New Jersey Task Force on Child Abuse
and Neglect Prevention Subcommittee

Standards for Prevention Programs

FAMILY SUPPORT America

Standards for Prevention Programs

Authors: Sharon Copeland & (name to come)
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Principles of Family Support Practice

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

To learn how these principles correlate to the Standards for Prevention Programs, see page 9.

Premises of Family Support

1. Primary responsibility for the development and well-being of children lies within the family, and all segments of society must support families as they rear their children.
2. Assuring the well-being of all families is the cornerstone of a healthy society, and requires universal access to support programs and services.
3. Children and families exist as part of an ecological system.
4. Child-rearing patterns are influenced by parentsí understandings of child development and of their childrenís unique characteristics, personal sense of competence, and cultural and community traditions and mores.
5. Enabling families to build on their own strengths and capacities promotes the healthy development of children.
6. The developmental processes that make up parenthood and family life create needs that are unique at each stage in the life span.
7. Families are empowered when they have access to information and other resources and take action to improve the well-being of children, families, and communities.

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Preface

Child welfare and other state systems of service have tremendous potential to bring about family and community well-being by supporting and strengthening families and preventing child abuse and neglect. The factors that put families at risk of abuse and neglect are well known, and state and local systems as well as community partnerships can be powerful forces in ameliorating them. The effectiveness of prevention approaches is also well known; they enable all systems to better accomplish their goals for improving child, family, and community outcomes. Yet for the most part, these systems do not focus on prevention. Instead, the approach that continues to dominate state funding and programmatic agendas is intervention—addressing child abuse and neglect after it occurs, when the chances of positive results are greatly reduced..

Family support is a successful prevention strategy. In all its aspect, family support works to nurture and promote strong and healthy children and families. Prevention programming can be made more effective and stronger by adhering to the principles and practices of family support. The ways in which staff members interact with families and the ways in which families interact with each other have an affect on outcomes for families. Family support directly addresses staff and family interactions in a positive manner. The family support approach recognizes that programs that are driven by family decision-making and adhere to the principles of family support will be more suited to families needs and will lead to higher quality programs and greater family successes. Family Support America, as a national organization, promotes and supports the application and adherence to family support practices.

Family support is

A set of beliefs and an approach to strengthening and empowering families and communities

A type of grassroots, community-based program designed to prevent family problems

A shift in human services delivery

A movement for social change

It's family support if it's

Building relationships based on equality and respect

Improving families' ability to access resources they need

Actively involving families in all aspects of the work

Building on strengths to effect change

Celebrating diversity and affirming cultural, racial, and linguistic identity

Strengthening community

Advocating for fair, responsive, and accountable systems

Family support practice is based on an ecological framework—child and family development is embedded within a broader community environment. Children and families are part of communities with cultural, ethnic, and socio-economic characteristics that are affected by the values and polices of the larger society. It is recognized that children will be happier and healthier when they are raised in strong families and are living in supportive communities.

The family support field has focused much of its energy on preventing child abuse and neglect, with thousands of family support centers and public programs promoting the conditions and behaviors that lead to strong, healthy, safe families. On the state level, through the seven-year implementation of the States Initiative, Family Support America has worked to promote the principles and practices of family support across a variety of systems in eight states, with the support of the Robert Wood Johnson Foundation. In these states, numerous systems—from child welfare to health to education to criminal justice—have infused strategies to prevent child abuse and neglect into a variety of programs and policies.

In publishing this monograph, Family Support America seeks to apply prevention approaches beyond local programs and selected states. The goal is to infuse this success-

ful prevention strategy into statewide systems nationally. The standards described here aim to bring together systems and agencies dealing with child protection as well as domestic violence, substance abuse, and other issues to make family-supportive prevention of negative outcomes the norm in state policy and programs.

The possible applications of these standards are endless, but examples include:

- Requiring that grantees seeking state funding from a variety of agencies adhere to these standards
- Applying language from the standards to mission statements and written materials for state agencies and their programs
- Building the standards into evaluation and review processes for state agencies and the programs they administer
- Integrating the standards into policy development at the state and community levels

Family Support America is confident that the dissemination of, promotion of, and forging of consensus around these standards will effect positive change at the state and community levels. *Standards for Prevention Programs* is a powerful tool for advancing family support by preventing child abuse and neglect across all systems, in all states.

Brief History of Family Support America

For 21 years, Family Support America has been the nation's catalyst, clearinghouse, and thought leader in family support, based on a bedrock belief: If you want to help families, ask parents what they want.

Everyone agrees that families are the foundation of society: When families are strong, communities thrive, and children are safer and happier. What sets Family Support America apart is our conviction that if you want strong families, you have to create a world where all parents are engaged in solutions for themselves, their children, their communities, and society as a whole—where they receive the support every family needs, and are partners in planning and providing that support.

Parents as equal partners. It's common sense. But before Family Support America was founded in 1981, only a small minority of family-serving professionals and policymakers saw the importance of shared leadership. Now, family support is a national movement, with support in federal and state legislatures, conferences that draw thousands, publications distributed worldwide, a set of best practices that unify and guide, and a growing network of strong parent leaders, family support workers, and others who are drawing the world's attention to our children.

New Jersey Standards for Prevention Programs

Introduction

Discussions by the New Jersey Task Force on Child Abuse and Neglect regarding the importance of preventing child abuse and the need for more prevention programs in the child welfare system led to the creation of an ad hoc Prevention