topics (e.g., culture and the protective factors); and building consensus among diverse local, state, and national stakeholders in order to foster sustainable, systemic change at multiple levels of the child maltreatment prevention field.

THE QIC-EC NATIONAL ADVISORY COMMITTEE

The overall work of the QIC-EC, as well as the focus of the research and demonstration projects, was informed by discussion and recommendations from a distinguished 16-member National Advisory Committee (NAC). The NAC was comprised of ethnically diverse individuals with extensive knowledge and expertise in multiple disciplines including child development, parent leadership, child welfare, prevention science, and research methodology. The NAC strongly supported the following approaches articulated in the QIC-EC implementation plan: (a) focus on promotion (i.e., increasing protective factors) and prevention (i.e., reducing risk factors); (b) address promotion and prevention in all domains of the social ecology; and (c) require research and demonstration projects to have broad collaborative partnerships, including community-based organizations and parent leaders. The NAC provided three additional recommendations which were fully incorporated into the work of the QIC-EC: (a) integrate scientifically rigorous methodology with professional experience and expertise in the context of families' culture, characteristics, and values; (b) identify alternative ways of documenting the effectiveness of prevention programs, beyond child abuse reports and substantiated cases; and (c) include "well-being" as a key outcome.

TABLE 1. **Research and Demonstration Projects Selected by the National Quality Improvement Center on Early Childhood (QIC-EC)**

Project and Location	Target Population	Interventions
The Family Networks Project (Columbia, SC)	Families of young children with developmental disabilities Project workforce	▪ Stepping Stones Triple P-Positive Parenting Program ▪ *Preventing Child Abuse and Neglect: Parent-Provider Partnerships in Child Care curriculum* (Seibel, Britt, Gillespie, & Parlakian, 2006)
Project DULCE: Developmental Understanding & Legal Collaboration for Everyone (Boston, MA)	Families who seek pediatric care at Boston Medical Center	▪ Medical-Legal Partnership | Boston ▪ Healthy Steps
The Strong Start Study (Denver, CO)	Pregnant women in substance use treatment	▪ High Fidelity Wraparound ▪ Early intervention services
Fostering Hope (Salem, OR)	Families who reside in high poverty neighborhoods	▪ Neighborhood Mobilization ▪ Provision of Comprehensive Services (e.g., home visiting with wraparound supports, parenting education)

The QIC-EC's Guiding Perspectives

The work of the QIC-EC was guided by seven foundational ideas: (a) incorporating characteristics of effective maltreatment intervention approaches, (b) addressing all levels of the social ecology, (c) focusing on childhood, (d) forging collaborations in maltreatment prevention, (e) improving adult capabilities, (f) understanding the nature of risk and protective factors, and (g) integrating the Strengthening Families Protective Factors framework in interventions focused on preventing child maltretament.

CHARACTERISTICS OF EFFECTIVE MALTREATMENT INTERVENTION APPROACHES

Decisions about selecting the QIC-EC research and demonstration projects were guided by lessons learned from the comprehensive literature review conducted during the first year of the QIC-EC. In reviewing evidence-based maltreatment intervention programs for children birth to 5 years old that were rated as "promising" or "proven" by at least one independent review system, Daro, Barringer, and English (2009) identified several common characteristics of effective interventions outlined in Table 2.

A SOCIAL–ECOLOGICAL FRAMEWORK

The CSSP was the QIC-EC's lead organization. Its theory of change affirms the necessity of working at all levels of the social ecology—individual, family and relational, community, societal, and policy—in order to make a difference in the lives of families and children. This theory of change

> *Puts families and children in the center of a multifaceted model that includes building protective factors for families, reducing risk factors for children, strengthening local communities, and connecting all of this to systems change and policy—and infusing it with a fierce commitment to equity across lines of race, ethnicity, and culture. (CSSP, 2013b, para. 3)*

Using a social–ecological framework (see Jargon Buster on p. 60) to guide the work of the QIC-EC was viewed as necessary to expand the scope and reach of efforts to prevent child maltreatment because risk and protective factors exist in all domains of the social ecology (see Figure 1). Thus, a combination of individual, relational, community, and societal factors must be addressed in order to promote healthy child, adult, and family well-being and to reduce the risk of negative outcomes. Daro asserted, "the problem [of child abuse and neglect] and its solution are not simply a matter of parents doing a better job but rather creating a context in which 'doing better' is easier" (cited in Shaw & Kilburn, 2009, p. 7). The research and demonstration projects were required to implement approaches that addressed the individual domain of the social ecology and the context within at least one other domain.

FOCUS ON EARLY CHILDHOOD

Scientists in the fields of neuroscience, pediatrics, and developmental psychology have provided much evidence about early childhood as the period in which the foundation for intellectual, social, emotional, and moral development is established (Munakata, Michaelson, Barker, & Chevalier, 2013; National Scientific Council on the Developing Child, 2010a, 2010b, 2012; Shonkoff, 2009). The QIC-EC focused on families of young children in recognition of not only the window of opportunity presented during this developmental period but also the disproportionate rate at which the youngest children are maltreated (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, 2012; U.S. Department of Health and Human Services, 2012). Wulczyn (2008) asserted "More children start their child welfare careers during infancy than any other period within the span of childhood" (p. 2). The research and demonstration projects tested and evaluated approaches for reducing the likelihood of child abuse and neglect in families with young children (birth to 5 years old) who were at high risk for maltreatment yet for whom there was no substantiated child protective services report.

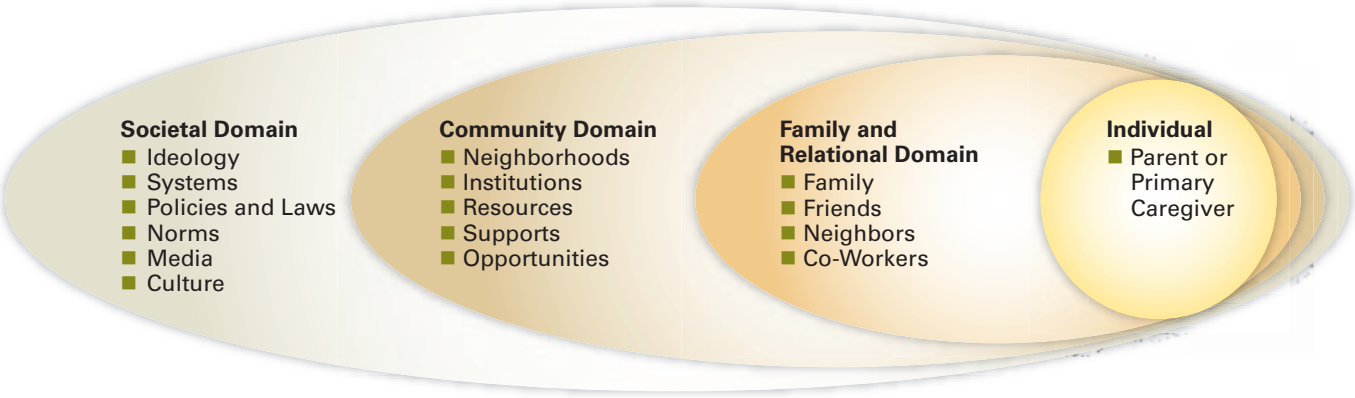
COLLABORATION IN MALTREATMENT PREVENTION

Child maltreatment prevention is much too complex for one organization, agency, or service system to successfully address on its own. Many children and families at high risk for maltreatment have a range of interrelated physical, health, emotional, and educational needs, underscoring the need for multiple, integrated supports. Collaboration among key stakeholders—including community-based organizations and parent leaders—is vital to the effective provision of needed services to children and families, to the success of efforts to prevent child maltreatment efforts, and ultimately to improved outcomes

TABLE 2. **Selected Characteristics of Effective Maltreatment Intervention Approaches**

Characteristic	Meaning
Maintain theoretical integrity	Define the problem, identify measurable goals, and construct a cohesive approach
Target the earliest stages	Maximize the child's early developmental potential
Impact the bi-directional interaction between individuals and their families	Serve children and parents individually and the family as a cohesive unit
Link prevention to the existing local network of social support services	Regard the approach as a new component within a preexisting system
Build relationships	Forge high-quality participant–provider relationships
Offer ongoing support and access to other interventions	Provide a variety of services for child, adult, and community development

FIGURE 1. **Social–Ecological Framework for the National Quality Improvement Center on Early Childhood**



Adapted from the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, (2013)

for young children and families (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, 2013) The QIC-EC's collaboration imperative was guided by Pollard's (2005) view of collaboration as both structure and process. "Collaboration entails finding the right group of people…ensuring they share commitment to the collaboration task at hand, and providing them with an environment, tools, knowledge, training, process, and facilitation to ensure they work together effectively" (p. 1).

IMPROVING ADULT CAPABILITIES

Central to the prevention of child maltreatment and the promotion of child well-being is the capability of the adults who serve as primary caregivers. "Success in this area requires adults and communities to provide sufficient protection and supports that will help young children develop strong, adaptive capacities…. Interventions that focus on adult capacity-building offer promising opportunities for greater impacts on children" (Shonkoff, 2013, para. 6). Although each QIC-EC research and demonstration project tested a different prevention approach, all approaches were designed to improve a target parent's knowledge, skills, or sense of competence that contributes to a trajectory of healthy child development and well-being and to the decreased likelihood of poor outcomes.

RISK AND PROTECTIVE FACTORS

Families are often targeted for child abuse and neglect prevention programs on the basis of various risk factors known to be correlated with child maltreatment such as low maternal age, substance abuse in the household, and domestic violence (Thomas, Leicht, Hughes, Madigan, & Dowell, 2003). Focusing primarily on risk factors to identify families seems appropriate if the goal is to provide services to families most in need; but this strategy has several key drawbacks. First, the prediction of which families may maltreat their children on the basis of identified risk factors is relatively unreliable. The notion of "risk" itself implies both an increased likelihood that maltreatment may occur because of various factors and the possibility of variability in reaction to the same factors (Fraser, Kirby, & Smokowski, 2004). This suggests that many families with child, parent, family, or community risk factors do not actually maltreat their children; other factors operate to mitigate these risks (Fraser, 2004).

Second, several of the commonly defined risk factors (e.g., maternal age or premature birth), are not amenable to an intervention's influence (Ross & Vandivere, 2009). Thus, a prevention program's approach can have only limited impact on reducing the overall risk for a given family. Third, and potentially most important, targeting families according to risk factors may have the unintended effect of discouraging them from participating; families do not want to be labeled as "high-risk" or potential child abusers. This stigmatization no doubt contributes to the difficulty that many prevention programs experience in recruiting families and keeping them engaged once they are enrolled in the program (Daro et al., 2009; Daro & Donnelly, 2002; Olds & Henderson, 1991). The challenge is to normalize prevention strategies so that needs are assessed and relevant supports are provided to all families served (Daro & Donnelly, 2002).

Finally, while risk factors are important in understanding and assessing family conditions that could lead to maltreatment, an exclusive or primary focus on risk factors may interfere with engaging a broad array of partners in child abuse prevention. The orientation of many child- and family-serving programs is to promote healthy physical, social, emotional, and cognitive development; to enhance children's early experiences; and to approach families from a strengths-based perspective, rather than a deficits- or risk-based perspective. A strengths-based orientation is conducive to engaging programs around a resilience framework and helping all practitioners to see how their work can be effective in preventing child maltreatment.

Thus, reducing risks is not enough to increase the likelihood that young children in vulnerable families are on a trajectory to optimal development rather than en route to poor outcomes because of neglect or abuse. Investigating and understanding protective factors are equally as important as researching risk factors. In the context of the QIC-EC, protective factors were conceived as conditions or attributes in individuals, families, communities, or the larger society that both decrease the probability of maltreatment and increase the probability of positive and adaptive outcomes,

even in the presence of risk factors (Fraser et al., 2004; National Research Council & Institute of Medicine, 2000; Thomas et al., 2003).

The Strengthening Families Protective Factors Framework

The focus of the QIC-EC was on the five interrelated protective factors articulated in the Strengthening Families Approach: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children. Although "nurturing and attachment" is regarded as a key component of the development of social and emotional competence in children, this construct was treated as a sixth independent protective factor in the QIC-EC research and demonstration projects. The purpose was to determine psychometrically whether items in the social and emotional competence and nurturing and attachment subscales of a new protective factors research instrument were measuring two distinct constructs or a single construct. The five Strengthening Families Protective Factors and the additional sixth protective factor of focus are described in Table 3.

The Overarching Research Question and Theory of Change

The QIC-EC research and demonstration projects were designed to impact three common outcomes as well as project-specific outcomes. Given the key perspectives described above, the following common research question guided the conceptualization, delivery, and evaluation of the research and demonstration projects: How and to what extent do collaborative interventions that increase protective factors and decrease risk factors in core areas of the social ecology result in increased likelihood of optimal child development, increased family strengths, and decreased likelihood of child maltreatment within families of young children at high-risk for child maltreatment? Table 4 provides the conceptual definitions of the three common outcomes and Figure 2 depicts the QIC-EC theory of change.

TABLE 3. **The Strengthening Families Protective Factors, Plus One**

Protective Factor	Definition
Parental Resilience	Managing stress and functioning well when faced with challenges and adversity
Social Connections	Having a sense of connectedness with constructive, supportive people and institutions
Knowledge of Parenting and Child Development	Understanding parenting best practices and developmentally appropriate child skills and behaviors
Concrete Support in Times of Need	Identifying, accessing, and receiving needed adult, child, and family services
Social and Emotional Competence of Children	Forming secure adult and peer relationships; experiencing, regulating, and expressing emotions
Nurturing and Attachment	Providing parent–child experiences that lay the foundation for a warm, secure bond

Additional Knowledge Development Activities

As the research and demonstration projects were implemented, the QIC-EC leadership team engaged in additional knowledge development activities that addressed two gaps in the prevention field which became more obvious as the research and demonstration projects began their work: cultural considerations and strengths-based assessment tools.

CONSIDERING CULTURE

Considering the culture of the participants in the design and delivery of a maltreatment prevention strategy is essential. Culture has a major influence on parenting beliefs, values, expectations, and practices (Kim & Hong, 2007; Melendez, 2005; Pinderhughes, Dodge, Bates, Pettit, & Zelli, 2000; Spicer, 2010).

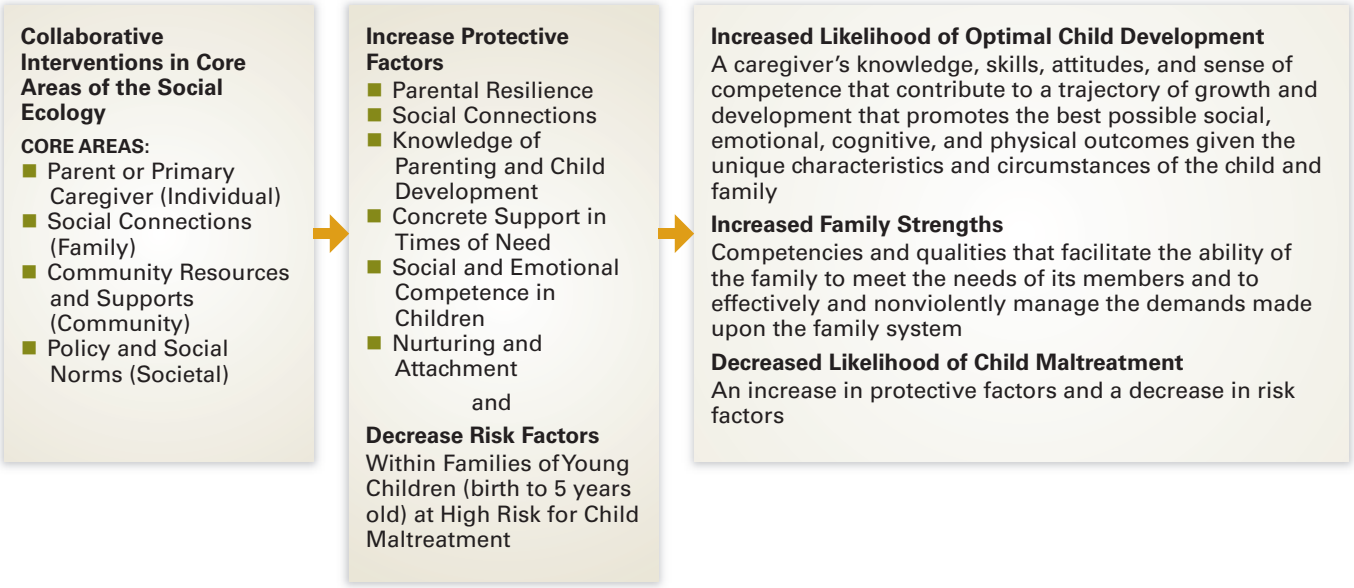
> *Cultural norms and parenting practices play an important role in how children are raised. They influence what values parents teach their children, what behaviors are considered appropriate, and which methods are used to teach these values and behaviors. Cultural norms can influence the acceptance, delivery, and/or effectiveness of healthy parenting programs or interventions. (Lubell, Lofton, & Singer, 2008, p. 3–4)*

Integrating cultural considerations into program planning decisions must go beyond the typical "culturally sensitive" practices of "delivering services in a participant's primary language, matching participants and providers on the basis of

TABLE 4. **Common Outcomes and Definitions**

Outcome	Definition
Increased Likelihood of Optimal Child Development	A caregiver's knowledge, skills, attitudes, and sense of competence that contribute to a trajectory of growth and development that promotes the best possible social, emotional, cognitive, and physical outcomes given the unique characteristics and circumstances of the child and family
Increased Family Strengths	Competencies and qualities that facilitate the ability of the family to meet the needs of its members and to effectively and nonviolently manage the demands made upon the family system
Decreased Likelihood of Child Maltreatment	An increase in protective factors and a decrease in risk factors

FIGURE 2. **QIC-EC Theory of Change**



race and ethnicity, and incorporating traditional child rearing practices into a program's curriculum" (Daro et al., 2009, p. 11). Tervalon and Murray-Garcia (1998) asserted that in order for those who serve racially, ethnically, linguistically, and culturally diverse young children and their families to be more effective and respectful, they must also conscientiously practice cultural humility. Cultural humility entails active self-reflection and critical consciousness of one's own assumptions, beliefs, values, and worldview (California Health Advocates, 2007; Tervalon & Murray-Garcia, 1998; Wear, 2008). Cultural humility shifts the focus of understanding from other people to self-awareness.

> *Cultural humility is an acknowledgement of one's own barriers to true intercultural understanding.... Knowing that one's own perspective is necessarily limited makes it much easier to be reflective and proactive in relation to one's prejudices and assumptions that may otherwise affect interactions with members of a different culture.... Approaching each encounter with the knowledge that one's own perspective is full of assumptions and prejudices can help one to keep an open mind and remain respectful of the person seeking care. (Unite for Insight, 2013)*

CULTURAL CONSIDERATIONS AND THE STRENGTHENING FAMILIES PROTECTIVE FACTORS

The QIC-EC leadership convened a consultative meeting with a group of 16 racially and ethnically diverse professionals with expertise in cultural studies, psychology, mental health, social work, education, child welfare, and parent leadership. The purposes of the consultative meeting were to (a) lay the foundation for future study regarding the cultural understandings and manifestations of the Strengthening Families protective factors and (b) identify critical questions, methodological strategies, and cautions in the conduct of such a study.

The Strengthening Families Protective Factors framework was designed as an approach, not as a model, to allow for diversity in implementation in different service settings as well as different cultural contexts. In addition, the framework was intended to delineate protective factors that are relevant across cultures with respect to describing conditions or attributes that mitigate risk factors—whether mild or severe—and actively enhance well-being in all families. This intent, however, has not been adequately investigated; so questions about the universality vs. cultural specificity of the Strengthening Families protective factors remain.

As advised during the QIC-EC consultative meeting on culture and the protective factors, the first step in addressing this issue is understanding the nature of "culture." Hall (1976) conceived culture as comprised of both surface structure elements (e.g., a group's music, traditions, style of dress) and deep structure elements (e.g., a group's worldview, values, beliefs). Using this perspective, it may be hypothesized that the protective factors are universal, in that they apply to all families, yet may be understood (deep structure) and manifest (surface structure) in culturally specific ways. Testing the assumption about the dual universality and specific cultural understandings and manifestations of the Strengthening Families protective factors is an important next step.

THE NEED FOR A STRENGTHS-BASED ASSESSMENT INSTRUMENT

At the outset of the QIC-EC, the leadership team found that although there were various instruments that included measurement of indicators of some of the Strengthening Families protective factors, there was not a single instrument that was designed to measure the presence, strength, and growth of all five factors. In addition, many parent assessment tools reviewed by the QIC-EC leadership focused on the identification of problems and weaknesses. An emphasis on deficits obscures the

recognition of a parent's strengths and capabilities that could serve as resources for addressing family challenges and crises. Thus, a new instrument, called the Caregivers' Assessment of Protective Factors (CAPF), was developed for preliminary use by the research and demonstration projects. The CAPF was designed to measure the extent to which parents acknowledge beliefs, feelings, and behaviors identified through expert consensus as indicators of the six protective factors of focus in the QIC-EC research and demonstration projects.

Using the 673 CAPF pre-test cases from the QIC-EC research and demonstration projects, exploratory factor analyses and reliability analyses were conducted in order to refine definition of the CAPF subscales. A significant finding was that the items in the Social and Emotional Competence of Children and Nurturing and Attachment subscales were measuring a single construct. Thus, it was not necessary to treat "nurturing and attachment" as a separate protective factor subscale because items about parental nurturing to foster a secure parent–child attachment were included in the Social and Emotional Competence of Children subscale.

On the basis of these analyses and in recognition of the fit between building the Strengthening Families protective factors and the nature of strengths-based assessment, initial revisions were made to the CAPF.

Epstein (2004) emphasized the importance of developing interventions and service plans based on individual and family strengths. He defined strengths-based assessment as "the measurement of those emotional and behavioral skills, competencies, and characteristics that create a sense of personal accomplishment; contribute to satisfying relationships;. . . enhance one's ability to deal with adversity and stress; and promote one's personal, social, and academic development" (p. 4). The validation and publication of the CAPF as a strengths-based instrument is one of the significant products of the QIC-EC.

A Zeitgeist for the Work of the QIC-EC

The work of the QIC-EC occurred during a 5-year period in which advances in the fields of neuroscience, developmental psychology, prevention science, public policy, and pediatrics burgeoned. These advances have contributed to a paradigm shift in understanding the developmental impacts and pathways of health, trauma, and disease and disorders (Shonkoff & Garner, 2012), including "the recognition of the need to improve well-being as a central focus of child welfare's work" (Center for the Study of Social Policy, 2013a, p. 1). Understanding more about these advances presented an opportunity for QIC-EC leadership to integrate research on early brain development, trauma, toxic stress, infant mental health, trauma-informed care, and executive functioning into the Strengthening Families Protective Factors framework (Center for the Study of Social Policy, 2013c).

The paradigm shift in understanding health and disease across the lifespan also provides support for the perspectives that guided the work of the QIC-EC: in particular, the importance of understanding the characteristics and processes of protective factors and of promoting the well-being of adults in the family system as a defining pathway to child well-being.

> *Advances in the biological and behavioral sciences provide tremendous opportunities for policymakers, researchers, practitioners, and philanthropists to transform the way they think about helping vulnerable children and their families. By building the skills and capacities of adult caregivers, creative new interventions could aid children whose developmental needs are not being met (Shonkoff, 2013, para. 11).*

It is the hope of the QIC-EC leadership that the overall perspectives and work of the QIC-EC, as well as the project-specific results and the cross-site evaluation results from the four innovative approaches, will contribute to a shift in thinking about the interconnected goals of the prevention of child maltreatment and the promotion of healthy child and family development and well-being.

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Project DULCE: Strengthening Families Through Enhanced Primary Care

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ABSTRACT

Project DULCE (Developmental Understanding and Legal Collaboration for Everyone) integrated the Strengthening Families approach to building family protective factors into routine health care visits for infants in a primary health care setting. The core collaborators—Boston Medical Center pediatric primary care, the Medical-Legal Partnership | Boston, and Healthy Steps—contributed to the DULCE collaborative care model, which emphasized concrete supports and improving parent knowledge of child development and parenting. The intervention was delivered on a universal basis and demonstrated an efficient, cost-effective way to reach families at risk because of economic hardship, making the approach suitable for widespread replication.

Pediatric primary care offers a powerful opportunity for incorporating child development information, family support, and assistance with concrete needs for infants and their families into routine health care visits. Change is constant during the first year of life with a newborn, for both baby and parents. The birth of a baby changes the family—there are new routines; new roles in the family; new equipment to manage; perhaps new housing or different employment status. The pediatric team can be a powerful ally in identifying and supporting changes that the family makes for their new baby.

Parents routinely seek information and support from the new baby's health care team during routine health care visits (formerly referred to as "well child visits"). The timing and frequency of those early routine health care visits builds on parental trust which can both support their own motivation to make the

changes and empower them within family and informal support structures (e.g., "the doctor says…"). Federal and state health care legislation has made it possible for the vast majority of families to access pediatric primary care services. As a result, pediatricians are the first and often the only professionals to interact with the family, to monitor how the baby is growing and developing throughout the early years, and to keep track of family dynamics and the parent–child relationship.

Project DULCE

Pediatric care is nonstigmatizing (with no identifying entrance criteria) and provides the right time (early infancy) and right place (health care has a high trust factor) for providing family support to new families. Project DULCE (Developmental Understanding and Legal Collaboration for Everyone), was a collaboration between the pediatric primary care clinic at Boston Medical Center (BMC), the Medical-Legal Partnership | Boston (MLP), and Healthy Steps for Young Children (Zuckerman, Parker, Kaplan-Sanoff, Augustyn, & Barth, 2004). DULCE family specialists and pediatricians served as a team, with joint routine health care visits that began with the first visits after nursery discharge until the baby's 6-month checkup. In addition, the family specialist offered developmental screening for the children, risk and protective factor screening and support, and home visits as well as other contacts in person, and by phone, email, and text.

Project DULCE integrated the Strengthening Families approach (see Jargon Buster on p. 60) to building family protective factors (Center for the Study of Social Policy, 2014; Schorr, 1997) into routine health care visits for infants in a primary health care setting. The Strengthening Families approach seeks to reduce the risk of child abuse and neglect by supporting key family strengths. These strengths include: parental resilience, parent knowledge of child development and parenting, concrete support in times of need, social connections, and social and emotional competence of children. These factors also contribute to secure attachments between parents and their infant. The DULCE intervention paid particular attention to parental knowledge and skills, helping families obtain the concrete supports they needed, and fostering secure attachment.

BMC

BMC provides pediatric primary care for an ethnically diverse population of more than 11,000 children, most of whom are poor. Similar to most U.S. pediatric practices, routine health care at BMC is based on the Bright Futures guidelines (Hagan, Shaw, & Duncan, 2008) developed by the Maternal and Child Health Bureau in collaboration with the American Academy of Pediatrics. Bright Futures recommends five routine visits by the time a child is 6 months old: within 1–2 weeks post nursery discharge, and then at 1, 2, 4, and 6 months old. The Bright Futures outline of the content of anticipatory guidance includes conveying information that assists parents in a broad range of topics. Recommended topics include injury and violence prevention, sleep issues, nutritional counseling, and fostering optimal development. Bright Futures further highlights

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Change is constant during the first year of life with a newborn, for both baby and parents.

parental well-being, infant behavior, growth and development, and parent–child relationship issues as salient factors for pediatricians to address during well-child visits in the first year of life (Hagan et al., 2008).

HEALTHY STEPS FOR YOUNG CHILDREN

DULCE collaborative care was based on the experience of the Healthy Steps program, an evidence-based model of care implemented across the country, and one of several evidence-based Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting programs. Developed as an approach to provide developmental information and parenting support through primary care pediatrics for families with infants and young children, Healthy Steps reinforces the ability of primary care to address the physical, emotional, and intellectual growth and development of children from birth to 3 years old (Kaplan-Sanoff, 2001).

Healthy Steps expands the child health care model to include a new member of the team—the Healthy Steps specialist—who enhances knowledge of child development and parent support through joint routine health care visits, home visits, and telephone support (Kaplan-Sanoff, Lerner, & Bernard, 2000). Specialists co-manage families with pediatricians, ensuring that the practice has the time and expertise to address each family's needs. Healthy Steps practices use a team approach, with both the pediatrician and the specialist interacting in the exam room at routine visits (Zuckerman, Parker, Kaplan-Sanoff, & Young, 1997). The specialist "holds the family in mind," maintaining a connection with families between routine health care visits. She provides continuity by calling the family to check in or by arranging a home or an office visit. Addressing such common topics as eating, sleeping, and crying during the first months of life can offer the possibility of exploring the parents' "ghosts" (Fraiberg, Adelson, & Shapiro, 1975) and "angels in the nursery" (Lieberman, Padrón, Van Horn, & Harris, 2005; Zuckerman &

Zuckerman, 2005). By offering a home visit, the specialist can use "kitchen therapy" (Fraiberg, 1987) to provide support within the comfort and familiarity of the family's home while also observing the family's daily routines. The role of the DULCE family specialist is based on the Healthy Steps specialist

This team approach offers families enhanced routine health care visits which emphasize the promotion of children's development (Kaplan-Sanoff, Zuckerman, & Parker 1998). Initial 3-year data indicated that the quality of pediatric care in the first 3 years of life was dramatically improved by changing the structure and process of pediatric care to support family strengths (Minkovitz et al., 2003). Families involved in the Healthy Steps program were more likely than non-participating families to:

1. Discuss concerns such as the importance of routines, discipline, language development, child's temperament, and sleeping patterns.
2. Use more positive and less harsh discipline strategies (i.e., avoid yelling, threatening, slapping, or spanking their child).
3. Tell someone in the practice when they are feeling sad or blue.

From the perspective of promoting healthy parenting, Healthy Steps helps parents better understand their child's behavior and development, thereby producing more favorable disciplinary practices and decreasing potential child abuse.

Healthy Steps specialists also offer screening and effective strategies for addressing adult mental health concerns which have been shown to impact child development outcomes (Center on the Developing Child at Harvard University, 2013). Healthy Steps mothers who had signs or symptoms of depression were 1.6 times more likely to report that they had discussed feeling sad with someone in their Healthy Steps practice (Minkovitz et al., 2003). A follow-up study when the child was 5.5 years old confirmed the initial findings reported when the children were 3 years old; Healthy Steps significantly changes the course of parenting for many parents enrolled in the program (Minkovitz et al., 2007). More recently, a study (Buchholz & Talmi, 2012) showed that Healthy Steps families were more likely to have addressed language development, social skills, importance of play, daily routines, sleep, healthy eating, temperament, parental feelings including postpartum depression, home safety, and breastfeeding during primary care visits than were controls. These discussions support the Strengthening Families Protective Factors of parental resilience, knowledge of child development, and social–emotional competence in children.

ROLE OF THE MLP

In order to best support the concrete needs of the diverse low-income population served, DULCE partnered with MLP, a national model that partners lawyers with health care teams in order to address patients' legal needs. MLP | Boston is the founding site of the national MLP network (now operating in nearly 300 health care settings across the U.S.) and a technical assistance leader in New England. The MLP model has been endorsed by, among other organizations, the American Medical Association and the American Bar Association.

The MLP model recognizes that many low-income, medically vulnerable patient-families need legal care to get and stay healthy. The family stress model (see Figure 1) illustrates the links between poverty and hardship and subsequent child maltreatment. Families who experience hardship in accessing the basic necessities of life such as food, shelter, heat, education, and health care are subjected to great stress. As one example, in winter many families who live in cold climates are forced to decide whether to "heat or eat." As a result, many poor children experience slow growth during the winter months (Frank et al., 2006). Economic stress in turn increases the risk of harsh parenting styles and intrafamilial conflict. Brain research from the Center on the Developing Child (2013) suggested that the impact of neglect on young children over time is more detrimental to their brain development than other forms of child abuse. MLP support serves to help optimize concrete supports (e.g., housing subsidies, utilities protection, and access to food) for families.

The role of a family's social context in determining a child's health status is becoming better understood (Robert Wood Johnson Foundation, 2011). At the foundation of MLP | Boston's work is the evidence-based premise that social determinants of health can be as impactful as biologic factors that predispose people to disease and functional limitations. Housing opportunity, educational opportunity, employment opportunity, environmental quality, poverty concentration, racial segregation, and numerous other social and environmental factors contribute to poor health. Many of these social problems can be addressed through legal advocacy. Sometimes it takes a legal advocate to provide comprehensive care to an individual or family whose housing conditions are causing health problems (e.g., asthma) or exacerbating chronic disease (e.g., sickle cell anemia). MLP | Boston partners with health care teams and supports them in screening, identifying, and referring patients' health-harming legal needs. It also facilitates free legal assistance for patients through a range of partners, including 20 law firm and in-house pro bono partners.

One clear example of a legal problem that can threaten a child's well-being focuses on a child born in this country to immigrant parents. Although the child is a legal U.S. citizen entitled to benefits, it is not unusual for household members' immigration-based eligibility to be misconstrued and the family's benefits to be miscalculated resulting in either a denial of food stamp benefits or an inappropriately low benefits award. Simple legal advocacy can reverse the erroneous determination and ensure that benefits are awarded retroactively, allowing the family the support needed to feed their child.

Project Background and Rationale

Project DULCE combines the reach and retention of primary health care for infants with the goals and strategies of universal home visiting. Almost all infants in the U.S. are seen for primary care. According to the Annie E. Casey Foundation (2012), by the

year 2010, 92% of American children had some form of health insurance. The implementation of the Affordable Care Act suggests that this number will rise, making virtually all American children eligible for health care. Federal data showing that more than 80% of U.S. children have received recommended immunizations by 3 months old demonstrates the widespread reach of routine health care for infants (Centers for Disease Control & Prevention, 2012).

Public policy in the U.S. provides families access to health care. Both public policy and social norms in this country encourage families to bring their children in for routine health care. This is expressed through multiple policies that affect young children. For example, health care providers must sign off on forms for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) program, and immunization records are required for registering in early childhood education, child care programs, and public schools. Because routine pediatric care is such an important and universal component of caring for young children, it stands in contrast to the perceived stigma that may be attached to other efforts to reach high risk families.

As described in Bright Futures, there are five routine well-care visits for infants from birth to 6 months old. This combination of reach and multiple scheduled interactions presents an opportunity to develop an efficient, low-cost method of reaching infants and their families.

The Strengthening Families approach to building family protective factors (Center for the Study of Social Policy, 2014; Schorr, 1997), which emphasizes the promotion of optimal child development and parental resilience, is compatible with the universal aspect of health care. All families benefit from support for protective factors as well as screening for and addressing risk factors. DULCE family specialists engaged families in formulating and achieving their own goals in raising their children, while screening for social risk factors which impact child development.

Routine primary care provided by the DULCE team of pediatricians and family specialists capitalized on the convenience of being able to reach families during the first 6 months of a baby's life through frequent scheduled routine health care visits. In doing so, it integrated family support into this period which is known to be one of high risk for severe or lethal child abuse. National data from 2011 suggested that most child maltreatment deaths occurred during the first year of life, and most of those during the first 6 months. Abusive head trauma, the most common form of lethal child abuse, peaks prior to 6 months old. With this background, Project DULCE set out to leverage the social support, reach, and intensity of pediatric health care with focused interventions based on evidence-based practices in home visiting and support programs.

FIGURE 1. **Link Between Poverty and Child Maltreatment**

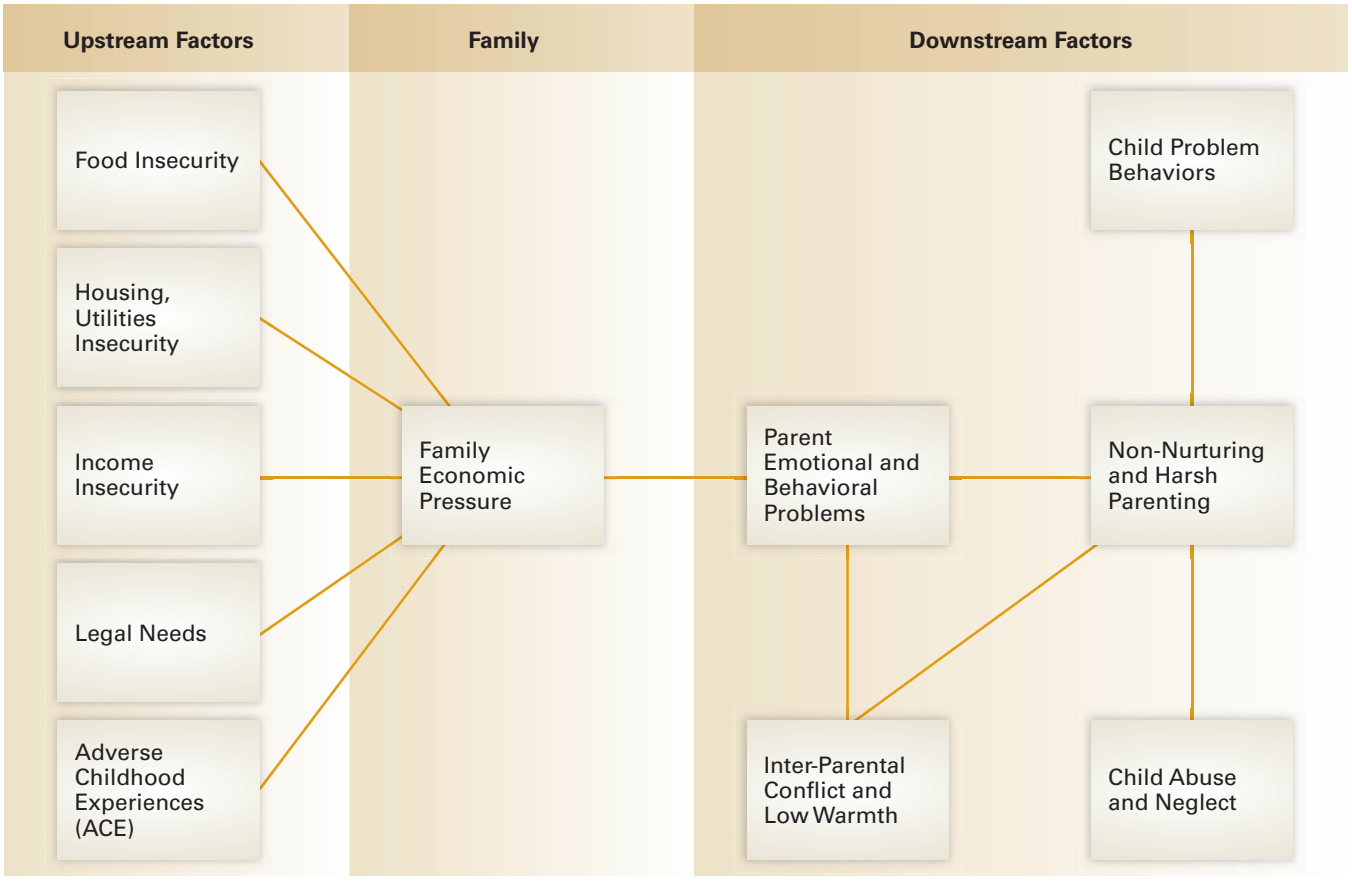

Photo: iStockphoto.com/michaeljung

Both public policy and social norms in this country encourage families to bring their children in for routine health care.

IMPLEMENTATION

Project DULCE was a research and demonstration project conducted within the pediatric primary care clinic at BMC. BMC, similar to other clinics affiliated with urban teaching hospitals, serves a largely poor population. During the time of the study, approximately 80% of the families seen at BMC received health care through Medicaid, Medicaid-managed care, or state-subsidized child health insurance.

Many similar settings—both academic health centers and community health centers—around the country provide primary health care for children living in poverty who experience considerable economic stress. DULCE family specialists worked to support family strengths in these low-income families. The Strengthening Families approach suggests that improving concrete supports and increasing parent knowledge are key elements of a strategy to preventing neglect and abuse of very young infants at a time when they are most vulnerable to the devastating effects of child maltreatment.

The project was evaluated using a randomized controlled trial design; results of the evaluation are currently being prepared for publication. The DULCE evaluation team recruited all families with healthy newborns who were receiving their pediatric routine health care at BMC. Those with significantly premature babies, those who received primary care in languages other than English or Spanish, and those with child protective services involvement were not recruited. Families were randomly assigned to either the intervention or control group after consent. Control group families receive standard, high-quality health care delivered by a BMC pediatrician and further instruction and support in safe sleep and safe transport.

The DULCE intervention goals focused on three protective factors within the overall Strengthening Families approach: (a) helping parents develop knowledge of child development and parenting, (b) increasing parental resilience through advocacy and growing feelings of parental competence in caring for their child, and (c) improving parents' access to concrete supports. With specialized training and support from MLP staff, the family specialist was able to guide families seeking information and assistance related to concrete supports such as housing options, food resources, utility service, child care, maternal mental health and employment. The core intervention included:

- Joint health care visits with the DULCE family specialist joining the family and pediatric team for each routine visit at 2 weeks, 1 month, 2 months, 4 months, and 6 months old.
- Home visits offered to each family. These visits, based on the home visit protocols of the Healthy Steps program for a newborn home visit, allowed the family specialists to interact with the mother and child in their own environment and conduct and discuss the child development and screenings for family risk and protective factors. Mothers often felt more comfortable interacting with their babies in their home settings and were more open to discussing their concerns about their child or their family in a private setting. Those families who were experiencing a crisis were offered—and usually accepted—more home visits, on the basis of the intensity of their need.
- Developmental screening for the infants and screening for concrete supports and protective and risk factors for the families. The family specialist administered a screening focused on the need for concrete supports, such as food and housing, and on parental risk and protective factors, such as maternal mental health, community affiliation, and exposure to violence; 20 families were identified who had particularly intense needs for assistance.
- Telephone, email, and text message support by DULCE family specialists. Many of the families used these methods of interacting with the family specialist, either to get questions answered or to follow-up after a visit to discuss topics in more depth.
- Ensure continuity of needed services. When the child was 6 months old, the family specialist ensured that the family was engaged with their primary care team and any other ongoing services at BMC or in their neighborhood, as necessary, including WIC, housing wait lists, utility shut-off protection, early intervention, and child care.

DULCE FAMILY SPECIALISTS

The DULCE family specialists delivered the intervention to each family. Recruitment and training of the family specialists was key to the project.

Recruitment

The intervention's efficacy rested on the training and skills of the family specialists. DULCE recruited highly competent child development specialists with master's degrees in child development, social work, or child life to team with the pediatricians to implement the program. Family specialists were chosen for their academic knowledge, clinical skills, ability to work in a complex setting, and ability to work as part of a team caring for a diverse group of low-income families.

Training

Extensive training, described in detail in the online implementation manual (Project DULCE, 2013), ensured that families could rely on the DULCE family specialists for entry into a comprehensive network of support that assisted the family in

adapting to the needs of their infant and extended family. Family specialists attended an intensive 1-day MLP | Boston training designed to teach non-legal professionals how to advocate for families regarding benefits and services they were eligible for and how to respond when families were denied or cut off from benefits. Training continued through consultation with the MLP paralegal or attorney who either guided the family specialist on the next step of the process or who contacted the family directly. Initially, the family specialist needed to consult on a regular basis with MLP staff regarding housing, child care, utilities, and other needed services. This individual coaching both allowed the family specialist to deliver an informed service to better assist families in their unique needs and provided ongoing training so that they were soon able to address common issues with less direct MLP support.

Family specialists were also trained by the Healthy Steps national project director in the Healthy Steps approach. They received additional training in the Fussy Baby approach from the National Fussy Baby Institute at Erikson Institute; Neonatal Behavioral Observation (NBO; Brazelton & Nugent, 1995), which was used during the newborn home visit; and the Strengthening Families approach. In addition, they attended in-service training on working with families struggling with domestic violence and addiction. These trainings allowed the family specialists to support families who were struggling with extremely fussy babies or mothers who were impacted by familial violence, addiction, or both. Many of the BMC pediatricians had already participated in an earlier Healthy Steps training, so they were prepared to co-manage families with the family specialist.

Supervision and Support

DULCE family specialists met weekly with the core clinical team of lead pediatricians, family specialists, and directors of Healthy Steps and MLP for case review. These regular meetings allowed the team to discuss cases, address concerns, and share best practices. Supervision was delivered in a group setting, as well as in one–to-one interaction, especially at the beginning of the intervention. Clinical supervision provided an opportunity to think about the family specialist's, child's, and parent's feelings, thoughts, and actions, and put in practice the reflective function; providers' reflective skills (listening, observing, responding, and wondering) can be a key element of change in parent–professional relationship (Tomlin, Sturm, & Koch, 2009). Reflective function in parents is central to the formation of secure infant attachment and can be supported through the parallel process in relationships by providers' safe and trusting relationships with parents (Fonagy, Gyorgy, Jurist, & Target, 2005). On one occasion, a family specialist needed to assist a family in the emergency room because the 2-month-old had a high fever and the mother was alone with the child at the hospital. The family specialist addressed the mother's distress and anxiety and helped her calm down and feel confident about the staff that was assisting her child. Through this intervention, the mother was then able to comfort and calm her baby and focus her attention on her baby's needs at that moment.

Interventions such as these were possible because the family specialists had been trained and mentored by their supervisor on reflective skills and how to apply them in the interaction with families.

Evaluation Findings and Implications

The research and demonstration project was designed to assess the feasibility and effectiveness of the DULCE model. First and foremost, the project demonstrated the feasibility of this approach. It can be implemented without disrupting the clinic's basic workflow by having the family specialist meet with families while they are waiting to see the pediatrician. This allowed their services to fit within the typical 1 hour that families spent at the clinic for each routine health care encounter and the careful planning engaged the pediatricians' enthusiastic support for infusing DULCE into the clinic. Second, the families accepted the project. Although our team had some concerns that families would find it too invasive, our data demonstrated that the dropout rate was slightly lower in the intervention (8.4%) than in control families (12.8%), demonstrating family acceptance of the DULCE intervention model.

Families sought out the support of their DULCE team. DULCE intervention families generally received the recommended intervention; all but one received at least one joint visit with the pediatrician and family specialist during a routine health care visit. Optional home visits were offered to every family; over half had at least one home visit. Families and family specialists connected through a variety of means: 97% of families engaged with the family specialist through phone calls, 39% met in person outside of a health care or home visit, 31% exchanged text messages, and 29% communicated through email.

The following themes emerged from a review of 20 individual participants who had the most intense interactions with the DULCE family specialists. (See box Case History: How DULCE Supported John's Family for one family's story).

1. Many of these mothers had recent experience with intimate partner violence. Family specialists supported mothers in a variety of ways, including improving access to concrete supports, improving connections to domestic violence advocates who helped families develop a safety plan, and discussing the relationship between infant crying and family stress.
2. Many families faced challenges due to concerns about the immigration status of one or more members. In one particular situation, the mother's immigration issues

Learn More

Project DULCE
www.bmc.org/Project-DULCE.htm

Medical-Legal Partnership
www.medical-legalpartnership.org

Medical-Legal Partnership | Boston
www.mlpboston.org

Healthy Steps for Young Children
www.healthysteps.org

Fussy Baby Network
www.erikson.edu/fussybaby

Case History: How DULCE Supported John's Family

The Project DULCE (Developmental Understanding and Legal Collaboration for Everyone) family specialist met baby John and his parents, Cynthia and Robert, at his 1-month routine health care visit when he was 22 days old. Cynthia and baby John lived in a shelter in the Boston area. Robert lived in a halfway house. Although they did not live together, Cynthia reported that Robert was supportive and involved. She also reported other social connections, such as support from some of Robert's family in the area, and some connections to concrete supports. The family was already enrolled in the Women, Infants, and Children (WIC) nutrition program and they received food stamps and cash assistance; they had a housing advocate and case worker provided by the shelter. Yet during the income screening the family specialist learned that the family still had some concerns about food insecurity and information was provided about the Boston Medical Center food pantry and other food pantries in the area. The family specialist followed up by phone between John's 1- and 2-month routine health care visits.

At the 2-month routine health care visit both parents came to the appointment again. Cynthia asked some appropriate questions about baby John's development. She also demonstrated knowledge of John's development, saying that she sees him doing a lot of things she didn't think would happen yet. For example, she reported she talks to him a lot and was noticing he was responsive to her vocalizations and beginning to smile. In addition to information about child development the family specialist followed up with a housing and utilities screening and learned that the family is waiting to see if they would receive a section 8 housing voucher. They also asked for assistance in accessing a pack n' play for safe sleep, as well as clothing and books for John. The family specialist made a request for these donations through the local Cradles to Crayons organization. During the 2-month routine health care visit, the family specialist offered a home visit to continue the discussion about John's development, tummy time strategies, and mother's concerns about spoiling. Cynthia eagerly accepted the offer.

The first two home visits were focused on child development and family support. During the first visit Cynthia spoke openly about how she thought John was doing, she noted new skills she observed, and she discussed her concerns about sending John to child care when she went back to school in September.

At the second home visit, Cynthia invited the family specialist to her room, where she had set up a small area on the floor with a child's play mat and some toys. The family specialist sat on the floor with her and observed John on his tummy. As they watched him, the family specialist asked questions about his development using the *Ages and Stages Questionnaire* (Bricker, & Squires, 2009) as a tool to guide the conversation. After a lengthy discussion about John's developmental accomplishments, the family specialist provided some strategies to use to continue to promote his development. Cynthia reported that John's father continued to see them frequently but she also felt like she had less family support than she had when John was first born. The family specialist encouraged Cynthia to think about a person she could call when she needed to take a break, and she was able to identify a cousin with whom she tries to go to the gym regularly.

Although one or two home visits were a typical part of the DULCE intervention, this family received three because the mother requested a third visit to follow up on concerns of social isolation and increased levels of stress associated with parenting that were expressed during a routine health care visit. Cynthia was starting to open up more with the family specialist as she gained trust in that relationship. The family specialist determined one more visit would be appropriate as the discussion was changing from observations of child development to other more sensitive family concerns.

At the third home visit Cynthia shared that a Department of Children and Families case that she hoped would go away was still open. She disclosed information about the domestic dispute that led to the department's involvement and also discussed the effects of Robert's alcoholism and mental illness on their relationship. Cynthia reported high levels of stress over concern for how best to care for and provide a safe environment for her child. The family specialist provided support for Cynthia during the visit and gave her information about counseling programs as the mother admitted she was feeling very overwhelmed. After this visit, the family specialist consulted with John's pediatrician, Boston Medical Center social workers, and the Medical-Legal Partnership about all the concerns Cynthia had raised during the home visit. The family specialist continued to have frequent communications with Cynthia to provide her with the information gathered from Medical-Legal Partnership, as well as information for a safety and support advocate line and the National Domestic Violence Hotline.

In the next 3 months that the family specialist and the family worked together, Cynthia continued to show great strength and resilience. While starting a job training program, sending John to child care for the first time, and dealing with crises in her relationship with Robert, she was also able to find an apartment to move into with her son using her newly obtained section 8 voucher. The family specialist continued to provide support and resources through phone conversations and meetings at routine health care visits. The family specialist provided Cynthia with information about utility shut-off protection and a fuel assistance program for her new apartment.

Although most parents take their new babies to the pediatrician for health care, few experience the intense and varied support that this fragile family received through DULCE. Although John's health and development were following normal developmental lines, his family, particularly his mother, was facing multiple stressors that increased the risk for an inappropriate parent–child relationship and for maltreatment. Although it was a time-limited intervention, the DULCE team supported Cynthia during a critical time in her life, as she navigated the transition to new parenthood, handled a volatile and troubled intimate partner relationship, strengthened her social support network, and found stable housing. These achievements allowed her to pursue her educational goals, moving her further toward her goals of economic self-sufficiency.

made her so despondent that she told the family specialist that she was considering suicide. The family specialist intervened by linking her with legal support for immigration issues and personally accompanied her to an emergency mental health intake. Fortunately, by the end of the study, the situation had resolved; the mother was feeling emotionally stable and able to move to another community where she had more family support. Another immigrant mother qualified for refugee status and was assisted in linking with specific supports for individuals seeking asylum in the U.S.

3. Many mothers lacked adequate education. In the high-intensity cases, the family specialist linked mothers to GED programs and English as a Second Language programs and helped them obtain child care to allow them to continue their education. Furthermore, these cases often involved the use of other formal and informal supports, and often involved other family members. For example, after the family specialist referred the infant's older sibling, a child with language delay, to an early intervention program, the child's mother asked for help with a referral for herself to the Massachusetts adult literacy hotline. In another case, the family specialist helped the grandmother enroll in an English as a Second Language program.

Pediatric primary care settings offer an ideal environment on which to scaffold programs that use relationship-based practice to strengthen families, prevent maltreatment, and optimize development. As one of the mothers commented, "It's amazing the services you can get just by coming to your daughter's physician…First, he referred me to you [family specialist]. Then you have connected my family to several services we needed. And [they] are also connecting me with other services…but everything started just by going to an appointment with my daughter's physician." As the DULCE model demonstrates, it is possible to deliver exceptional quality child development information and family support to high-risk families in a cost-effective approach and without stigma.

[illegible], is associate professor of pediatrics, Boston University School of Medicine, and national director of Healthy Steps. Dr. Kaplan-Sanoff has trained more than 75 sites nationwide to implement Healthy Steps in pediatrics and family medicine. She is the child development coordinator for Project DULCE and has been responsible for the adaptation of Healthy Steps in many communities. She is also involved in training pediatricians, pediatric residents, and fellows in child development and infant mental health.

[illegible] MD, PhD, is a professor of pediatrics at Boston University School of Medicine and director of the Division of Family and Child Advocacy at Boston Medical Center. He is a national leader in developing a health care approach to the prevention of violence and abuse and is a member of the American Academy of Pediatrics' Committee on Child Abuse and Neglect, a senior fellow at the Center for the Study of Social Policy in Washington, DC, and a board member of Prevent Child Abuse America.

[illegible], is executive director of Medical-Legal Partnership | Boston (MLP | Boston), the founding site of the national MLP network. She previously served as deputy director and staff attorney at Medical-Legal Partnership for Children, the precursor organization to MLP | Boston that housed both national and local programs and focused on pediatric populations. Ms. Morton is a national expert on how legal strategies can be deployed to address social determinants of health and how the health care community and legal community can better align to leverage these strategies in service of peoples' health and well-being. Her early years as an MLP public interest lawyer included a focus on immigration advocacy. Ms. Morton has published and presented extensively on MLP practice.

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[illegible] MSW, is adjunct assistant professor at the School of Social Work, Pontifical Catholic University of Chile, a part-time professor at the School of Psychology, Diego Portales University, and an infant and child psychotherapist in private practice. Ms. Velasco-Hodgson is a bilingual clinician with more than 10 years of experience specialized in providing clinical services to children and their families exposed to trauma or other difficult life experiences. She attended psychology school in Chile and, after obtaining a Fulbright Scholarship, she completed her master's in social work at Boston College. She was a family specialist for the first year of DULCE Project, and has collaborated with the National Child Traumatic Stress Network Translation Review Committee since 2011. She currently works in Chile and her interests include trauma prevention and intervention, child development, and child–parent bonding and attachment.

[illegible] is a program manager at Boston University. Ms. Morakinyo is a seasoned health care professional with more than a decade of industry experience. Ms. Morakinyo has a strong background in program planning, implementation, and evaluation, with recent successes in implementing federally funded grants targeting families of young children.

[illegible], is the associate vice president for research at Massachusetts School of Professional Psychology. He is a research psychologist with a long-standing commitment to evidence-based programming from both a research and social policy perspective. Dr. De Vos is committed to improving treatment for children and families who are suffering and to enhancing prevention for youth and families at risk.

[illegible] MA, earned a master of arts in child development in 2010. Ms. Krathen worked most recently as a child development specialist in the neonatal intensive care unit High Risk Infant Follow-up Clinic at Santa

Clara Valley Medical Center in San Jose, CA, where she launched the home visiting Bayley developmental assessment program to help improve clinic follow-up for the high-risk infants and provided assessment and support to families in the children's natural environment. Previous to this position Ms. Krathen was a family specialist for Project DULCE at Boston Medical Center. She also has several years of experience working in early intervention in Massachusetts.

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Errata

On page 29 of the July 2014 issue, the citation in the box in the middle column should read:

St. John, M. S., Thomas, K., Noroña, C. R., & Irving Harris Foundation Professional Development Network Tenets Working Group. (2012). Infant mental health professional development: Together in the struggle for social justice. *Zero to Three, 33*(2), 13–22.

Selective Prevention Approaches to Build Protective Factors in Early Intervention

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ABSTRACT

Young children with disabilities may be at elevated risk for behavior problems as well as maltreatment. Preventive approaches that can be infused into early intervention services are needed to support parents, build competencies among young children, and enhance protective factors that may temper risk. Two interventions—Stepping Stones Triple P, an evidence-based parenting intervention, and Preventing Child AbuseThrough Parent–Provider Partnerships, a workforce intervention—were selected for use in two studies designed to strengthen families of young children with disabilities. These studies, collectively known as the Family Networks Project, are described with specific attention to how the interventions used in these studies fit within a protective factors framework and within early intervention service systems. Information on project implementation and evaluation is presented, along with recommendations for future research.

Children with disabilities are at higher risk for experiencing or developing behavior problems than are typically developing children (Dekker, Koot, van der Ende, and Verhulst, 2002; Handen & Gilchrist, 2006; Ozonoff, Goodlin-Jones, & Solomon, 2007; Shapiro, Kilburn, & Hardin, in press; Sofronoff, Jahnel, & Sanders, 2011). Even minor problem behaviors that are present in typically developing children tend to occur more frequently, to a more severe degree, or for a longer length of time among children with disabilities (Sanders, Mazzucchelli, & Studman, 2003). Rates of behavior problems also appear to vary with type of disability. As an example, autism spectrum disorders (ASDs) and intellectual disabilities both appear to increase risk for emotional and behavioral problems even when controlling for factors such as age, gender, and maternal mental health (Totsika, Hastings, Emerson, Lancaster, & Berridge, 2011). In a study of challenging behaviors within a group of at-risk toddlers in the early intervention system, those with ASDs were found to demonstrate a higher level of behavioral problems than toddlers with general developmental delays (Fodstad, Rojahn, & Matson, 2012). In a small study of children with developmental coordination disorder, approximately 69% of parents reported significant emotional and behavioral problems (Green, Baird, & Sugden, 2006).

Although high prevalence rates of behavior problems in children with developmental delays are problematic, what is of equal importance is that these challenges are accompanied by high rates of parental concern about child behavior (Blanchard, Gurka, & Blackman, 2006). Data from the 2003 National Survey of Children's Health found that 10–20% of parents of young children had concerns about their child's functioning; rates of parental concern about children's emotional or behavioral problems among school-age children can be as high as 41% (Blanchard et al., 2006).

Children with disabilities may also be at elevated risk for child maltreatment. Child maltreatment is complex and multidetermined, with influences operating at the individual, family, and community levels of the social ecology (Li, Godinet, & Arnsberger, 2011; Shook Slack et al., 2011). Risk factors include parental anger and stress, as well as family factors such as levels of conflict and cohesion (Stith et al., 2009). For parents of children with disabilities, lack of social support and higher demands may contribute to higher rates of stress (Svensson, Eriksson, & Janson, 2013). The vulnerability of this population is highlighted by research that has linked child maltreatment and disabilities (Sullivan, 2009; Sullivan & Knutson, 2000). However, two recent reviews raise questions about the strength of this relationship. Leeb and colleagues (Leeb, Bitsko, Merrick, & Armour, 2012) found mixed empirical evidence supporting the link between maltreatment and disabilities using epidemiological data. Widely varying rates of maltreatment were noted across studies; such disparate results appear to be due to methodological issues, including variations in how populations and how disability and maltreatment are defined (Leeb et al., 2012). In a review and meta-analysis by Jones et al. (2012), substantial variation was found between studies in prevalence rates and risk for violence among children with disabilities. However, with estimates of

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Young children with disabilities are at higher risk for the development of behavioral problems as compared with typically developing children; young children with disabilities may also be at higher risk for maltreatment.

risk pooled across 11 studies, children with disabilities were found to be at increased risk for violence compared with their nondisabled peers (Jones et al., 2012).

Rates of officially substantiated maltreatment vary with child age. Children younger than 1 year old have the highest rates of victimization, and children 2 years old or younger accounted for 27.1% of the child victims in federal fiscal year 2011 (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau [USDHHS], 2012). Given these elevated prevalence rates of maltreatment among young children and some empirical evidence of elevated risk for maltreatment among children with disabilities, it is possible that children younger than 2 years old with disabilities may be more vulnerable for maltreatment relative to those without disabilities. This relative vulnerability of children with disabilities could be influenced by a confluence of risk factors: for example, increased rates of child behavior problems, increased parental stress, and increased social isolation. Such risk factors, along with high rates of parental concern about behavioral problems, suggest that early intervention efforts that build parent confidence and competence in managing children's behavior and that strengthen ties to community supports are needed to promote optimal child and family functioning.

In contrast to approaches that focus on risk factors, recent research has increased focus on protective factors. For example, Li et al. (2011) identified high levels of family social support as protective against child maltreatment in at-risk elementary school children, particularly among mothers with low education. Social support also appeared to reduce risk of maltreatment among mothers who had lower levels of stress or depression (Kotch, Browne, Dufort, & Winsor, 1999). Parent self-efficacy has been found to have an inverse relationship to child protective services involvement for neglect (Shook Slack et al., 2011). However, because relatively less attention is given to the role of protective factors within child maltreatment prevention and early intervention for young children with disabilities, this area shows promise for further study (Quality Improvement Center on Early Childhood [QIC-EC], 2009).

One effort undertaken to address this issue was launched by the Center for the Study of Social Policy ([CSSP] 2004). CSSP identified a set of five protective factors from the extant literature that reduced the likelihood of child maltreatment. This strategic effort has been infused into various service systems through the "Strengthening Families Through Early Care and Education" initiative. This approach comprises five protective factors: social connections, knowledge of parenting and child development, concrete supports in times of need, parental resilience, and social and emotional competence of children.

The CSSP initiative began with early childhood settings because of their universality and their potential to reach large populations of very young children. This initiative included the creation of self-study materials for child care centers and a training curriculum for child care professionals (i.e., the *Preventing Child Abuse and Neglect Through Parent–Provider Partnerships,* Seibel, Britt, Gillespie, & Parlakian, 2006, or PCAN [see Jargon Buster on p. 60], curriculum developed by ZERO TO THREE). The initiative is now reaching well beyond child care settings to include child welfare, early intervention, physical health, mental health, and policy systems. Its protective factors framework has been broadly disseminated through child and family service

systems and organizations at the national, state, and local levels (see Learn More).

Although the protective factors framework has brought national attention to the importance of promoting a vision of child health and well-being, research is lacking on proactive application of these factors to strengthening families (see Jargon Buster on p. 60) or how use of this framework may alter child or family functioning or both. Furthermore, it is not clear how existing interventions may align with, or possibly promote, these protective factors. Increasing the understanding of how interventions can build family strengths and thus prevent maltreatment, especially for very young children who may be at risk for maltreatment, is an important next step. This question became the driving force behind the QIC-EC. The focus of the QIC-EC was on developing and disseminating knowledge of ways to promote optimal development and prevent maltreatment in children less than 5 years old. The Family Networks Project (FNP), funded under this effort as one of four Research and Demonstration Projects, was designed to increase the understanding of how two extant interventions, alone and in combination, might affect child and family functioning. The remainder of this article describes the rationale for selection of two specific interventions, how these interventions align with the Protective Factors Framework, and how they were implemented and evaluated.

As noted earlier, young children with disabilities are at higher risk for the development of behavioral problems as compared with typically developing children; young children with disabilities may also be at higher risk for maltreatment. Parenting interventions—and behavioral family interventions in particular—have demonstrated a positive effect on child and family functioning (Sanders, 2008; Taylor & Biglan, 1998). Several evidence-based parenting interventions exist for parents of typically developing children; however, fewer exist for parents of young children with disabilities. One exception is Stepping Stones Triple P (SSTP), a variant of the larger, multilevel suite of Triple P-Positive Parenting Program (Triple P; see Jargon Buster on p. 60) interventions that has been developed specifically for parents of young children with disabilities (Sanders et al., 2003; see box What Is Triple P-Positive Parenting Program?).

Triple P interventions share a focus on enhancing parental competence and confidence

What Is Triple P-Positive Parenting Program?

The Triple P-Positive Parenting Program (Triple P) is a multitiered system of evidence-based education and support for parents and caregivers of children and adolescents. The system works as both an early intervention and prevention model. Triple P may be offered in clinical and nonclinical settings by a multidisciplinary workforce of social service, mental health, health care, and education providers. A single practitioner may provide Triple P services to interested parents, or on a larger scale, an entire county or state jurisdiction may implement Triple P as a public health approach.

The overarching aims of Triple P are:

- To promote the independence and health of families through the enhancement of parents' knowledge, skills, confidence, and self-sufficiency;
- To promote the development of nonviolent, protective, and nurturing environments for children;
- To promote the development, growth, health, and social competence of young children; and
- To reduce the incidence of child maltreatment and behavioral or emotional problems in childhood and adolescence.

Triple P is a culturally sensitive intervention being offered in 25 countries and in 34 states in the United States, with various materials translated into 17 non-English languages. Stepping Stones Triple P is the version of Triple P designed specifically for parents of young children with disabilities. Triple P is backed by more than 30 years of research conducted by academic institutions in the United States and abroad (see Learn More).

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Strategies that are taught to parents are developmentally tailored, applicable to a wide range of child behaviors, and are designed to promote children's development of self-regulation.

within a public health model that offers parenting information and support across a range of intensity levels from universal communication strategies to indicated interventions, matched to parent desires and needs (Sanders, 2008). SSTP interventions (as well as Triple P interventions for parents of typically developing youth) share a common set of core principles, including creating safe and engaging environments, creating a positive learning environment, using assertive discipline, having realistic expectations, and taking care of oneself as a parent (Sanders, Markie-Dadds, & Turner, 2007). Two additional core principles specific to SSTP are adapting to having a child with a disability and being part of the community (Sanders et al., 2003). Parents are supported in selecting parenting strategies based on these principles. In a recent meta-analysis of 12 studies, SSTP was found to be effective for reducing difficulties in key outcome areas of child behavior (by means of both parent self-report and direct observation), parenting style, parenting satisfaction, and parental efficacy, as well parental relationships in two-parent families (Tellegen & Sanders, 2013). A smaller but positive effect was found on parent personal adjustment (Tellegen & Sanders, 2013).

Triple P interventions in general, and SSTP in particular, are highly compatible with the Protective Factors framework as detailed here.

Knowledge of Parenting and Child Development

Triple P is based on a public health model of parenting. The Triple P system of interventions offers universal access to high-quality parenting information and supports the ability of parents to increase knowledge of parenting strategies. Triple P parenting strategies are developmentally linked and tied to concrete and practical interactions that occur in common, everyday situations. Within Triple P, prevention and skill development is emphasized before strategies to manage problem behaviors.

Social and Emotional Competence of Children

Parenting strategies used in Triple P and SSTP are designed to support positive parent–child relationships, encourage desirable behavior, teach new skills and behaviors, and help parents manage misbehavior in constructive, nonpunitive ways. Strategies that are taught to parents are developmentally tailored, applicable to a wide range of child behaviors, and are designed to promote children's development of self-regulation.

Concrete Support in Times of Need

The goal of Triple P universal communication and intervention strategies is to increase the accessibility of parenting support while decreasing the stigma associated with seeking support. Parents are encouraged to take care of their own needs through the key principle of "taking care of yourself as a parent." This can involve a range of behaviors, including accessing concrete supports when needed. Partner support strategies are also available for parents who want and need additional skills in this area.

Parental Resilience

The self-regulatory framework within which Triple P interventions is delivered—with a focus on self-sufficiency, self-efficacy, self-management, personal agency, and problem solving—is designed to improve parent ability to manage challenges related to parenting more effectively (Sanders & Mazzucchelli, 2013). This self-regulatory focus supports parental resilience. In addition, strategies to address parental stress and depression can be included in Triple P interventions as necessary.

Social Connections

With the recognition of the importance of social connections, initial strategies taught in Triple P interventions focus on ways to improve the parent–child relationship and to enhance parent–child connections. For parents who have a parenting partner, connections between parenting partners are emphasized along with a goal to increase interactions around parenting issues. The population-level application of the Triple P system of interventions—which includes universal communication strategies to disseminate information on positive parenting strategies, along with multiple options for length and format of interventions (including one-on-one or group-based models)—serves to increase the accessibility and availability of parenting support on a broad scale. Furthermore, as parents learn effective strategies for building skills in children and for managing child misbehavior, the likelihood of keeping or making social connections in everyday situations is increased.

In summary, Triple P interventions, including SSTP, are highly compatible with the protective factors framework and serve as one way to operationalize this framework through a comprehensive set of principles and parenting strategies based on those principles. However, parenting interventions alone may be insufficient to affect the potential for child maltreatment, which is a multidetermined construct. Thus, for the FNP, a second intervention was selected to influence the social context for families of young children with disabilities.

Because the target population for FNP was parents of children less than 2 years old with disabilities who were eligible for Individuals With Disabilities Education Act (IDEA) Part C services, the FNP approach to affecting the social context for these families involved workforce development for one existing group of professionals within the early intervention system: service coordinators. These professionals serve a critical role as the single point of contact within IDEA Part C for families. Thus, service coordinators are in an ideal position to form strong, supportive relationships with families. Enhancing this relationship and supporting both parents and the parent–child relationship can potentially reduce risk for maltreatment. Because of these factors, the PCAN curriculum (Seibel et al., 2006), noted earlier as being designed specifically to support the

protective factors framework, was selected for use in the FNP (see box Preventing Child Abuse and Neglect Through Parent–Provider Partnerships in Child Care).

The PCAN curriculum (Seibel et al., 2006) was developed specifically to prevent child abuse and neglect of infants and toddlers by supporting parent–provider partnerships in child care settings. The FNP provided the opportunity to apply the PCAN curriculum to a new workforce (early intervention service coordinators). The primary rationale for selection of the PCAN curriculum is that it was designed to support the protective factors framework developed by CSSP. More specifically, PCAN focuses on promoting effective parent–child relationships, increasing understanding of the effects of abuse and neglect on young children, and helping both the workforce and supervisors reduce risk for maltreatment through reflective practice. Content areas covered in PCAN curriculum include: building collaborative relationships with families; healthy brain development, including the importance of responsive relationships in development; understanding social–emotional development; temperament and the concept of "goodness of fit" between child temperament and parental functioning; cultural influences on caregiving; understanding and responding to potential maltreatment; providing supportive responses to troubled parent–child interactions; and increasing understanding of challenging behaviors in young children.

Preventing Child Abuse and Neglect Through Parent–Provider Partnerships in Child Care

Preventing Child Abuse and Neglect Through Parent–Provider Partnerships in Child Care (PCAN; Seibel, Britt, Gillespie, & Parlakian, 2006) is a curriculum designed to help infant–family professionals use their natural relationships with families to reduce the risk of child abuse and neglect. It has been used with more than 1,300 trainers in 30 states who, to date, have trained more than 35,000 infant–family professionals. Evaluations show that participation in this training, coupled with implementation of the curriculum, increases trainers' confidence that they can teach others to play a role in the primary prevention of child abuse and neglect. Trainers find that the material guides them in bringing up complex issues in a way that promotes open discussion and learning. Knowledge assessments indicate that they have learned key concepts and feel more confident that they can strengthen protective factors and support families. The PCAN curriculum is for use by experienced trainers with strong backgrounds in infant–toddler development, early childhood education, and the prevention of child abuse and neglect. Direct service providers working with young children and families who have attended the PCAN training session have reported an increase in their ability to building stronger partnerships with families and feel more competent in discussing challenging topics that may arise. Also noted by providers is an increase in the ability to see the signs and symptoms of abuse and neglect. They have attributed this to a stronger provider–parent relationship.

Project Description, Implementation, and Evaluation

To assess the potential effects of both SSTP and PCAN as interventions, two studies, collectively known as the FNP, were conducted in two separate geographic regions of South Carolina. To be eligible for either study, families had to: have a child between 11 and 23 months old who was eligible for IDEA Part C services (due to a disability or a diagnosis carrying a high likelihood of disability); have no history of involvement with child protection agencies or services; and reside within one of the counties forming the multicounty geographic region for each study. SSTP was delivered by professionals who had undergone specific training to become an SSTP-accredited provider and were closely supervised throughout intervention delivery. SSTP providers participated in regular supervision sessions. SSTP sessions were audiotaped and rated by a supervisor for fidelity; SSTP providers also completed content fidelity checklists for each session. For both studies, SSTP was delivered in family homes.

A range of key outcomes areas specific for SSTP and PCAN were selected for both studies and included parent self-report measures of child behavioral–emotional functioning, parenting style, parent personal functioning, parental self-efficacy, and the working alliance between parents and providers. Observations of parent–child interactions were also conducted to assess the quality of the parent–child relationship. As with all of the QIC-EC research and demonstration projects, a range of common evaluation measures were also collected, including parent ratings of protective factors, social networks data, information on parenting stress, and official records of maltreatment. Assessment measures for both studies were collected at baseline and post-treatment (approximately 5 months after baseline); outcomes specific for SSTP as well as official records of child maltreatment were also collected at a 12-month follow-up point. At a larger level, the feasibility and practicality of both SSTP and PCAN delivery within existing early intervention service systems were also examined. Further details of the design of both studies are briefly described here.

STUDY ONE

Study One was designed to examine the initial efficacy of SSTP to affect protective factors among parents of children less than 2 years old with disabilities. This study was conducted with families residing in a seven-county region. Forty-nine families of children 11 to 23 months old with disabilities who were eligible to receive IDEA Part C services were recruited and randomly assigned to one of two groups: (a) IDEA Part C services as usual or (b) IDEA Part C services as usual plus SSTP. The primary hypothesis was that families receiving SSTP in addition to IDEA Part C services as usual would demonstrate improvements in the parent–child relationship, child behavior, and parent competence and confidence, which would, in turn, result in the greatest increase in protective factors operating at the individual level of the social ecology (knowledge of parenting and child development, social and emotional competence in children, parental resilience) as compared to families receiving only IDEA Part C services as usual.

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With the recognition of the importance of social connections, initial strategies taught in Triple P interventions focus on ways to improve the parent–child relationship and to enhance parent–child connections.

STUDY TWO

In the second study, SSTP was examined against a backdrop of early intervention service coordination enhanced by specific workforce (service coordinator) training in PCAN. Study Two began with an action research approach used to modify the PCAN curriculum for an early intervention workforce (Shapiro & Kilburn, 2014). The modified PCAN training was then offered to all service coordinators within the five-county region serving as the site for Study Two. Families eligible for this study were on the caseloads of IDEA Part C service coordinators who participated in PCAN training. Thus, all families who were enrolled in this study received early intervention service coordination enhanced by specific service coordinator training in PCAN. Forty families were recruited and randomly assigned to one of two groups: (a) PCAN plus IDEA Part C services as usual or (b) PCAN plus IDEA Part C services as usual plus SSTP. We hypothesized that the enhanced collaborative intervention—SSTP plus service coordination enhanced by PCAN—would result in stronger positive effects on the parent–child relationship and parent competence and confidence, which would, in turn, result in the greatest increase in protective factors operating at the individual and community levels of the social ecology as compared to families receiving service coordination enhanced by PCAN with parenting services as usual.

General Findings

A brief summary of select preliminary findings from each study is discussed in turn. Detailed study descriptions and complete outcome details are reported elsewhere (Shapiro et al., in press).

Study One outcomes included significant attrition (more than 40%) from the intervention group, which affects the ability to reach firm conclusions about impact. The majority of families who discontinued SSTP services reported being "too busy" to receive the full 10-session intervention, despite this intervention being provided in family homes. It is also possible that study selection criteria, which did not include a requirement that parents had a concern about their child's behavioral functioning, may have had a negative effect on parent motivation for participation. An important conclusion reached from this experience is that more brief parenting interventions may be desirable, especially when families are receiving multiple services (as is the case for many families whose children are eligible for IDEA Part C early intervention services).

Study Two began with an action research approach to modifying the PCAN curriculum for an early intervention workforce audience. The modified PCAN training curriculum was rated as relevant and useful to an early intervention workforce and resulted in knowledge changes as assessed from pre- to post-training. With regard to the SSTP intervention, attrition from the intervention was much lower (20%) as compared to that in Study One. It is possible that the PCAN-trained service coordinators were better able to support families in terms of engagement in the SSTP intervention; the protective factor of social connections (in this case, between parents and service providers) may have positively affected this area. Families in the SSTP intervention group did demonstrate change on local evaluation measures including parent-endorsed symptoms of depression, parenting style, and in the observed parent–child relationship as compared to families who did not receive the intervention. Thus, the combination of PCAN for service providers with family-level SSTP had a positive impact on domains related to the protective factors of parent resilience and parenting and knowledge of child development.

Implications and Next Steps

In conclusion, the FNP selected two extant interventions (SSTP and PCAN) as a way to operationalize the CSSP Protective Factors Framework. Modified PCAN training appears to be seen as useful, relevant, and acceptable to an early intervention

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workforce and offers a concrete way to infuse the protective factors framework into the early intervention service system. Notably, the protective factors language is now being included in early intervention policies in South Carolina, and plans for increasing PCAN training for this workforce are underway.

Future research is needed to examine the specific effect of PCAN provider training on parent–provider relationships. When comparing outcomes from Study One and Study Two, the combination of PCAN training for an early intervention workforce with SSTP for families appears to have resulted in better family participation in the parenting intervention. However, because families were not randomly assigned to the combination of PCAN and SSTP, this conclusion remains tentative. Future studies that randomize families to receive early intervention services with providers either trained or not trained in PCAN would provide more direct evidence of the impact of PCAN training on family outcomes.

For families of very young children with disabilities who complete SSTP impact on parent personal functioning, parenting style, and the observed quality of the parent–child relationship over the 12-month time frame of the study was seen. Influence on child behavior was not seen; however, it is important to recall that SSTP in the FNP was used as a selective prevention strategy (i.e., elevated rates of child behavior problems were not a criteria of study entry). To increase the effect and uptake of SSTP, future studies are planned that examine brief forms of the SSTP intervention with parents of children in early intervention who are beginning to demonstrate problem behaviors. Such brief interventions can increase access to evidence-based parenting programs for parents of young children with disabilities being served by early intervention service systems.

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Strong Start Wraparound: Addressing the Complex Needs of Mothers in Early Recovery

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ABSTRACT

The Strong Start Study tested an innovative, High-Fidelity Wraparound intervention with families in early recovery from substance use. The Strong Start Wraparound model addressed the complex needs of pregnant and parenting women who were in early recovery to increase the protective factors of parental resilience, social connections, concrete support in times of need, knowledge of parenting and child development, and capacity to support the social and emotional competence of children. The study enrolled pregnant women who recently had been admitted to substance use treatment and randomized half into Strong Start Wraparound and half into standard care. Findings showed that Strong Start Wraparound families had more supports and less family conflict at 1 year postpartum as well as fewer self-reported mental health symptoms. Implications of these findings for the use of Wraparound with this population are discussed.

Maternal substance use, especially during pregnancy and the postpartum period, has been a recognized risk factor associated with maltreatment (Chaffin, Kelleher, & Hollenberg, 1996; Kotch, Browne, Ringwalt, Dufort, & Ruina, 1999; Magura & Laudet, 1996; Wolock & Magura, 1996). Risks are present with not only the mother, whose parental functioning can be impaired from substance use, but also the baby, who could have compromised health and developmental outcomes from prenatal substance exposure (Behnke & Smith, 2013). Additional risk is associated with social factors such as the mother's lack of education, low income, and inadequate housing (Kotch et al., 1999; Palusci, 2011; Wu et al., 2004) as well as commonly co-occurring mental health conditions such as depression and history of trauma (Chaffin et al., 1996; Covington, 2008; Grella, 1997; Saladin, Brady, Dansky, & Kilpatrick, 1995). Yet, pregnancy and the postpartum period is a time in most women's lives when they are known to be highly motivated to reduce their substance use in the interest of their child (Murphy & Rosenbaum, 1999). Beginning a specialized treatment program for pregnant and postpartum women is often evidence of this motivation. The team-based Wraparound intervention piloted in the Strong Start Study aimed to leverage this motivation by helping mothers in early recovery build protective factors within their families by addressing their multiple and complex needs.

Prenatal Substance Exposure and Maltreatment of Infants

The younger a child is, the greater the risk of experiencing maltreatment. Infants and toddlers are the age group most likely to be maltreated in the United States. The maltreatment rate for babies younger than 1 year is 21.9 per 1,000 same-aged children in the population, compared with the rate of maltreatment for all children birth–18 years old of 9.2 per 1,000 children and youth (U.S. Department of Health and Human Services, 2012).

Prenatal exposure to drugs is considered an indicator of maltreatment, especially if there is evidence of maternal substance use at the time of birth. An estimated 11% of babies born in the U.S. each year, (451,000) have been prenatally exposed to alcohol and drugs, although most are not identified at birth (Young, Boles, & Otero, 2007). According to the American Academy of Pediatrics (AAP), the most common substances of concern are nicotine, tobacco, marijuana, cocaine, methamphetamines, and opiates (Behnke & Smith, 2013). Fetal growth and resulting birth weight are negatively affected by all six categories of drugs examined in the AAP report, with the exception of marijuana. Prenatal exposure to alcohol has the strongest and potentially life-long effects to overall development and functioning, although exposure to opiates has the most immediate health effect due to withdrawal experienced by newborns.

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Pregnancy and the postpartum period is a time in most women's lives when they are highly motivated to reduce their substance abuse in the interest of their child.

Nationally representative child welfare data has revealed infants as the largest age group of children in out-of-home placement with 61% of cases involving parental substance use, and half of the infants less than 3 months old at the time of placement not reunifying with their families (Wulczyn, Ernst, & Fisher, 2011). Research has found that when maternal substance use is identified, infants are more likely to be removed from mothers who also have mental health problems, lack coping skills, and have personal histories of maltreatment (Minnes, Singer, Humphrey-Wall, & Satayathum, 2008).

Substance Use During Pregnancy

During 2012, drug use among pregnant women 18 to 25 years old in the United States was 9% and dropped to 3.4% for pregnant women 26 to 44 years old (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013c). Alcohol use among pregnant women 15 to 44 years old was reported at 8.5%, with 2.7% of women surveyed reporting binge drinking and 0.3% reporting heavy drinking. Compared with alcohol use among nonpregnant women, pregnant women show an overall lower rate of alcohol use and less problem drinking (SAMHSA, 2013c).

Pregnant women represent 4.8% of all admissions to substance use treatment programs, a percentage that has remained relatively stable over the past decade (SAMHSA, 2013b). Access to treatment for pregnant and postpartum women with substance use problems is limited, with only 12.5% of treatment facilities offering such specialized programs (SAMHSA, 2013a). In addition, only 37% have programming for co-occurring mental and substance use disorders and 21.7% have programming for persons who have experienced trauma—both program types critical to addressing the needs of women (SAMHSA, 2013a).

High-Fidelity Wraparound Intervention

Wraparound with women in recovery who are parenting infants is not intended to provide specialized treatment, but can help support sustained recovery by extending their available support system and accessing other resources to aid family safety and stability. The Wraparound intervention used in the Strong Start Study is grounded in the principles, theory, and practice standards developed through the National Wraparound Initiative (Bruns & Walker, 2008). Wraparound is not a treatment or service, per se; rather, it is a process of team-based planning and collaboration designed to address the complex needs of women recovering from substance use problems. Since the 1980s, Wraparound has been considered an individualized care coordination approach that is used primarily with children and youth who have serious emotional and behavioral challenges. Use of this Wraparound approach allows them to remain in their home communities and is aligned with the system-of-care approach for behavioral health that is both strengths-based and family-driven (Bruns et al., 2010; Suter & Bruns, 2009; Winters & Metz, 2009). There is a growing evidence base for the Wraparound process as the model is used in more states and with diverse groups (Bruns, Sather, Pullman, & Stambaugh, 2011; Suter & Bruns, 2010). The use of the Wraparound intervention in the Strong Start Study is an innovative approach in work with pregnant and postpartum women who are in early recovery from substance use and who are parenting infants. These families have complex needs and are often involved with multiple systems such as child welfare, substance use treatment, mental health, and probation. The Strong Start Wraparound intervention provides the facilitated collaboration needed to strengthen participating families by (a) helping them build an ongoing support network and access needed resources, (b) supporting the parent's sustained recovery from substance use, and (c) monitoring the health and development of their young children.

APPROACH

Implementation of Wraparound in accordance with national standards follows a systematic approach to engaging with a family and understanding their life from their perspective. The Wraparound facilitator and the family support partner have initial conversations with women in the study about all aspects of their lives and ask about their most important concerns. The facilitator then records this information in the Wraparound Strengths, Needs, Culture Discovery document that is reviewed by the woman for accuracy and then shared with the Wraparound team. During the first team meeting, the family's priority needs are identified and the team begins planning ways to address the needs. The initial Wraparound Plan is the written document prepared by the facilitator, circulated to all team members, and used as an ongoing reference as action steps are completed during implementation of the plan. A final Transition Plan is written with the family as the formal Wraparound facilitation is ending as a way of acknowledging gains and identifying ongoing needs and resources.

Wraparound is not a treatment or service, per se; rather, it is a process of team-based planning and collaboration designed to address the complex needs of women recovering from substance use problems.

In this article, I use qualitative data from Wraparound documents prepared with each family in the Strong Start Study to explore how the intervention contributed to improved outcomes by increasing protective factors known to prevent maltreatment. I examined family information from the Strengths, Needs, and Culture Discovery document to determine the priority needs as families began the Wraparound intervention. I then examined data from the initial Wraparound plan to identify goals that were the focus of planning and used final Wraparound plans to determine attainment of those goals. The transition plan developed with families as they finished Wraparound intervention provided data on their experience with the process and how they benefited from it.

PARTICIPANTS

Pregnant women 18 to 44 years old who entered specialized substance use treatment programs, Special Connections, were invited to participate in the Strong Start Study and were informed about the study during their admission to the treatment program. Participants' average age was 27.4 years. Major ethnic group identification was 58.3% White, 44.0% Hispanic, 16.7% Black American, 16.7% Native American, and 7.1% indicating multiracial identities. "Never married" was the status of 38.1% of participants, and 10.7% were separated or divorced. Almost half the participants (48.8%) were either married to or living with the father of their child. Women signed up for the study at different stages of pregnancy, with 19.0% enrolling during the first trimester, 47.6% enrolling during the second trimester, and 23.8% enrolling during the third trimester. The remaining 11.9% enrolled during late-term pregnancy and gave birth before beginning Wraparound intervention. The primary drug being used at admission to treatment was cocaine (17.9%), followed by marijuana (16.7%), amphetamines and heroin at 11.9% each, other opiates (10.7%), and alcohol (8.3%).

IMPLEMENTATION

Seventy-five percent of the families who were randomized into Wraparound intervention engaged in the process, established a Wraparound team, and held an initial team meeting for integrated planning purposes. Families participated in Wraparound for an average of 9 months and had an average of seven team meetings. The preferred team–membership for Wraparound is more natural support persons than professional support persons. ***Natural support persons*** typically included family members and friends. Inclusion of natural supports on the Wraparound team was often challenging due to substance use by those closest to the woman in recovery, or estranged relationships related to the woman's substance use. However, the participation of only one consistent and reliable natural support person on the Wraparound team proved to be important. ***Professional support persons*** typically included the treatment provider, a child welfare caseworker, and a probation officer. Participation by these professionals varied significantly from one team to another and from one county agency to another. In the Strong Start Study, there were fewer natural support persons (45.4%) compared to professional support persons (54.6%), reflecting a common need of families to rebuild a social network that is supportive of recovery.

During the Wraparound discovery process with the family, they are asked by the facilitator to describe their desired future through a written family vision statement that is shared with the team during the initial meeting. The Wraparound team's goal is to support the family in realizing that vision through a strengths-based and culturally relevant planning process. The family vision and the family's identified priority needs inform the creation of the team mission statement during the initial team meeting; this mission statement serves as the guide and reference for the team's work going forward. The team's mission represents a contract with the family that is grounded in Wraparound principles, including respect for family voice and choice.

Through this Wraparound team–based process, the woman's identified strengths are considered inherent resources that she can draw upon in addressing priority needs and attaining related goals. The team listens to and honors the woman's hopes for her life and her family. The goal of the team is to provide consistent, reliable support, helping the woman take care of herself so that she is able to take care of her children. In the Strong Start Study, teams met at various locations, including the family home, the treatment facility, a church, a jail, and a hospital. Such flexibility

facilitated participation by team members and for the family, especially when transportation presented a barrier. At times, however, the locations of these meetings and the attempt to schedule meetings at family-friendly times were barriers to some professional support persons when their agencies did not allow for community-based or after-hours meetings.

Building Protective Factors Through Strong Start Wraparound

Themes that emerged from a qualitative analysis of Wraparound documents using the constant comparison method illustrated how the intervention proved well-suited to the lives of women who were parenting during early recovery. Predominant themes were (a) preparation for motherhood, (b) ambivalence in asking for and receiving help, (c) meeting basic needs, (d) perseverance, and (e) reconciliation. In this article, these themes are woven within the Protective Factors framework and are presented in participants' voices via firsthand descriptions of their experiences in Strong Start Wraparound.

The intervention helped strengthen families through protective factors beginning with building social connections when the Wraparound team was established, building concrete supports by accessing resources to meet basic needs, and building parental resilience by supporting parents in sustaining their recovery and developing healthy ways of coping. The routine screening, celebration of milestones, and discussion of ways to promote development by the family support partner through Wraparound also contributed to helping mothers in the Study build two other protective factors: (a) knowledge of parenting and child development and (b) capacity to support the social and emotional competence of their infant.

Building Social Connections: It Takes a Team

The adage "It takes a village to raise a child" describes the combined efforts of a Wraparound team in helping a woman in recovery prepare and begin her parenting role. The Wraparound team created a social network for a woman in early recovery and provided critical social connections for both the mother and her baby. Team members selected by the parent became sources of support beginning during pregnancy and continuing through the first year of the baby's life. The specific inclusion of natural supports (i.e., family and friends) on the team was key to establishing ongoing social connections available to the family. When the father of the baby was present, and when the mother identified him as a source of support, he was included as a team member. Participants expressed respect and appreciation for members of their team and the different perspectives that they offered. Participants noted that team members' ideas and input provided guidance and support in their lives—as one woman said, "Wraparound helped to identify what I needed help with … talking out loud, not keeping it to myself."

Whereas some pregnant women enter substance use treatment on their own initiative, many others are referred by probation or child welfare. Regardless of referral source, most women are aware that they need help. The difficulty in asking for help was a barrier acknowledged by women who participated in Strong Start Wraparound intervention. Some felt shame about their drug use and thus were uncomfortable asking for help. Others indicated that they did not know who would be there to help or care about them. "To be honest, from the beginning, I didn't know how to ask for help," said one woman in describing this common phenomenon among participants. Strong Start parents indicated that learning what help was available—and learning how to accept and receive that help—benefited their families and was an important life lesson for their future, as well. One participant said, "I learned to reach out … [now] I will be able to do this on my own when I need help."

Given the poor relationship histories of many women with substance use problems, the purposeful structure of the Wraparound team in bringing together both natural and professional supports provided a context in which women could experience social connections in a unique, therapeutic way. Participants noted that the positive nature of the Wraparound process contributed to their trust in the team. Women who were in early recovery had an opportunity to identify their needs and what they wanted for their families—and to benefit from the team's guidance, encouragement, and acknowledgment of their successful efforts to move forward in their lives.

Participants came to appreciate the need for positive social connections that often meant resolving conflicts with their own families. Reconciliation of relationships within the family was a common experience of participants, and the woman's recovery was sometimes parallel to a beginning recovery process by friends and other family members who had also been involved with substance use. The evidence of improved family relationships could be seen in the reconnection and support that was described by many women. Being close with their family, having the support of their own parents, and learning positive ways to talk with one another were some examples that were given of such improvement.

Wraparound participants at 1 year postpartum reported somewhat more supports than the standard care group. Wraparound participants also reported less conflict in their family relations that, for some, included realizing the enduring support from their families. One member reflected, "Going through difficult times has shown the family [that we] are fortunate and [that we] are very grateful for what [we] have."

Concrete Supports: Maslow's Hierarchy Revisited

Maslow's (1943) theory of motivation based on a hierarchy of human needs was reflected in the priority that participants placed on meeting their families' basic needs. During the Wraparound discovery process, families are asked to identify the

TABLE 1. **Matrix of Prioritized Goals by Related Protective Factors**

Ranking of life domains by goals	Life domain	PF1	PF2	PF3	PF4	PF5
1	Health/Mental Health	●			●	●
2	Legal			●	●	
3	Family relations		●		●	
4	Financial/Income			●		
5	Housing			●		
6	Education/Training	●		●		
7	Transportation			●		
8	Social/Recreational	●	●			
9	Spirituality	●	●			
10	Civic/Community		●	●		

PF 1 = Parental resilience; PF 2 = Social connections; PF 3 = Concrete supports; PF 4 = Knowledge of child development and parenting; PF 5 = Capacity to support child's social-emotional competence

main concerns that they have in their lives. These concerns are then prioritized within universal life domains, including those related to basic family needs such as income, housing, and health care. Helping a family meet its basic needs through Wraparound contributed to strengthening the protective factor of concrete support in times of need.

Participants agreed that, of all their needs, recovery—framed within the life domain of health and mental health—was the highest priority on which attainment of all other needs depended. As shown in Table 1, other priority needs following recovery were ranked as follows: legal, family relations, financial, and housing. These priority needs were reframed as goals for planning purposes and were considered within the protective factors framework as contributing to parental resilience, social connections, and concrete supports.

During the first meeting, the team develops the initial Wraparound plan by identifying specific ways to attain the goals in meeting the family's basic needs. Strong Start participants found that the written plan was helpful in keeping track of goals and staying organized. The Wraparound process that reaped the greatest benefit, as reported by participants, was breaking down a given task into doable action steps that made that task manageable rather than overwhelming. Success in taking one step provided encouragement in taking another step—a process that contributed to self-efficacy as reflected in the following comments:

- "Wraparound helps breaking down needs to small and specific steps."
- "Developing a plan and sticking to it helped."
- "The Wraparound team process helped me see the importance of being prepared and organized … [I felt] better and in control."

Once the team members established priority goals and identified action steps, they systematically reviewed and revised progress or addressed roadblocks, holding participants accountable while supporting their follow-through and attainment of goals. Wraparound facilitators reviewed plans at the time of transition and gave each priority area a rating: 3 = *the goal had been attained*; 2 = *progress toward the goal had been made*; and 1 = *no progress was evident*. Full goal attainment was highest in the family relations and health domains, with good progress toward goals in the legal domain. Progress was also noted in the domains of housing and financial (see Table 2). Given that participating families typically had multiple, complex needs with limited resources, the progress in these important areas of life is a notable achievement.

HOUSING DOMAIN

Having a place to live was a basic need for families in the study. Families in both groups reported multiple moves, with only 7.1% in the Wraparound group having no moves in the past 12 months; 28.6% of families reported four or more moves during the past 12 months. Housing goals were met by 41.9% of women, with progress made by another 38.7%; 19.4% made no progress. Families were grateful to have housing and felt relieved to have a place to live. For some families, this meant an

TABLE 2. **Rating of Goal Attainment by Life Domain**

Ranking of goals by life domain	Rating of goal attainment			Examples of goals
	3	2	1	
Health	55.8%	30.1%	14.1%	Recovery, healthy baby
Legal	47.4%	43.9%	5.3%	Compliance with court, probation
Family	62%	28%	10%	Reconcile relationships, regain custody
Financial	41.7%	37.5%	16.7%	Source of income, job, TANF
Housing	41.9%	38.7%	19.4%	Affordable, stable, place to live
Education	22.6%	48.4%	29%	Finish GED, pursue training

TANF = Temporary Assistance to Needy Families

apartment of their own or staying with other family members. For still other families, a transitional housing program with a stay of up to 2 years added to their stability and security while they were in early recovery.

FINANCIAL DOMAIN

A fundamental need for any family is the ability to pay or provide for their needs on a regular basis through income from gainful employment, Temporary Assistance to Needy Families (TANF), or disability benefits. For pregnant women in the study who had no other source of financial support, TANF benefits began during the last trimester. Typically, by the time their infant was 1 year old, women were employed. Most women were working full time and described the jobs as "good," especially noting those jobs that provided benefits for the family. Some said that they "loved" their jobs and felt "positive" about being able to pay bills and provide for the family's needs. At 12 months postpartum, 79.2% met or made progress toward their financial goals.

EDUCATION DOMAIN

At 12 months postpartum, 71% of participants had attained or made progress toward their educational goals. Although most participants had vocational interests beyond high school, completing the General Educational Development (GED) test remained a common educational goal for those who had not graduated. For other women, continuing their education meant (a) finishing training so that they could be certified in a vocation, (b) taking online classes, or (c) enrolling in community college. A few women were using their education loans to cover living costs for their families, thus enabling them to attend school.

HEALTH DOMAIN

At baseline, 78.6% of women reported experiencing a traumatic life event, with 40.5% meeting diagnostic criteria for post-traumatic stress disorder (PTSD). Despite these high rates of trauma, even direct team advocacy with community mental health programs could not address the systemic barriers to accessing professional treatment for many participants. It is interesting to note that, despite barriers to accessing formal mental health treatment, women participating in Wraparound reported fewer mental health symptoms and less severe PTSD symptoms at 12 months postpartum than did women in standard care.

Increasing awareness of and access to concrete supports through Wraparound helped families meet their basic needs, thereby improving their stability during early recovery. An important change in self-efficacy was noted among participants: confidence in their own abilities to secure and use concrete supports when needed. One woman noted, "I'm using resources that I didn't know were out there!"

Parental Resilience: One Wraparound Action Step at a Time

Parental resilience refers to parents' ability to cope with stress and difficulty in a positive and healthy manner. When this protective factor is strengthened in pregnant and parenting mothers of infants, recovery from substance use is supported, as is the ability to provide nurturing and protective caregiving. Success in recovery depends on getting through life "one day at a time" without using alcohol or other drugs. In Strong Start Wraparound, parenting during the early recovery period is supported one action step at a time and involved safety planning for the infant. Examples of action steps related to recovery and parenting from Wraparound plans include:

- "Ann will stay in the present and do 'one day at a time.'"
- "Julie will attend the Relapse Prevention Group one time a week and will attend parenting class one time a week."
- "Sue and her baby will live at the residential treatment program and will comply with all recommendations of the treatment team, the guardian ad litem, and the caseworker."
- "Jordan will cooperate with all requests for urine samples and will comply with and successfully complete substance abuse treatment, including maintenance of a drug and alcohol free lifestyle."
- "When Karen experiences a craving to use she will contact [her addictions counselor] who will assist her in being admitted to the residential program with her son."

Increased parental resilience was further demonstrated with a number of women in the study who were sustaining their first year of recovery from substance use; this major accomplishment was celebrated with the Wraparound team. Through the treatment program and the Wraparound teams, women received help in focusing on their own physical and mental health as well as the health of their infants; 85.9% of participants met or made progress toward their health goals. The relationship with their treatment provider and support in addressing past traumas were reported by the women as being important to their recovery process. Women continuing in recovery at 12 months postpartum expressed their desire to remain clean and were continuing in treatment or actively working a 12-step program with a sponsor. Completing a treatment program and reaching the first anniversary of their sobriety dates were important milestones. As one participant reflected, "It gets easier to be sober the longer you're sober."

Support in sustaining their recovery and persevering despite the difficulties that they faced exemplified resilience among the women in the Wraparound group who were successful. An optimistic and hopeful attitude about their future—which allowed women to see the possibilities in their lives as they transitioned from Wraparound—was further evidence of the improved mental health necessary for parenting a young child. Reflection on life changes by one participant who sustained her recovery and dealt with the effects of her substance use on her family offers evidence of her resilience in this way, "Wraparound has been a part of my growth and has helped me become stronger … I have

a little bit of a voice now … I can't tell you how empowered I feel!"

The relationship with the father of their child was noted by many women as a positive factor, especially when the father was doing well in his own recovery. Whether married or single, many women reported that they parented and enjoyed their child together with the father. Some fathers were members of the Wraparound team and, thus, were directly involved in the planning process to meet the family's needs. In the case of a few families, the parents identified couples counseling as a need in their relationship. This need was addressed through the Wraparound planning process by identifying resources for the couple and developing action steps to access services. Whether or not the father participated in Wraparound, a positive relationship with the father represented an important social connection that provided a source of support associated with a woman's recovery at 12 months postpartum. The father's role—especially when he addressed his own recovery needs—helped strengthen the protective factor of parental resilience within the family.

Both groups of women in the study significantly reduced their substance use, as measured when their babies were 12 months old. This result indicated that the participants had benefited from the specialized women's treatment programs in which they learned and were using healthier ways of coping with life. For women in the Wraparound group, the motivation for their recovery was to be, as they described it, "better" mothers. Some described themselves grateful to be alive and with their children, given the toll that substance use had taken on their lives. Most recognized the need for ongoing support, were accessing resources, and had established closer connections with friends and family. As one participant noted, "Wraparound was a good framework … [to] keep me in line with my goals. Keeping me sober was work I had to do on my own."

Knowledge of Child Development and Parenting: Great Expectations

Preparing for the birth of their baby was a common motivation of women in the Strong Start Study. As a group, women indicated that beginning their recoveries during this time was done in consideration of their baby's health and preparation for their imminent parenting role. Parenting education was provided through the women's treatment programs and included information on the possible effects of prenatal exposure to alcohol and other drugs. Women expressed appreciation for being part of these parenting groups and for the help that they received in understanding their children's needs.

Through the Wraparound intervention, the family support partner conducted developmental screenings with parents beginning when the infant was 2 months old. Based on screening with the *Ages and Stages Questionnaire* (ASQ), most infants were found to be within the typical range of development. Several infants were monitored for delays and subsequently fell within the typical range without receiving formal intervention. Access to services for developmental delays is another issue for families affected by substance abuse. On the basis of state early intervention eligibility criteria, a child may have delays yet may not qualify for services. For example, one infant who was known to have significant alcohol and other drug exposure through the fourth month of gestation showed motor delays on screening; however, at 8 months old, his delays were not sufficient to qualify him for early intervention services. The parents noted that he had developed adaptive behaviors in his creeping style by age 12 months, although he was not walking. On follow-up, he was receiving early intervention services at 15 months old focused on his gross motor development.

Supporting Social–Emotional Competence: How Are the Babies Doing?

Maltreatment risk is known to be higher when infants and young children have developmental delays or disabilities. All infants in the Strong Start Study had experienced prenatal exposure to alcohol and other drugs that could affect their developmental outcomes. As a collaborative partner, the state Part C agency recommended that the Study conduct developmental screenings to identify infants needing further evaluation for early intervention services. When delays were noted, the Wraparound family support partner assisted parents in connecting with the Child Find program through the local school district.

This focus on the baby provided the opportunity to discuss typical developmental milestones with parents and to suggest activities that promote growth, such as "tummy time" for play and talking to the baby for language development. This routine monitoring of infant development, celebrating growth, encouraging healthy parent–child interactions, and openly discussing concerns related to prenatal substance exposure by the Wraparound family support partner provided both positive reinforcement for mothers and a source of ongoing support, especially when early intervention services are indicated.

Strong Start Wraparound: Helping Families Get a Strong Start

Helping Strong Start families stay focused and grounded was the benefit that participants mentioned most often. Three important team qualities—attention, as women identified goals for their family; persistence in follow-up; and acknowledgement when progress was made—provided life lessons that parents said they would continue to use after their participation in Wraparound intervention ended. Some of their comments included the following:

- "When I first started [Wraparound], I was discouraged. I saw it as another thing I had to do and thought it wasn't going to help. [The team] gave good advice and emotional support … I would look forward to going to the meetings … I had hope after talking to them."

- "It was like a team came together to help me better myself; the team revolved around me … I really enjoyed someone helping me to break down the steps, motivat[ing] me to keep on track, remind[ing] me of my goals and deadlines, and encouraging me to follow through."
- "Working on things step by step always gave me a sense of accomplishment and motivation to keep going … I never felt judged. They were very understanding [and] helped me just to deal with life … It was helpful to have them say 'You've got it, you can do it, [we're] proud of you,' Wraparound was a great experience for me."

The team becomes a consistent, reliable source of support, helping the woman take care of herself so that she is able to take care of her children.

The Wraparound Fidelity Index (WFI; Wraparound Fidelity Index, n.d.) measures adherence to Wraparound principles for family teams. For completion of the WFI, the study coordinator interviewed women who participated in Strong Start Wraparound (caregivers) and team facilitators. Results showed good Wraparound fidelity in the study, with a Caregivers' Total WFI score of 1.63 out of a possible 2 and a Facilitators' Total WFI score of 1.65 out of 2. The similarity of ratings by mothers and facilitators also suggests close agreement between the two groups on how Wraparound was implemented through the study.

Discussion

Women in early recovery from substance use and simultaneously parenting infants benefited from a high-fidelity wraparound approach such as that provided through the Strong Start Study. The Wraparound team gave women access to professional and natural supports that helped them stay focused on their goals. In addition to sustaining recovery, Wraparound helped women prepare for and care for a new child by accessing the necessary resources and supports that allowed them to provide a safe, stable home for themselves and their children.

HELPING MOTHERS, HELPING BABIES

Participants in Strong Start Wraparound intervention developed more supports and better family relationships. Almost half the women were co-parenting with the father of their child, and the relationship was a positive support for the women's recovery. Although most participants did not receive formal mental health treatment, women in the study had fewer and less severe mental health–related and trauma-related symptoms at the end of their participation. These outcomes reflect the active problem solving, support, and associated reduction in stress through the high-fidelity Wraparound process.

The benefits to women in recovery and their infants from the Strong Start Wraparound intervention are consistent with other research findings on (a) factors related to women's successful recovery from substance use and (b) reducing maltreatment risks. First, the social connections provided through the Wraparound team offer the support and resources known to be important to sustaining early recovery from substance use (Carten, 1996; Gregoire & Snively, 2001; Marsh, D'Aunno, & Smith, 2000) and reducing maltreatment risk (Kotch et al., 1997; Wu et al., 2004). Second, assisting the family in addressing basic needs such as income and housing contributes to stability as they prepare for a new child and is important to the security needed by young children for optimal development (Sandstrom & Huerta, 2013). Third, research has found that addressing goals in other life domains such as education, vocational training, or employment are positively correlated with sustained recovery (Carten, 1996; Greenfield et al., 2003; Weisner, Delucchi, Matzger, & Schmidt, 2003) and contribute to future self-sufficiency. Fourth, the reduction in the severity of trauma-related symptoms has also been positively correlated with sustained recovery (Hien, Cohen, & Miele., 2004; Hien et al., 2010) and is an important area for further study with this population. Finally, self-efficacy—a central tenet of the Wraparound theory of change—was evidenced in the participants' increased confidence and sense of competence in themselves and their abilities and is a recognized factor in sustained recovery following treatment (Greenfield et al., 2000; Kelly, Hoeppner, Stout, & Pagano, 2011). These findings suggest that women who begin substance use treatment during their pregnancy and receive adequate supports during the first year postpartum may have better outcomes in sustaining their recovery and in their capacity to parent.

POLICY IMPLICATIONS

The findings from this study can inform child welfare policy in recognizing the potential for adequate caregiving of infants by their mothers in early recovery given appropriate intervention supports. Strong Start Wraparound in partnership with women's specialized treatment programs and the Part C early intervention system addresses the needs of both the mother and infant with a focus on family recovery. Given the low reunification rates once infants are removed from parental custody, the alternative of keeping a mother and infant together in a residential women's treatment facility with a Wraparound intervention should be a policy consideration for families in early recovery. Wraparound can also provide continuity for families during transition from residential treatment into the community while maintaining structure and support through an ongoing team planning process. Strong Start Wraparound offers the facilitated collaboration necessary when there are multiple systems involved with a family and is consistent with practice recommendations from the National Center for Substance Abuse and Child Welfare (Young et al., 2009) for the integrated planning that is needed with families in this population. On the basis of the interest and

engagement of families in this study, mothers in recovery who are parenting infants may prove to be willing participants in such programming efforts.

Conclusion

High-fidelity Wraparound shows promise as an innovative and effective intervention in supporting the early recovery needs of women who are parenting infants by helping them build protective factors critical to safe and stable family life. For these women, pregnancy can be the motivation to enter treatment for their substance use as they prepare themselves to parent. The Strong Start Wraparound approach provides the facilitated collaboration and team support that can help these mothers sustain their recovery, access resources to meet their basic needs, and provide a nurturing home environment for their children.

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The Fostering Hope Initiative

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ABSTRACT

The Fostering Hope Initiative is a neighborhood-based Collective Impact initiative that promotes optimum child and youth development by supporting vulnerable families, encouraging connections between neighbors, strengthening systems to ensure collective impact, and advocating for family-friendly public policy. This article describes the intervention and discusses the results of the project evaluation. The partnership's current and planned activities and priorities are also addressed, including development of a new measure to assess protective factors among families at risk for child maltreatment.

The Fostering Hope Initiative (FHI) is a neighborhood-based Collective Impact initiative (see box Collective Impact Initiatives) sponsored by Catholic Community Services of the Mid-Willamette Valley and Central Coast (CCS). FHI promotes optimum child and youth development by supporting vulnerable families, encouraging connections between neighbors, strengthening systems to ensure collective impact, and advocating for family-friendly public policy in Oregon.

Collective Impact Initiatives

Research conducted by the Stanford Social Innovation Review shows that successful collective impact initiatives typically have five conditions that together produce true alignment and lead to powerful results: a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and a backbone support organization.

SOURCE: www.ssireview.org/articles/entry/collective_impact

Project Description

FHI's vision is that every child and youth in every neighborhood lives in a safe, stable, nurturing home; is healthy; succeeds at school; and goes on to financial self-sufficiency. The FHI collaborative includes representatives from education, the business community, Latino organizations, faith-based groups, the public and private sector social services network, health care, and individuals. CCS, as the "backbone organization," supports collaboration across sectors for collective impact.

The purpose of the FHI is to strengthen families, promote optimum child development, and reduce the incidence of child maltreatment in targeted high-poverty neighborhoods through strategies that address each domain of the social ecology. The project (a) provides services such as home visiting, parent education and support, and volunteer respite care to mitigate sources of toxic stress and teach parents to be more resilient in the face of stress; (b) mobilizes neighborhood residents to connect with each other to promote family protective factors and thereby make their neighborhood a better place to raise children; (c) improves collaboration, quality, and accountability across partners through implementing strategies of collective impact; and (d) advocates for family-friendly public policy that pays for

outcomes rather than units of service and supports collaboration. Principles guiding the project include the following:

- Services must be family-centered, strengths-based, individualized, culturally competent, developmentally appropriate, and outcome-driven.
- The project must address the neighborhood through community outreach, neighborhood mobilization, and activities that bring families together.
- The project must be founded on principles of quality management, including a focus on the client, teamwork, and a scientific approach to data collection and analysis for program improvement.

LOCATION

For the Center for the Study of Social Policy's Quality Improvement Center on Early Childhood (QIC-EC) Research and Demonstration project, FHI selected six high-poverty neighborhoods in two counties in northwestern Oregon: Marion and Yamhill. Neighborhoods were defined by elementary school catchment areas. Marion County neighborhoods included two treatment sites (Washington and Swegle) and two comparison sites (Hallman and Hoover). All are in high-poverty northeast Salem, where approximately 80% of students qualify for free and reduced lunch. In addition, the neighborhoods ranked in the top 30% of neighborhoods in the city for crime. Approximately 78% of students in these schools reported an ethnicity other than White, as compared with an average of 30% across Oregon schools, with about 61% Hispanic students (18% average across Oregon schools). About 50% of the students in these schools were in English as a Second Language programs. In addition, the project selected two neighborhoods in Yamhill County: the Sue Buel Elementary catchment area in McMinnville (treatment neighborhood), and the Edwards Elementary catchment area in Newberg (comparison neighborhood). Although fewer data were available on the Yamhill County neighborhoods at the time that they were selected for inclusion in the Initiative, the mayor, chief of police, and superintendent of schools identified these as their city's high-poverty, high-crime neighborhoods.

PROJECT PARTICIPANTS

The target population for the project consisted of high-risk families with children less than 24 months old and for whom there had been no substantiated report of abuse or neglect at the time of enrollment. We used the New Baby Questionnaire (NBQ) to identify high-risk families during the screening process. Families were identified as high-risk if NBQ responses to items 1, 2, or 3 were present:

1. They report depression.
2. They report issues with drinking, drug use, or both.
3. They have any two or more risk factors in the list below:
   - Mother is 17 years old or younger (teen parent).
   - The primary caregiver is unmarried.
   - Prenatal care began more than 12 weeks into the pregnancy.
   - Lack of comprehensive prenatal care (fewer than five visits to a health care provider).
   - Education of the primary caregiver is less than a high school diploma.
   - Primary caregiver and spouse or partner are unemployed or seasonally employed.
   - Family experiences trouble paying for basic expenses "some" or "most of" the time.
   - "Some" or "serious" problems in marital or family relationships.

Families meeting the above criteria and residing in the selected neighborhoods were eligible to participate in the Initiative.

SERVICES RECEIVED

FHI used Healthy Families America (HFA), an evidence-based home visiting model with two modifications: the infant or pregnancy did not have to be the first birth for the family, and the target child could be as old as 24 months at the start of service (HFA requires service to begin within 3 months of birth). The home visitors also used the Parents as Teachers (PAT) curriculum during their home visits. The PAT curriculum was selected for the project because it is evidence-based, strengths-based, and culturally sensitive, with handouts and activity materials provided at two levels of reading ability to support parents with limited education or literacy.

In addition to receiving home visiting with wraparound supports, these families were eligible to participate in a variety of other services provided in the treatment neighborhoods including parent education classes, parent support groups (see box Community Café), community dinners, and other neighborhood engagement activities such as Annual Night Out parties, family literacy nights, play groups, coffee clubs, community gardens, and walking groups, all of which were designed to increase protective factors and decrease risk factors associated with child maltreatment.

Community Café

The Community Café is a form of democratic group conversation based on the World Café Model. Participants are seated in small café-style tables in groups of 3 to 5 and participate in progressive rounds of questions that matter to the community. Conversations and ideas are captured on paper and participants are encouraged to listen for patterns; share insights; and connect ideas, thoughts, and conversations. After small group discussions are complete, the larger group participates in a conversation to share discoveries.

SOURCE: Community café: Changing the lives of children through conversations that matter. (n.d.). **www.thecommunitycafe.com/documents/QuickGuideEnglish.pdf**

Project Evaluation

CCS's external research partner, Pacific Research and Evaluation, conducted the project evaluation for the grant. The evaluation was guided primarily by the following research question: How and to what extent do collaborations that increase protective factors and decrease risk factors in core areas of the social ecology result in optimal child development, increased family strengths, and decreased likelihood of child maltreatment, within families of young children at high risk for child maltreatment? (QIC-EC, 2009)

The evaluation design compared participants from targeted neighborhoods who received FHI home visiting and neighborhood-based services (i.e., treatment group) with families recruited from similar neighborhoods who did not receive coordinated services through the Initiative (i.e., comparison group). Tables 1 and 2 display the enrollment and demographic data for the final study sample. The majority of participants from all six study neighborhoods were Hispanic/Latino.

As shown in Table 2, the treatment and comparison groups were generally similar with regard to age, gender, marital status, education level, and household income.

In addition to providing basic demographic information, participants completed a series of standardized measures selected in collaboration with the QIC-EC. The measures were aligned with the areas of inquiry posed in the overarching research question for the project (i.e., optimal child development, increased family strengths, and decreased likelihood of child maltreatment). The sections to follow will discuss the results of two of the measures: the Parenting Stress Index™, Third Edition (PSI-3; Abidin, 1995) and the Adult Adolescent Parenting Inventory-2 (AAPI-2; Bavolek & Keene, 2005). The PSI-3 assesses the stress an individual is experiencing within the role as parent. The AAPI-2 is an index of risk of child maltreatment in five specific parenting and child-rearing behaviors. The measures were administered in the caregiver's primary language (English or Spanish) at baseline (when they entered the project) and 12 months following baseline.

In addition to administering the measures, the evaluators also conducted focus groups and interviews with the home visitors and parent educators and with a sample of parents and primary caregivers to hear their perspectives on the program's successes and challenges.

TABLE 1. **Final Study Enrollment**

Neighborhood	Final Study Total	% Hispanic Study Participants
Swegle	28	67.9%
Washington	27	63.0%
Sue Buel	15	86.7%
TREATMENT TOTALS	**70**	**70.0%**
Hallman	28	89.3%
Hoover	20	90.0%
Edwards	17	58.8%
COMPARISON TOTALS	**65**	**81.5%**
TOTAL	**135**	**75.6%**

TABLE 2. **Study Participant Demographics**

Demographic	Treatment	Comparison
CAREGIVER		
Mean age in years	28.3	29.5
% female	98.6%	100.0%
% married	50.0%	49.2%
% with less than a high school diploma/ GED	50.0%	58.5%
Household income under $30,000	88.5%	92.1%
CHILD		
Mean age in months	8.9	9.4
% female	36.8%	45.3%

Results

During the focus groups, the home visitors reported attending first to families' basic needs (e.g., food, housing) and providing "crisis services" (e.g., mental health, domestic violence). As a result, families gained trust in the home visitors and saw them as a source of concrete and social support. Once crisis services and basic needs had been addressed, home visitors reported that they worked with all of the protective factors to some degree, tailoring services to each family's needs. According to the project staff, in both home visiting and parent education, special emphasis was placed on the "nurturing and attachment" protective factor.

Data from the PSI-3 and the AAPI-2 were analyzed with analysis of covariance (ANCOVA), a statistical technique that is appropriate when groups demonstrate baseline differences. This approach was used because there were slight differences between the treatment and comparison groups on some demographic variables, in addition to some statistically significant differences on some subscales of the baseline measures.

Both the PSI-3 and the AAPI-2 generated statistically significant results, pointing to notable differences between caregivers who received wraparound services and supports through the FHI and caregivers who did not receive coordinated services through FHI. Specifically, program group participants felt more competent in their child-rearing abilities as measured by the PSI-3 Competence subscale. They were also more likely to have appropriate expectations of their children as measured with Construct A (Expectations of Children) of the AAPI-2 (see

TABLE 3. **Analysis of Covariance (ANCOVA) Results: Overall**

Measure/Subscale	*df*	*F*	*p*
PSI-3 Competence Subscale	116	4.55	.04
AAPI-2 Construct A—Expectations of Children	132	3.93	.05

NOTE: PSI-3 = Parenting Stress Index (Abidin, 1995); APPI-2 = Adult Adolescent Parenting Inventory-2, (Bavolek & Keene, 2005).

Table 3). Statistically significant results are those with *p* values less than or equal to .05. Such values indicate that the differences between the two study groups (in this case, differences between treatment and comparison group participants) are unlikely to have occurred due to chance and can be attributed with an acceptable level of confidence to the intervention (i.e., the FHI).

In addition to the investigation of differences between the program and comparison groups overall, the research team hypothesized that two subpopulations may have responded more positively to the intervention. Specifically, we hypothesized that Hispanic/Latino participants—who comprised the majority of the sample and demonstrated greater receptivity to the community engagement components of the Initiative—may have received a more substantial benefit from their participation. The research team also hypothesized that participants residing in Marion County, where the partnership had a significantly longer history of collaboration, also might have fared more positively. These hypotheses were confirmed by the analysis. Both subpopulations within the program group generated statistically significant results on the Competence subscale of the PSI-3 ($p < .05$) when compared to caregivers who did not receive coordinated program services.

The Child and Total Stress Domains of the PSI-3 also yielded statistically significant results for both of these subpopulations, indicating reduced stress from baseline to 12 months for the treatment group relative to the comparison group. The Child Domain evaluates sources of stress as gathered from the parent's report of child characteristics (distractibility/hyperactivity, adaptability, reinforces parent, demandingness, mood, and acceptability). The Total Stress Domain is a composite of the Child Domain and the Parent Domain, which measures sources of stress related to parent characteristics (competence, isolation, attachment, health, role restriction, depression, and spouse/parenting partner relationship). In addition, Marion County participants generated a statistically significant *p*-value for the Parent Domain as a standalone. Hispanic/Latino participants generated a significant result for Construct A of the APPI-2 (see Tables 4 and 5).

Finally, through a data-sharing agreement with the Department of Human Services, FHI participants were tracked throughout the study period. Upon completion of the project in October 2013, none of the study participants in any of the treatment or comparison neighborhoods had been the subject of a substantiated case of child maltreatment.

TABLE 4. **Analysis of Covariance (ANCOVA) Results: Marion County**

Measure/Subscale	*df*	*F*	*p*
PSI-3 Competence Subscale	89	7.22	.01
APPI-2 Construct A—Expectations of Children	101	3.52	.06
PSI-3 Parent Domain	89	4.76	.03
PSI-3 Child Domain	90	4.52	.04
PSI-3 Total Stress	89	5.81	.02

NOTE: PSI-3 = Parenting Stress Index (Abidin, 1995); APPI = Adult Adolescent Parenting Inventory-2 (Bavolek & Keene, 2005).

TABLE 5. **Analysis of Covariance (ANCOVA) Results: Hispanic/Latino Participants**

Measure/Subscale	*df*	*F*	*p*
PSI-3Competence Subscale	87	6.52	.01
APPI-2 Construct A—Expectations of Children	99	4.05	.05
PSI-3 Parent Domain	86	3.22	.08
PSI-3 Child Domain	88	10.04	.00
PSI-3 Total Stress	86	7.48	.01

NOTE: PSI-3 = Parenting Stress Index, Third Edition (Abidin, 1995); APPI-2 = Adult Adolescent Parenting Inventory-2, (Bavolek & Keene, 2005).

The results of the evaluation indicated that the FHI was effective in reducing parent stress and in generating appropriate expectations of children. These results provide evidence that replication or expansion of the Initiative is warranted, and that efforts are likely to generate the greatest benefit when there is strong interagency collaboration or a commitment to collective impact. This expectation is supported by the results generated for Marion County, the location where the partnership had a long history of collaboration and where the relationships were marked by trust and commitment to the mission, vision, and goals of the Initiative.

The fact that the results were more positive for Hispanic participants is somewhat difficult to interpret. The FHI model is neighborhood-based, informal, and based on an empowerment model. According to CCS staff, these design elements were embraced by Latinos in the target neighborhoods. In addition, FHI partnered with a local Latino outreach organization and service providers, and members of these agencies participated in both the leadership and implementation of FHI. Finally, staffing differences were present when comparing Latino and non-Latino home visitors. According to program administrators, Latino visitors tended to employ a "friendship model," embracing their role as neighborhood organizers and extending direct invitations to program participants to engage in various community events. Non-Latino home visitors, however, viewed themselves more narrowly as home visiting professionals, focusing on

implementing the HFA model with fidelity and allocating less time to the community engagement activities. Although there was no effort to match Latino participants exclusively with Latino home visitors, this did occur by necessity when a bilingual home visitor was needed. Thus, although the evaluation results clearly showed that Hispanic/Latino participants demonstrated more positive outcomes, the reason(s) for this difference is not clear. Any one of the factors described here, or some combination of them, may have resulted in improved outcomes for this group.

Developing a New Measure: The Strengthening Families™ Protective Factors Grid

The FHI collaboration is committed to continuously improving quality and accountability. All partners regularly discuss the Strengthening Families Protective Factors, and some have adjusted their policies and procedures to amplify their important role in building protective factors. Because of the FHI collaborative, more service agencies have become aware of the importance of helping families to build protective factors, and this has become a common objective of their work.

To support the partnership's engagement with the protective factors and in alignment with the objective of shared measurement included in FHI's collective impact structure, the local evaluator, in partnership with FHI Executive Team members and the Center for the Study of Social Policy, have developed the Strengthening Families Protective Factors Grid (see Learn More box). The Grid is designed to serve as a source of evaluation data while also providing a way for direct service staff to engage families in conversation regarding important life issues including the protective factors. Staff and client complete the ratings by engaging in a conversation in which they reach consensus on the items.

The Grid is currently being piloted with families receiving various levels of service ranging from weekly home visiting to brief, "light touch" assistance such as a single case management visit focused on resource or referral linkages.

Sustaining the Work

As the project moves beyond funding provided by the Center for the Study of Social Policy's QIC-EC, future efforts will focus on the following:

- **Collective impact backbone support for collaboration.** CCS will continue to seek funding to sustain and improve the functions of a backbone organization, as well as to support the collaboration activities of its partners.
- **Neighborhood mobilization.** CCS has adopted the Assets-Based Community Development approach to community building and has sought additional funding to support Neighbor Connectors using this approach for each FHI neighborhood. FHI will increase the number of bilingual/bicultural neighbor connectors in response to the significant numbers of Spanish-speaking residents in the FHI neighborhoods.
- **Safe families for children.** Voluntary respite care. CCS is committed to continuing to work with faith communities in the three-county area that are interested in sponsoring this faith-based respite care program. In response to a significant increase in the number of referrals and a need to increase capacity, a successful campaign was recently concluded and resulted in 102 additional families volunteering to provide respite care.
- **Parenting education.** As a longstanding provider of parent education, FHI will partner with Early Learning Hub, Inc., a new nonprofit organization in Marion County, Oregon, to help build a common vision for parenting education in the region, support expanded access to best practice parenting education programs, and help make parenting education a community norm.
- **Health.** The scope of FHI is broadening to include greater attention to health disparities and outcomes, and FHI is currently engaging health care administrators and practitioners in the collective impact initiative. A representative of It Takes a Neighborhood—a Kaiser Permanente project in cooperation with Northwest Human Services—has now joined the Executive Council, providing invaluable support in both building connections with the health care industry and working with the FHI collective impact coordinator to define health care pilot projects within FHI. FHI has also recently partnered with the Northeast Oregon Network on a Centers for Disease Control Community Transformation grant, and FHI neighborhoods have added community gardens and exercise classes to support healthy eating and active lifestyles among residents.
- **Advocating for policy change.** CCS and its partners will continue to advocate for policy change at the state level, working to devise policies that are more family-friendly, support collaboration across

Learn More

Catholic Community Services of the Mid-Willamette Valley and Central Coast **www.ccswv.org**

Fostering Hope Initiative **www.fosteringhopeinitiative.org**

Pacific Research and Evaluation **www.pacific-research.org**

For questions about the Strengthening Families Protective Factors Grid, please contact Dr. Steven Rider

providers, fund activities to strengthen families and promote optimum child development at both a family and neighborhood level, and reinvest cost savings from reductions in foster care and a reduced need for residential treatment facilities—and concomitant savings in other state systems such as remedial education, juvenile justice, physical and behavioral health—into effective programs such as the FHI.

Ste e Rid , D , is the president of Pacific Research and Evaluation. He earned his doctorate in clinical psychology at the University of Arizona and has been conducting research and program evaluation for more than 20 years. Dr. Rider has directed a wide range of local and state projects as well as studies funded by a variety of federal agencies, including the National Institutes of Health, the National Science Foundation, the Centers for Disease Control and Prevention, and the Departments of Education, Health and Human Services, Labor, Defense, and Justice. He has authored journal articles and book chapters, and has presented numerous papers at regional, national, and international scientific conferences. Dr. Rider has taught college courses in statistics and research methods and has expertise in qualitative and quantitative methods, measure development, and survey research.

K Wi , MA, earned a master's degree in program evaluation and organizational behavior from Claremont Graduate University. For more than a decade she has been conducting applied research for community-based, state, and national organizations including studies addressing child maltreatment prevention, interagency collaboration, mental health, parenting education, and school readiness. With expertise in all aspects of evaluation design and implementation, Ms. Winters has guided single and multiyear projects using a variety of mixed-method and quasi-experimental designs. She is currently a research associate at Pacific Research and Evaluation in Portland, Oregon.

y e Da MB , holds a master's in education, specializing in severe behavioral handicaps, from the University of Illinois, Champaign-Urbana. She is currently senior partner of the woman-owned consulting firm, Dean/Ross Associates. She retired from the University of Oregon, having been a senior research assistant in educational and community supports in the College of Education for more than 30 years. Based on her special interest in quality systems management, she authored the book *Quality Improvement in Employment and Other Human Services: Managing for Quality Through Change*. The book applies principles and methods of continuous quality improvement to human services. For more than a decade, Joyce has supported early childhood programs through Catholic Community Services of the Mid-Willamette Valley and Central Coast—writing proposals for funding, as well as assisting in database design, systems development, staff training, and policy/procedure development.

i m Sp mo , MPA, is a recognized leader of social services innovation. Jim holds a master's degree in public administration from Lewis and Clark College. He serves on the Harvard University Frontiers of Innovation Site Advisory Council, the Marion County Early Learning Hub, and the Yamhill County Early Childhood Coordinating Committee. He has served on numerous other state and local boards and committees including the Oregon Juvenile Justice Advisory Committee, the Oregon Alliance of Children's Programs Board of Directors, and the Marion County Health Department Advisory Board.

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A Systemic Approach to Implementing a Protective Factors Framework

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ABSTRACT

The leadership team of the National Quality Improvement Center on Early Childhood ventured into the frontiers of deep change in social systems by funding four research projects. The purpose of the research projects was to learn about implementing a protective factors approach with the goal of reducing the likelihood of child abuse and neglect. In tandem, the cross-site evaluation team ventured into the evaluation frontiers by using developmental evaluation, an approach designed to investigate systemic change in complex social systems. The article discusses the evaluation methodology, ways to understand and influence systems change, key learning about provider and partnership support for parents, outcomes for parents, guiding principles for implementing a protective factors approach, and implications for a long-term research and practice agenda.

The National Quality Improvement Center on Early Childhood (QIC-EC) funded four research and demonstration (R&D) projects in 2010. Although the four sites differed with regard to setting, intervention, and population served, all four used the Strengthening Families™ protective factors framework as the basis for bringing about fundamental change in social systems to more effectively support parents of young children and reduce the likelihood of child abuse and neglect. In this context, social systems include formal and informal organizations, partnerships among organizations, and the social networks of communities. The protective factors framework is the cornerstone of the Strengthening Families approach to mobilizing partners, communities, and families in support of healthy child development (Center for the Study of Social Policy, 2011). The framework includes five interrelated protective factors: parental resilience; social connections; knowledge of parenting and child development; concrete support in times of need; and social and emotional competence of children.[1] These protective factors individually are correlated with the desired QIC-EC outcomes of optimal child development, increased family strengths, and decreased likelihood of child maltreatment (Horton, 2003).

The QIC-EC leadership team recognized that using the protective factors approach involved changing core aspects of social systems that affect parents, not just changing direct interventions with parents. Consequently, the QIC-EC required that each of the four project interventions include both an evidence-based or evidence-informed practice (in which providers worked directly

[1] A sixth protective factor—nurturing and attachment—was also investigated to determine if it was an independent factor or a component of the Strengthening Families protective factors framework. The work in the R&D projects indicated that the nurturing and attachment factor was embedded in the other protective factors. This relationship was reinforced in the exploratory factor analyses conducted on the pre-test case data from the Caregiver's Assessment of Protective Factors, one of the measures used across the projects. These analyses found the items in the Social and Emotional Competence subscale and the Nurturing and Attachment subscale were measuring a single construct (Parsons, Jessup, & Moore, 2014a).

with parents to support them in building protective factors) and a collaborative partnership of individuals and organizations concerned with the connection between the direct work with parents and the larger community and societal systems in which the direct work was occurring.

The R&D sites were funded for a 40-month period. The Strong Start project, in Colorado, worked with women in substance abuse treatment programs (Teel, this issue, p. 27). Project DULCE, in Massachusetts, focused on parents of infants from birth to 6 months old in a low-income and immigrant community served by the Boston Medical Center primary care pediatric clinic (Sege et al., this issue, p. 10). Fostering Hope, in Oregon, focused on parents of young children in low-income and immigrant neighborhoods in six high-poverty neighborhoods in two counties (Rider, Winters, Dean, & Seymour, this issue, p. 37). The Family Networks Project worked with parents of young children with disabilities enrolled in the Part C early intervention program in two regions of South Carolina (Shapiro, this issue, p. 19). Each site had its own project director and local evaluator. The sites worked with parents (nearly all mothers) of young children from birth to 5 years old.

In all sites, listening to parents played an important role in shaping how the interaction between providers and parents unfolded.

Strengthening Families is an approach, not a specific intervention. The Strengthening Families approach is intended to be implemented through small but significant changes in everyday actions and be incorporated into existing programs, strategies, and social systems over extended periods of time such that the social systems are fundamentally adjusted. It is not a quick fix but rather a fundamental shift in the way of thinking about the prevention of child maltreatment and support for the well-being of young children and families.

Early on, the QIC-EC cross-site evaluation work clarified an important distinction with respect to protective factors that was relevant for both the work of providers and the role of partnerships. The parents themselves are building and using the protective factors in their everyday lives as they interact with their children, family, friends, peers, providers, community, and the larger society. The providers and other organizations and entities support the parents as the parents build their own protective factors. This is a significant departure from many service-oriented perspectives that confer credit on providers for building the capacity of the parents.

In this article, we describe the cross-site evaluation methodology, what we learned about implementing a protective factors approach, and the implications for a long-term research and practice agenda. See Parsons, Jessup, and Moore (2014a) for the supporting data and a more detailed discussion of each of these topics.

The QIC-EC Cross-Site Developmental Evaluation

The QIC-EC leadership team wanted a cross-site evaluation that recognized the complexity of social systems. Rather than attempting to eliminate or ignore the complexity, they sought an approach that acknowledged and embraced complexity. In response, we chose developmental evaluation (Patton, 2011). Intended for complex situations and interventions, developmental evaluation supports those working with complex systems, interventions, and environments that evolve over time.

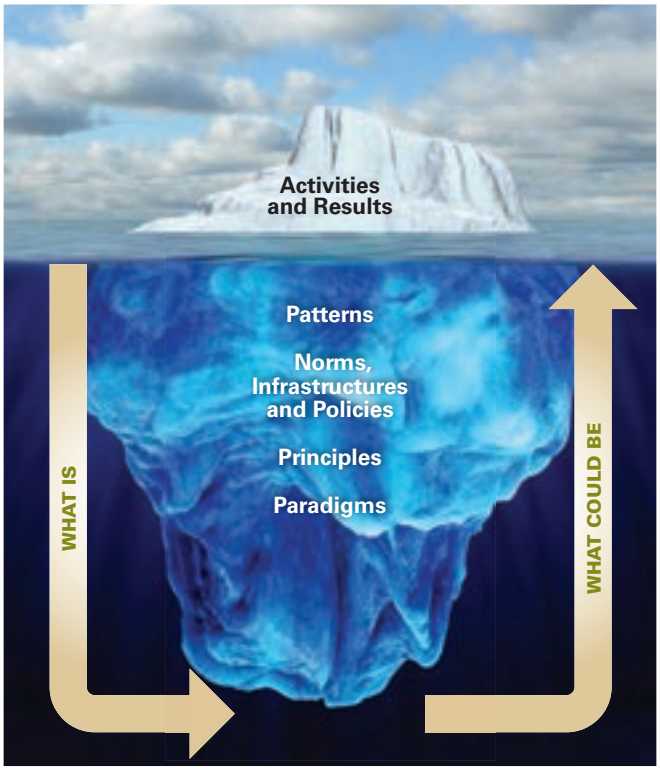
A developmental evaluation takes into account that change happens in "fits and starts" and through different cycles and timeframes across the levels within hierarchical organizations, informal organizations, social networks, and the domains of the social ecology. It draws on theories about complex adaptive systems as well as theories about hierarchically designed social systems (Parsons, 2012; W. K. Kellogg Foundation, 2007).

Years ago, social systems could be changed to better meet the needs of the people by introducing individual new programs or policies. Evaluators would look at refining an initial program of direct service through formative evaluation to standardize a set of key activities that produce predictable outcomes. The intention was to make a program ready for a carefully controlled summative evaluation to determine if the program works.

Today's social systems are complex, highly intertwined, and dynamic. New interventions overlap with existing programs. Making an intervention effective may require adaptation—or even elimination—of existing programs and practices as well as changes in system structures. The nature of the needed changes may not be immediately apparent. Consequently, other forms of evaluation are needed. Although formative and summative evaluation methods continue to be important, they are enhanced when they are accompanied by evaluation approaches, such as developmental evaluation, that recognize the complex connections of programs operating within organizations and larger social systems.

Developmental evaluation often includes bounded formative and summative evaluations nested within an evaluation approach that investigates the surrounding complex of social systems. In other words, one need not reject former evaluation methods; rather nest them within a developmental evaluation design that incorporates and goes beyond evaluation of evidence-based programs and practices to gain increased depth of understanding and opportunities to make significant systemic change.

FIGURE 1. **The Iceberg Diagram: Visibility and Depth of Change**



Iceberg image: iStockphoto.com/jgroup

SYSTEMIC CHANGE

The iceberg diagram in Figure 1 illustrates the system features that provide opportunities to change social systems (Parsons, Jessup, & Moore, 2013). The tip of the iceberg illustrates the observable activities and results of a specific intervention for, say, parents. To understand how to influence systems change, evaluators need to look below the surface to the norms, infrastructures, and policies that more significantly define social systems than do specific programs. They are the leverage points—places in systems where a small change can lead to a significant shift in individual and collective behavior that, in turn, leads to different visible activities and results. By identifying potential deeper system leverage points, the evaluator can assist initiative leaders to take action to efficiently move toward their desired outcomes. The deeper one goes in the iceberg, the more effective and sustainable the shift is likely to be. However, those deeper changes often are more difficult to accomplish.

To understand how to influence systems change, we (the cross-site evaluation team leaders) looked below the surface to understand norms, infrastructures, and policies; we moved beyond the direct work of providers with parents into looking at the work of organizations and partnerships. We focused on identifying patterns of similarities, differences, and relationships across the four sites. From the data, we identified patterns that seemed to connect the actions of providers and parents to the norms, infrastructures, and policies of relevant organizations.

Moving deeper, we sought to understand the implicit guiding principles that shaped the actions of people across the systems.

The guiding principles are connected to people's underlying paradigms (also referred to as their world view or mental model). We considered ways in which elements of the existing social systems were and were not congruent with the paradigm of a protective factors framework.

The protective factors framework is an expression of a strengths-based paradigm. Currently, many aspects of social systems are built on a paradigm of deficits, that is, the focus is on what is lacking or weak within a person or situation. The QIC-EC is built on a paradigm of strengths, that is, the focus is on supporting and extending strengths within a person or situation.

The large arrows on the sides of the iceberg illustrate our cross-site evaluation process. We worked down through the increasingly less visible characteristics of the social systems to understand the underlying paradigm that was shaping the current activities, norms, infrastructures, policies, and other features. The arrow on the right illustrates the aspects of the evaluation processes that involved understanding the differences in how participants functioned when they acted in accord with the new paradigm (in this case, the protective factors framework).

MIXED METHODS

Developmental evaluation often uses a mix of research designs and methods tailored to fit the context. Within the QIC-EC, each R&D project developed its own experimental or quasi-experimental evaluative research design to explore the connection between the intervention by providers and results for parents. Each project's principal investigator and evaluator gathered and analyzed parent outcome data on a set of common outcome measures selected by the QIC-EC as well as locally determined measures. We and our colleagues then used the parent outcomes data that was gathered using the common measures for cross-site analyses. To understand how the use of

FIGURE 2. **National Quality Improvement Center on Early Childhood Cross-Site Evaluation Data Sources**

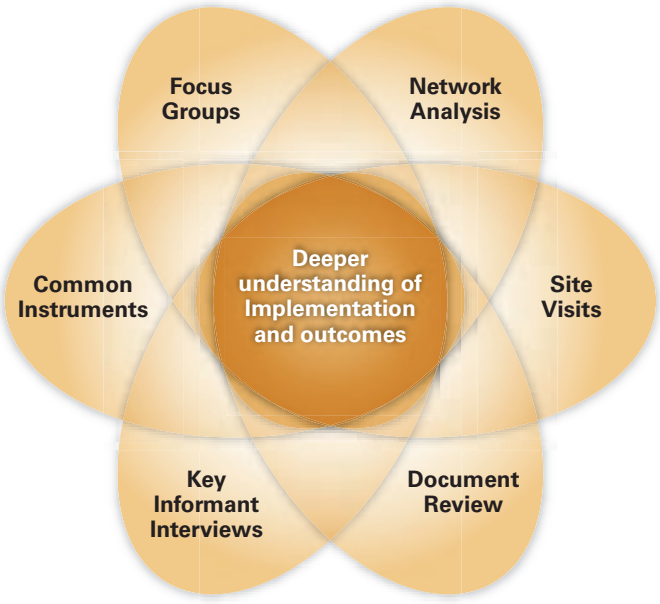


Photo: iStockphoto.com/dimafoto

The Strengthening Families approach is intended to be implemented through small but significant changes in everyday actions

the protective factors approach may be related to the parent outcomes, we gathered data about common patterns across the interventions. These data were largely qualitative and often involved the use of rubrics to guide data collection and analysis.

Data about the collaborative intervention (which included the work of the partnerships) came from a variety of sources. During our annual site visits, we collected data through interviews that addressed the link between providers' work with parents and system norms, infrastructures, and policies. We also conducted document reviews, parent focus groups, and partner online surveys that allowed for network analysis. By working back and forth among these data sources, we looked at patterns across sites to develop an understanding of how implementation of a protective factors approach occurred and was linked to results for parents and changes in system features. We also used the data to make explicit a set of guiding principles for implementing the protective factors framework that had not yet been articulated through previous Strengthening Families research. Figure 2 illustrates the mix of data sources we used to gain insight into the systemic changes occurring or that might need to occur for implementation of the protective factors framework.

PARTICIPATORY AND ITERATIVE

In a developmental evaluation, evaluators engage with the leadership and stakeholders of the initiative being evaluated in a participatory and iterative process. We engaged the project principal investigators, local evaluators, and the QIC-EC leadership team in an interactive and iterative process of interpretation of the evidence and further data gathering with new questions and issues that moved to deeper levels of understanding over time. The process included in-person meetings two or three times each year and phone conversations at least monthly. The QIC-EC project director also participated in site visits to learn firsthand about the project work and to interact with the cross-site evaluation team during the visit. The work involved a continual movement between the parts (e.g., the project sites), the whole (e.g., the QIC-EC), and the greater whole (e.g., the child maltreatment prevention field).

Key Learning From the Cross-Site Evaluation

In conversations with stakeholders during site visits, we drew on the iceberg diagram to illustrate and communicate the nature of systemic change. Generally speaking, when talking with providers, we were seeking to understand the specifics of their activities and the results for parents (the tip of the iceberg). When working with the leaders of the providers' organizations and the organizations within the partnerships, we focused more heavily on the norms, infrastructures, and policies that these key leaders and influencers of the social systems were affecting.

The cross-site evaluation data gathering and analysis moved back and forth through the levels of the iceberg from the activities and results at the tip of the iceberg to the paradigms at the deepest level of the iceberg. Through this iterative process, we identified patterns that helped us understand what it meant to implement the protective factors framework through different interventions with different populations in different contexts. The cross-site evaluation yielded key learning in four areas:

- provider support for parents,
- cross-site parent outcomes,
- partnership support for parents, and
- guiding principles for implementing the protective factors framework.

We discuss each of the areas of learning in the next four sections of the article.

Provider Support for Parents to Build Their Protective Factors

Provider support to parents can be understood as an activity at the tip of the iceberg. The providers in the R&D projects included home visitors, family specialists, early intervention personnel, and wraparound facilitators. Because of their particular roles, these providers were in a position to address all of the protective factors with the parents within the boundaries of their particular evidence-based model. The work of the providers was shaped by the evidence-based intervention model they used and their organization's infrastructure, policies, practices, and norms. The findings showed that providers supported the building of parents' protective factors by (a) using the protective factors framework, (b) building relationships between parents and providers, and (c) starting interventions where parents were. The findings also provided insight into how providers received support from their organizations. The QIC-EC leaders drew on examples of how providers supported parents as they enhanced their documents about the Strengthening Families protective factors framework (Center for the Study of Social Policy, 2011) and in their explanation of the core meaning of the protective factors (Center for the Study of Social Policy, 2013a).

USING THE PROTECTIVE FACTORS FRAMEWORK

As the cross-site evaluation data accumulated and as project leaders and providers became more explicit about how they used the protective factors framework, it became evident that it was more powerful for providers to use the protective factors as a coherent framework rather than as a set of separate factors. When the providers introduced all of the protective factors to the parents and helped the parents see the protective factors as a framework, both providers and parents were more inclined to use the protective factors to guide decision making. In such situations, participants came to understand the protective factors approach and were able to move back and forth between using the protective factors framework as a whole and engaging the protective factors as separate entities.

BUILDING RELATIONSHIPS BETWEEN PARENTS AND PROVIDERS

No matter what intervention was used, the relationship between provider and parent was key to the support that was provided. In all sites, listening to parents played an important role in shaping how the interaction between providers and parents unfolded. Giving parents choices in how and what services they received supported mutually respectful and trusting relationships and helped to equalize the power imbalance that often exists between providers and recipients of services.

Building strong relationships required that differences be embraced and supported, and that all participants recognized that learning and growth was a shared and mutual process—not something given by one and received by the other. In the focus groups, parents repeatedly called attention to the caring atmosphere and mutual respect engendered by providers. Both providers and parents recognized that it was the depth of trust and respect within the relationship that helped parents to share more openly about serious issues they were facing (e.g., abusive relationships, thoughts of suicide, fears of being deported).

The QIC-EC leadership team recognized that using the protective factors approach involved changing core aspects of social systems that affect parents, not just changing direct interventions with parents.

STARTING WHERE THE PARENT IS

Across sites, providers generally began their work with parents by identifying areas where they could help parents reduce their most immediate stress. In general, providers discussed tailoring their approach to the unique circumstances of each family, while staying within the boundaries of their particular intervention. This allowed them to "start where the parent is" and then move to addressing issues that felt less urgent to parents or were more difficult for parents to discuss early on.

SUPPORTING PARENTS THROUGH ORGANIZATIONAL SUPPORT FOR PROVIDERS

Provider support was the visible activity at the tip of the iceberg, yet underlying the activities of provider support were the norms, infrastructure, and policies of the provider organizations. Providers worked within an organization and within a broader system that included multiple organizations. How the organizations functioned affected the ability of the providers to work effectively with parents. When organizations adjusted their practice to operate in ways that were philosophically congruent with the protective factors approach, they were able to support providers to support parents as they built their protective factors. For example, the front desk staff of one agency (until retrained) required a parent with a newborn who was late for an appointment to reschedule for another day. For families who lacked control of their transportation options, the expectation to reschedule was incongruent with a respectful, caring relationship. Through staff training, the organization was able to find a new balance between efficiency and respectful, caring, trusting relationships with those they served and supported.

Cross-Site Parent Outcomes

The cross-site parent outcomes were related to optimal child development, family strength, and reduction of child abuse and neglect. They can be understood as the results at the tip of the iceberg.

Following numerous discussions with project site personnel and with us, the QIC-EC leadership team selected six common measures—instruments to use pre- and post-intervention to measure background factors and parent outcomes with parents in both the treatment and comparison groups by each project. Three of the six common quantitative measures were nationally validated instruments: the Adult-Adolescent Parenting Inventory (Bavolek & Keene, 2001), the Parenting Stress Index (Abidin, 1995), and the Self-Report Family Inventory (Beavers & Hampson, 1990).

One instrument—a social network map (Tracy & Whittaker, 1990)—was adapted for use in the QIC-EC. Two instruments were developed specifically for this project: the Caregiver's Assessment of Protective Factors, and a background information form that included questions about family conditions.

Each of the sites conducted their own site-specific analyses of the common measures to understand the link between their intervention and parent outcomes. We and our colleagues analyzed the common measures across the sites using methods designed to determine possible linkages between implementing the protective factors framework and outcomes for parents.

Overall, only a few results that compared treatment and comparison group parents on the common quantitative measures (either by site or across sites) were statistically significant, or approached statistical significance. However, four such cross-site differences were of particular interest. Although these results are concentrated within a few of the many variables that were measured, relative to the comparison group, the treatment group showed:

- enhanced concrete support in times of need,
- increased protective factors overall, and
- unchanged family risks (whereas the comparison group showed increased family risks).

In addition, among parents entering a program with higher stress (i.e., those with a Parenting Stress Index total stress score of 260 or higher), parents in the intervention condition increased social connections while those in the comparison condition decreased theirs. See Parsons et al. (2014a) for details of the analysis methods, further data, and possible interpretations of the patterns.

Bringing about systemic change calls for new types of interactions between researchers, evaluators, practitioners, and parents.

Given that the average duration across all interventions for a parent was only about 6 months and that the interventions were not necessarily fully aligned with the protective factors framework, the lack of more robust findings was not surprising. On the other hand, given these conditions it was encouraging to see that these results did occur across these diverse interventions. The outcomes help provide a focus for further research and practice about issues such as the link between the protective factors framework, existing practices, and any new intervention; the duration and intensity of an intervention; the nature of the interaction between provider and parent; and the similarity between the intervention and existing practice. For example, rather than inquiring into the duration and intensity of interventions across families, a study might look into the results of interventions that continue until family needs are met (which might be brief or low-intensity for some families and longer or higher-intensity for other families).

The results also highlighted the need for measures that are congruent with a strengths-based protective factors framework. The QIC-EC leadership team found that, when identifying common outcome measures, the majority of choices were deficit-based, with a more traditional focus on risk-reduction.

Partnership Support for Parents

Requiring that each site include an established partnership—a core group of organizations that had previously collaborated and established a trusting relationship—was an innovative and unusual requirement for research studies of evidence-based practices. The types of entities involved in the partnerships in the R&D projects included social services agencies, nonprofit organizations, and hospitals, as well as other formal and informal organizations and networks that influence the parents within a community or the larger society. Some partnerships also included parents. Looking at partnership activity from the angle of the iceberg metaphor, we saw that the partnerships were important for effecting systemic change because so much of the partnership work occurs at the level of norms, infrastructure, and policies.

Although the partnerships were at the early stages of making sustainable systemic changes through changes in provider–parent relationships and changes in norms, infrastructure, and policy, as the project progressed, the partnerships increasingly realized how they could be major players in creating an enabling environment within the community and the larger society. The partnerships provided a means for partner organizations to understand the systemic changes necessary to ground the interventions in the protective factors approach. Partnerships saw new ways to be players in creating an enabling environment within the community and the larger society that supported parents directly to use and build their own protective factors and indirectly through providers and the provider organizations who support parents.

Through the cross-site evaluation, we learned the following about the role of partnerships:

- Partnerships bring the language and concepts of protective factors into their organizations.
- Partnerships stimulate a broad community-wide network of flexible and responsive supports for providers and parents.
- Partnership meetings are a place to discuss difficult issues.
- Partnerships help members to see their multiple roles in creating the long-term enabling environment for providers and parents by attending to norms, policies, and the infrastructure of organizations and communities.

Change to Guiding Implementation Principles

Complex systems theory points to the importance of guiding principles—rather than detailed rules—when changing complex social systems. This theory base is reflected in the iceberg diagram in Figure 1. As the guiding principles are enacted in tandem with the protective factors to shift the systemic norms, infrastructures, and policies of the social systems, the visible activities and results also change. The paradigm of the Strengthening

Families protective factors framework is the "what" and the guiding principles are the "how."

One of the major results of the cross-site evaluation was the articulation of a set of five guiding principles that can now be refined and tested in future research and practice. These guiding principles emerged as the R&D project providers and partnerships engaged in the practices discussed about supporting parents in building their protective factors. We focused on understanding how the multiple actors in each site implemented the protective factors framework. The guiding principles are:

- Use the protective factors framework as a mental model for decision-making and action.
- Create and build mutually respectful, caring, trusting relationships.
- Address disparities in power and privilege.
- Provide flexible and responsive support.
- Persist until needs become manageable.

See box Guiding Principles for more details about each principle.

The guiding principles were generated on the basis of interactions between parents and providers, interactions between providers and their organizations, and interactions between members of the partnerships. The guiding principles express ways of acting and working at these key intersections to support parents as they build their protective factors. The guiding principles are a companion to the protective factors paradigm; the guiding principles provide a basis for implementing the protective factors framework—a framework that consists of interconnected, overlapping, and mutually reinforcing protective factors. For example, two providers working in different contexts may use different interventions addressing the protective factors while both adhere to the guiding principles; a policymaker would apply a guiding principle in a different way than would a provider working with a parent.

The five principles provide guidance on how the protective factors approach can be put into practice through small but significant changes in everyday activities and "become part of existing programs, strategies, systems and community opportunities" (Center for the Study of Social Policy, 2011). As participants in the systems that support parents to build their protective factors repeatedly apply these guiding principles, they begin to touch deeply on the norms, practices, infrastructures, and policies that bring about and help sustain complex systems change. Across different populations, different contexts, different actors, and as work proceeds at different paces, the guiding principles along with the protective factors become a compass to direct one's action. The guiding principles ensure that avenues of support are responsive to parents, integrate the protective factors framework, and strengthen relationships across the social ecology on an ongoing basis.

Guiding Principles

The following principles provide guidance to providers, organizational leaders and managers, policymakers, and others on how to implement the protective factors within their spheres of influence.

Principle 1
Use the protective factors framework as a mental model for decision-making and action. Be active, intentional, and explicit in using the protective factors framework. Use the framework as a conceptual whole and the individual factors, as appropriate, to respond to parents' needs and strengths, to allocate resources, and to adjust practices, norms, infrastructures, and policies.

Principle 2
Create and build mutually respectful, caring, trusting relationships. Be active and intentional in developing relationships based on respect, caring, and trust. Build relationship-based practices, norms, and policies into interactions with the multiple participants in a situation: parents, women, men, children, families, communities, neighborhoods, providers, partnerships, and organizations (public, private, provider, faith-based, and nonprofit).

Principle 3
Address disparities in power and privilege. Be active and intentional in working toward reducing disparities in power and privilege that undermine respectful, trusting, caring relationships. Build practices, norms, infrastructures, and policies among partners and institutions that provide for ongoing reflection and action to reduce disparities in power and privilege.

Principle 4
Provide flexible and responsive support. Personalize services and support to the unique strengths, needs, and resources of parents. Encourage practices, norms, infrastructures, and policies that allow appropriate, individualized responses.

Principle 5
Persist until needs become manageable. Maintain support to parents until their needs become manageable. Support sustainable, adaptive responsibility for managing and resolving parent needs by developing practices, norms, infrastructures, and policies across organizations, communities, and the broader society.

Call to Collective Action

The cross-site evaluation generated a deep understanding of how to sustainably ground a protective factors framework in today's complex array of social systems. Given what we learned through conducting the cross-site evaluation of the QIC-EC R&D projects, we suggest a long-term agenda that closely links research, evaluation, and practice. We encourage a developmental approach to continue the movement toward establishing a protective factors framework as the foundation of social systems that affect parents of young children.

Bringing about systemic change calls for new types of interactions between researchers, evaluators, practitioners, and parents.

Learn More

For further information about using developmental evaluation and understanding complex adaptive systems, see the following sources:

Questions That Matter: A Tool for Working in Complex Situations
B. Parsons & P. Jessup (2011). Ft. Collins, CO: InSites.
www.insites.org/091312_WorkSession_MA/QuestionsThatMatter(031712).7-10.pdf

Evaluating Social Innovation
H. Preskill &T. Beer (2012) **www.fsg.org/tabid/191/ArticleId/708/Default.aspx?srpush=true**

Their combined perspectives and interactions are essential to accomplish the challenges and opportunities ahead. Leadership strategies such as those used by the QIC-EC leadership team to develop ongoing "inquiry-based communities of learning" in combination with evaluation approaches such as developmental evaluation hold promise for sustaining movement toward deep and lasting systemic change.

Those involved in continued research, evaluation, and practice about protective factors have four important resources from the QIC-EC work:

- Expanded Strengthening Families documents about the protective factors framework (Center for the Study of Social Policy, 2011, 2013a, 2013b),
- Guiding principles for implementing the protective factors framework,
- Expanded measurement resources, and
- Insights into the role of partnerships.

The expanded Strengthening Families protective factors documents, which integrated new research and drew on examples from the QIC-EC R&D projects, are central to future research (Browne, this issue, p. 2). The document describing the core meaning of the protective factors (Center for the Study of Social Policy, 2013b) is of particular importance for future research and evaluation.

The expanded protective factor framework provides the "what" of the protective factors approach to the prevention of child abuse and neglect; the principles provide the "how." Both the protective factors framework and the guiding principles are relevant across role groups within organizations and partnerships. Understanding of how to best implement a protective factors approach will continue to grow as future researchers, evaluators, and practitioners intentionally build interventions from the protective factors framework and guiding principles or integrate them into existing interventions focused on the reduction of child maltreatment.

The new Caregiver's Assessment of Protective Factors under development by the Center for the Study of Social Policy will be a valuable measure of parent outcomes. One of the key issues highlighted through the work of the QIC-EC was the dearth of measures philosophically congruent with a protective factors approach to child maltreatment prevention.

In addition, the rubrics we developed in cooperation with the QIC-EC leadership team (Parsons et al., 2014) serve as examples for developing rubrics or other measurement devices to understand the extent to which the guiding principles and protective factors are used by providers and partners in their interventions. Such measures are needed to understand how the use of the protective factors framework and guiding principles relates to changes in norms, infrastructures, and policies as well as in activities and results for parents and children. These measures can deepen the understanding of issues such as the importance of the frequency, intensity, and duration of the intervention with parents, the degree to which individual needs are addressed, and the role of partnerships.

The cross-site evaluation findings support the importance of partnerships for sustainable and deep change in social systems. The changes in social systems needed to support the protective factors framework require rethinking the boundaries and interconnections among existing programs, systems, and organizations. Partnerships need guidance and examples of how to find the powerful points of influence to stimulate sustained change in social systems (Meadows, 2008). Partnerships also can benefit from explicit theories of the roles of the partnerships in undertaking change within the relevant social systems at the community and societal domains of the social ecology.

As leaders of the cross-site evaluation team, we have been in a unique position to see patterns across the QIC-EC sites and share our findings with the sites, the leadership team, and the greater field of child maltreatment prevention. And, yet, there was one group of stakeholders that we did not survey or interview. That group was the children themselves, who, at all the sites, were too young to speak for themselves. But it was their care and well-being that was at the heart of this project and it is with them in mind that we hope that this research will be carried forward and the protective factors framework and guiding principles will be embraced by parents, supporters, providers, partnerships, researchers, and policymakers. It is through the efforts of all of these groups that the hope of optimal child development and well-being thrives.

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Building a Lasting Foundation for Promoting Protective Factors Across Children's Bureau Programs

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ABSTRACT

Over the years, various federal and non-federal organizations have disseminated and promoted a number of protective factor frameworks to reduce risk and optimize family functioning and child development. There is a growing interest in and commitment to examining factors that transcend the traditional deficit-based approach to addressing social and health problems which have focused primarily on risk factors. This article provides a brief history, current efforts, and recommendations for future directions for embedding a protective factors approach throughout the Children's Bureau's child maltreatment prevention, intervention, and treatment activities.

There is a significant body of research across a range of disciplines that points to the importance of reducing risk factors and promoting protective factors in order to prevent the adverse effects of child maltreatment, domestic violence, mental and behavioral health disorders, substance abuse disorders, and other health and social problems. This vast literature points to a variety of different risk and protective factors depending on the topic of interest and problem to be addressed. Over the last 20 years, practice and research have begun to shift away from simply identifying risk factors to promoting protective factors and understanding the underlying protective and promotive processes. A growing body of evidence from research and practice shows that many children and youth, even those who have experienced trauma or other adversity, are able to avoid or mitigate negative outcomes more readily than others. These characteristics, or protective factors, are associated with improved outcomes, and can be assessed as interim results to help determine the effectiveness of investments in services and supports. For example, some of those characteristics include relational skills, self-regulation skills, parenting competencies, and positive peers. These characteristics can be conceptualized as protective factors, as well as measured as outcomes during or after an intervention (Development Services Group, Inc., 2013).

Promoting Protective Factors at the Children's Bureau

The Children's Bureau has focused on promoting protective factors to prevent child maltreatment for the last decade, in concert with a push to identify measurable outcomes and rigorously evaluate prevention programs. Many states and their local programs were frustrated by the limitations of using child protective services data as the primary source of data for examining outcomes of child abuse prevention programs. The field was very interested in identifying other short-term and interim outcomes that more accurately reflected the domains that were most likely to be affected by prevention programs, such as parenting, family support, and home visiting programs. Program administrators felt short-term and interim outcomes such as providing family support, improving parenting skills, and promoting positive parent–child interactions were more amenable to change, especially for the types and duration of interventions that were being funded.

Around the same time, Prevent Child Abuse America's work with the Frameworks Institute on reframing child abuse and neglect was also a focus of the field's thinking. This work included a landmark research study that examined all news articles and messages about child abuse and neglect that had been communicated to the general public over the last few decades. The researchers learned that most people understood that child abuse and neglect is a serious problem, but many were unsure of what individuals could actually do about it (Aubrun & Grady, 2003; Frameworks Institute, 2003). There was a strong interest in using language that was more strengths-based to educate communities about child maltreatment prevention and what it could do.

In 2003, the national child abuse prevention conversation was heavily influenced by work that the Center for the Study of Social Policy (CSSP) was leading as part of their Strengthening

Families Through Early Care and Education Initiative. Through a deliberate process of examining practice in the field and consulting with experts and the available research, CSSP developed a Protective Factors Framework and started working closely with several states pilot the testing and implementation of this approach in early education settings. Around the same the time, the Children's Bureau was working closely with the Community-Based Child Abuse Prevention (CBCAP) grantees, several of whom were also involved with pilot testing the Strengthening Families initiative, as part of a CBCAP Outcomes Workgroup. These state grantees advocated for focusing on a set of five protective factors, or outcomes, that were similar to those identified by CSSP: knowledge of parenting and child development, parental resilience, social connections, concrete support in times of need, and social and emotional competence of children. CBCAP grantees were also interested in adding nurturing and attachment as another critical outcome, or protective factor, that prevention programs were striving to improve. In the end, this set of outcomes that were focused on promoting protective factors were incorporated into a CBCAP Conceptual Framework that is used to guide program planning and activities funded by CBCAP today (Children's Bureau, 2013).

Protective Factors Survey

As part of this early work and the emphasis on evaluating prevention efforts, several members of the CBCAP Outcomes Workgroup expressed interest in developing a tool for measuring protective factors. CBCAP grantees worked with the FRIENDS National Resource Center for CBCAP (a national technical assistance center funded by the Children's Bureau) to develop and pilot test a measurement tool for five protective factors included in the CBCAP Conceptual Framework as short-term and intermediate outcomes (i.e., parenting skills, knowledge of child development, social support, nurturing/attachment, and parental resilience). Social and emotional competence of children was listed as a long-term outcome, but was not included in the constructs to be measured by this Protective Factors Survey (PFS; Counts, Buffington, Chang-Rios, Rasmussen, & Preacher, 2010).

Although there were other instruments designed to measure individual protective factors, PFS was the first instrument that assessed multiple protective factors focused on the prevention of child abuse and neglect (Counts et al., 2010). The University of Kansas Institute for Educational Research and Public Service developed and conducted the psychometric testing on the PFS. In five studies, the tool was found to be a valid and reliable measure of multiple protective factors against child maltreatment (Counts et al., 2010). The PFS is now being used in 42 states as part of those states' overall effort to evaluate outcomes for prevention programs. The tool was also translated into Spanish, and that version is now being tested for reliability and validity (FRIENDS, 2013).

The Prevention Resource Guide and Prevention Website

Along a parallel track, the Children's Bureau worked with the Child Welfare Information Gateway on public awareness materials for National Child Abuse Prevention Month. Each year, The Children's Bureau works closely with FRIENDS and a national network of prevention partners who provide input on the development and dissemination of a Prevention Resource Guide and prevention website. Because of the momentum and interest around promoting protective factors, the Children's Bureau decided that the Resource Guide should be used to identify specific strategies that individuals and organizations could use to promote protective factors and prevent child maltreatment in their work. In the last few years, the Children's Bureau partnered with CSSP to develop a calendar of activities to accompany the Resource Guide, which includes daily suggestions of strategies to promote protective factors within families. The Tip Sheets for parents, with content derived from suggestions offered by national prevention partners, are also included in the Resource Guide. The Resource Guide and accompanying website have been produced using these strategies since 2007, and this process continues to the present day. (See Learn More box.)

The Quality Improvement Center on Early Childhood

In 2008, the Children's Bureau funded a National Quality Improvement Center on Early Childhood (QIC-EC), to generate new knowledge around building protective factors to prevent child maltreatment for children from birth to 5 years old and their families. CSSP was the grantee, and key partners include the National Alliance of Children's Trust and Prevention Funds and ZERO TO THREE. The QIC-EC provided funding and

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There is an ever-growing need to better understand the ways in which protective factors apply across cultures, ethnicities, and genders.

support for four research and demonstration projects to test different collaborative interventions that were designed to increase protective factors, strengthen families, and improve child health and development. Unique features of the funded projects include the implementation of strategies designed to improve outcomes at multiple levels of the social ecology. The corresponding cross-site evaluation was designed to measure changes in the patterns of behavior and whether protective factors were built across the QIC-EC projects. (More information about each of the projects and the cross-site evaluation can be found in this issue of *The Journal of Zero to Three*.) As part of cross-site evaluation, the QIC-EC also developed and is testing the reliability and validity of a new measure, the Caregiver's Assessment of Protective Factors, which is specifically designed to measure whether protective factors have increased as a result of the various interventions tested by the QIC-EC projects.

Promoting Protective Factors for Vulnerable Populations

Despite the robust work in child maltreatment prevention and a growing body of literature, there has been limited work to build a common understanding of this philosophy that can be applied to the most vulnerable children and families which are being served by Administration on Children, Youth, and Families (ACYF) programs. This includes five population groups of primary concern:

- Infants, children, and adolescents who are victims of child abuse and neglect;
- Runaway and homeless youth;
- Youth in or transitioning out of foster care;
- Children and youth exposed to domestic violence; and
- Pregnant and parenting teens.

Because youth in each of the populations have already experienced trauma or adversity associated with increased risk for poor outcomes, the Children's Bureau funded a comprehensive literature review of protective factors for these populations. The study offers new insight into how such in-risk populations modify risk or buffer the effects of adverse experiences. Comparatively few studies of protective factors have been conducted with samples of in-risk children and youth where the issue is not prevention of a problem but coping with or transitioning through one or more existing problem situations.

The review was guided by the following questions:

- What is the nature of protective factors for children and youth served by ACYF-funded strategies?
- What is the strength of evidence pertaining to protective factors?
- Which protective factors are most likely to be amenable to change in the context of programs and policies offered by ACYF?

The literature review identified 19 factors with emerging, limited, moderate, or strong evidence that improved outcomes for populations served by ACYF. The study further highlighted 10 factors that were found to have the highest levels of evidence across the five ACYF populations (Development Services Group, Inc., 2013). These factors and definitions are listed in Table 1.

This project also identified factors that were specific to each of the ACYF populations, provided detailed cross-walks with the factors and the references for the supporting studies, and

TABLE 1. **Ten Protective Factors Across Administration on Children, Youth, and Families Populations**

Individual level
Relational skills: Relational skills encompass two main components: (a) a youth's ability to form positive bonds and connections (e.g., social competence, being caring, forming positive attachments and prosocial relationships); and (b) interpersonal skills such as communication skills, conflict resolution skills, and self-efficacy in conflict situations.
Self-regulation skills: Self-regulation skills refer to a youth's ability to manage or control emotions and behaviors. This skill set can include self-mastery, anger management, character, long-term self-control, and emotional intelligence.
Problem-solving skills: Includes general problem-solving skills, self-efficacy in conflict situations, higher daily living scores, decision-making skills, planning skills, adaptive functioning skills, and task-oriented coping skills.
Involvement in positive activities: Refers to engagement or achievement in school, extracurricular activities, employment, training, apprenticeships, or military.
Relationship level
Parenting competencies: Parenting competencies refers to two broad categories of parenting: (a) parenting skills (e.g., parental monitoring and discipline, prenatal care, setting clear standards and developmentally appropriate limits) and (b) positive parent–child interactions (e.g., close relationship between parent and child, sensitive parenting, support, caring).
Positive peers: Refers to friendships with peers, support from friends, or positive peer norms.
Caring adult(s): This factor most often refers to caring adults beyond the nuclear family, such as mentors, home visitors (especially for pregnant and parenting teens), older extended family members, or individuals in the community.
Community level
Positive community environment: Positive community environment refers to neighborhood advantage or quality, religious service attendance, living in a safe and higher quality environment, a caring community, social cohesion, and positive community norms.
Positive school environment: A positive school environment primarily is defined as the existence of supportive programming in schools.
Economic opportunities: Refers to household income and socioeconomic status; a youth's self-perceived resources; employment, apprenticeship, coursework, or military involvement; and placement in a foster care setting (from a poor setting).

organized the factors into conceptual models for each ACYF population. (Development Services Group, Inc., 2013).

PROTECTIVE FACTORS AND DISCRETIONARY GRANT PROGRAMS

There is a growing recognition within the field of child welfare that protective factors are a critical aspect of all work aimed at serving vulnerable children and families. The Children's Bureau is currently working to build on this increased interest that has arisen in the field by encouraging its funded grantees to incorporate knowledge of protective factors into their work. Currently, a number of Children's Bureau grantees are diligently working to incorporate guidance, trainings, and survey instruments related to protective factors into their ongoing work. These efforts will ensure that their respective policies and practices promote the development of protective factors within the vulnerable children and families that they serve, ultimately leading to improved well-being outcomes. While many Children's Bureau-funded efforts currently incorporate protective factors knowledge into their work in some manner, there are a number of ongoing grantee clusters that can be specifically highlighted for their work in this field.

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CHILD WELFARE-EARLY EDUCATION PARTNERSHIPS TO EXPAND PROTECTIVE FACTORS

Two clusters of grants, totaling 18 grantees, were funded in fiscal years 2011 and 2012 for the purpose of building infrastructure capacity between child welfare agencies and early childhood systems to ensure that infants and young children in or at-risk of entering foster care have access to comprehensive health and quality early care and education services. Central to these grants is the requirement to promote and use multidisciplinary interventions that build on protective factors and mediate the effects of adverse experiences. Protective factors are fundamental to resilience, which must be fostered within the vulnerable young children served by these grants, and building these factors is integral to successful intervention (Children's Bureau, 2012a).

The Connecticut Department of Children and Families (CTDCF), funded through this grant program, serves as a prime example of how the use of protective factors has been incorporated into this work. Specifically, CTDCF has used this grant funding to provide training on the Strengthening Families framework to child welfare staff and early childhood staff in their targeted communities in the state. The training aims to build staff capacity to work together using a protective factor framework to support the well-being of children and families. Participation in these trainings helps staff to build a common understanding of protective factors as a shared framework for action, provide a shared understanding of the unique developmental needs of young children who have experienced trauma, and engage staff in cross-system planning on how to embed this protective factors framework into their work on the ground. To accomplish this last goal, CTDCF also worked to develop a series of tools to help both early childhood education and child welfare staff use a common framework to support collaborative service delivery and put the concepts learned during the trainings into practice.

The Colorado Department of Human Services, another grantee funded through this grant program, has also made a concerted effort to embed the principles of the Strengthening Families framework into the work that both their child welfare and early childhood education staff are doing on the ground. Strengthening Families training was provided to staff working with vulnerable children and families in order to both promote optimal child development and prevent child maltreatment. By providing trainings on Strengthening Families to both child welfare and early childhood education staff, Colorado aimed to allow multiple systems to share a common language when building the protective factors into their policies and procedures.

SUPPORTIVE HOUSING FOR FAMILIES IN THE CHILD WELFARE SYSTEM

In 2012, the Children's Bureau awarded five grants dedicated to supporting the provision of supportive housing for a subset of families who come to the attention of the child welfare system due to severe housing issues and high service needs. The grants aim to provide housing and other necessary supports in a strategically coordinated manner in order to improve child and family well-being and keep children from entering out-of-home placement. The focus of grants on improving the well-being of vulnerable children and families also allows for the incorporation of a protective factors framework into their work (Children's Bureau, 2012b).

CTDCF, a grantee within this grantee cluster as well, incorporates the Strengthening Families framework into their work in this sector. The supportive housing model implemented though their grant specifically aims to enhance the protective factors within families served in order to improve well-being. The Connecticut child welfare system, as a whole, uses the Strengthening Families framework when working with all families beginning at the intake phase and continuing through intervention and service delivery. Therefore, all families being referred to the supportive housing services provided through this grant will have been assessed on the basis of the five Strengthening Families protective factors, and their service plan will include specific strategies to foster any specific factors that may be underdeveloped. While the housing provided through this program will address the concrete support protective factor included in Strengthening Families, the

additional wrap-around services that are a part of the supportive housing model may address other factors.

A number of other grantees within this cluster have also incorporated the Strengthening Families framework. For example, the grantee agency located in Iowa (Four Oaks) indicated that they have implemented the framework because the child welfare-involved families with which they work often need help in building protective factors that will allow their children to remain in the home, be safe, and thrive. Families with many complex needs, such as those served through this supportive housing program, are often in need of interventions that work to increase various protective factors in order to improve their overall well-being and ability to thrive. Other grantees have indicated that they are using specific curricula, such as the Botivin Life Skills Curriculum, or are engaging partners in their communities that provide targeted interventions, such as tailored after-school programming for youth, in an effort to build protective factors in the children and families that they serve.

It has been much easier to communicate the benefits of promoting health and well-being as opposed to preventing negative and adverse events.

PROTECTIVE FACTORS ACROSS OTHER FEDERAL AGENCIES

It is worth noting that focusing on protective factors is not unique to the Children's Bureau. Several other agencies have been moving in this direction. A few notable examples of existing risk and protective factor frameworks include: Institute of Medicine and National Research Council report, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities* (2009); the Centers for Disease Control and Prevention (CDC) *Essentials for Childhood* (2013); the Maternal and Child Health Bureau's adoption of the *Life Course* model (2010); the Center for Substance Abuse Prevention at the Substance Abuse and Mental Health Services Administration focus on wellness and optimal health in their Project LAUNCH initiative for early childhood (Substance Abuse and Mental Health Services Administration, 2010); and the Family and Youth Services Bureau supports Positive Youth Development (2014) in its programs and its federal partnerships.

Efforts to develop and incorporate new knowledge of protective factors are also ongoing within numerous federal agencies. The Division of Violence Prevention at CDC has convened an Expert Panel on Protective Factors for Youth Violence Perpetration. This group was convened to review and advance research on direct protective and buffering protective factors for youth violence perpetration, and will consider buffering aspects as well. This work is being implemented in phases, with the recently completed first phase having focused on direct protective factors.

The U.S Department of Housing and Urban Development has also done a great deal to incorporate the use of protective factors into a number of their programs. Ongoing work at the department currently incorporates both risk and protective factors in their approaches to addressing housing instability and homelessness of children, youth, and families. In addition, they incorporate into their work the knowledge that housing can be seen as a protective factor, and similarly homelessness can be seen as a risk factor, that may affect health outcomes of children and families.

The U.S. Department of Defense (DoD) works to incorporate knowledge of protective factors into their work with families through their ongoing Family Advocacy Program, which aims to prevent domestic abuse and to ensure the safety of victims and help military families overcome the effects of violence in cases where abuse has already occurred. Through this program, DoD is looking at protective factors for integrating prevention programs across the four branches of the military. DoD also offers a New Parent Support Program for military families, which embeds the Strengthening Families framework into its services.

FUTURE DIRECTIONS

The Children's Bureau's experiences over the last decade underscore the importance and relevance of a protective factors framework across various programs and settings along the entire continuum of services from prevention to treatment. Powerful connections across disciplines and other federal agencies have been forged because of the focus on promotion and prevention as opposed to solely emphasizing the problems and risk factors. Several Children's Bureau programs and many federal agencies have recognized the value of a protective factors approach. Over the next few years, the evidence base for this approach will continue to grow. Early results from the QIC-EC research and demonstration programs indicate promising results (see other articles in this issue). Feedback from Children's Bureau grantees has indicated that a protective factors approach has been much more successful at engaging participants, staff, and community partners. It has been much easier to communicate the benefits of promoting health and well-being as opposed to preventing negative and adverse events. Experiences from our current projects demonstrate that promoting protective factors is possible and within the reach of many types of programs across a number of disciplines and perspectives. Engaging programs and communities in promoting protective factors has served to be a catalyst for shifting the thinking and has built common ground across disciplinary boundaries.

Nevertheless, this work has only just begun. We recognize that more work and ongoing research is needed to fully integrate a protective factors approach into mainstream practice. First of all, there are still very few valid and reliable measures of protective

factors that can be used for program evaluation and intervention research. As such, the body of evidence is still emerging. The ACYF literature review on protective factors found that various definitions, applications, and measures of protective factors have been used across studies and programs tested. The variation in these definitions of protective factors limits the field's ability to interpret and generalize evidence of protective factors across focus populations. In addition, the variation in the focus of studies of protective factors means that certain factors have been studied in far greater detail than others. For example, a considerable number of investigations have focused on individual and family protective factors, while relatively few studies have examined the effects of community-level protective factors on children and families (Development Services Group, Inc., 2013).

CDC will have more to contribute to the evidence base on community and societal level protective factors in the next few years. CDC recently funded four state health departments through their Essentials for Childhood initiative, and they are focusing on four goals that are critical for creating the context for safe, stable, nurturing relationships and environments. These projects will raise awareness and commitment to building these relationships and environments and prevent child maltreatment; use data to inform actions; create the context for healthy children and families though norms change and programs; and create the context for healthy children and families through policies (Centers for Disease Control and Prevention, 2013). This is also an area that the QIC-EC cross-site evaluation hopes to address—but more research is clearly needed.

The Institute of Medicine (2013) highlighted the need for more research on understanding resilience and child maltreatment. Other important dimensions for inquiry pertain to "unpacking" the change mechanisms and mediating or moderating roles performed by protective factors. The research suggests that protective factors are cumulative in their effects. However, the mediating and moderating mechanisms of any given protective factor are not well understood (Development Services Group, Inc., 2013).

Additional research must also be done to better understand protective factors and resilience as they relate to diverse populations. Current research on protective factors and resilience does not sufficiently account for cross-cultural and gender-specific factors, processes, or mechanisms, and there is a lack of knowledge regarding the ways in which protective factors and resilience are understood by different populations (Development Services Group, Inc., 2013). As our communities become increasingly diverse, there is an ever-growing need to better understand the ways in which protective factors apply across cultures, ethnicities, and genders.

Photo: © iStockphoto.com/pojoslaw

Protective factors are fundamental to resilience.

The growing recognition of protective factors as a critical aspect of work in child welfare and other sectors is long overdue. There is a powerful synergy between what research demonstrates children need in order to thrive and avoid bad outcomes and what the family support and child maltreatment prevention practice community has been working toward for many years. We must continue to learn from prior work, generate new knowledge, and use that information for ongoing learning and continuous quality improvement. We look forward to the next decade as we continue to strengthen and support the foundation we have built at the Children's Bureau for promoting protective factors and improving the safety, health, and well-being of all children and families.

Learn More

Protective Factors Survey
http://friendsnrc.org/protective-factors-survey

Administration for Children, Youth, and Families
The complete ACYF literature review, cross-walks, and conceptual models **www.dsgonline.com/ACYF**

Child Welfare Education Gateway, *Prevention Resource Guide* and Website
www.childwelfare.gov/preventing

Botivin Life Skills Curriculum
http://lifeskillstraining.com

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Jargon Buster

Given the multidisciplinary nature of our work with infants, toddlers, and families, we often come across words or acronyms that are new or unfamiliar to us. To enhance your reading experience of this issue of *The Journal of Zero to Three*, we offer a glossary of selected technical words or terms used by the contributing authors in this issue. Please note that these definitions specifically address how these terms are used by the authors in their articles and are not intended to be formal or authoritative definitions.

The Preventing Child Abuse and Neglect Curriculum (PCAN)	The PCAN curriculum (Seibel, Britt, Gillespie, & Parlakian, 2006) was developed specifically to prevent child abuse and neglect of infants and toddlers by supporting parent–provider partnerships in child care settings. PCAN focuses on promoting effective parent–child relationships, increasing understanding of the effects of abuse and neglect on young children, and helping both the workforce and supervisors reduce risk for maltreatment through reflective practice. [Find it in Shapiro, p. 20]
Protective Factors	Protective factors are conditions or attributes in individuals, families, communities, or the larger society that both decrease the probability of maltreatment and increase the probability of positive and adaptive outcomes—even in the presence of risk factors. [Find it in Harper Browne, p. 2]
Strengthening Families Approach	Strengthening Families is a research-based, cost-effective strategy to increase family strengths, enhance child development, and reduce child abuse and neglect (Center for the Study of Social Policy, 2014). It focuses on building five protective factors that also promote healthy outcomes. Those five protective factors are parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children. [Find it in Sege et al., p. 11; Shapiro, p. 21]
Social-Ecological Framework	A social-ecological framework posits that a combination of individual, relational, community, and societal factors must be addressed in order to promote healthy child, adult, and family well-being and to reduce the risk of negative outcomes. [Find it in Harper Browne, p. 4]
Triple P-Positive Parenting Program (Triple P)	Triple P-Positive Parenting Program (Triple P) is a multitiered system of evidence-based education and support for parents and caregivers of children and adolescents. The system works as both an early intervention and prevention model. Triple P may be offered in clinical and nonclinical settings by a multidisciplinary workforce of social service, mental health, health care, and education providers. [Find it in Shapiro, p. 21]

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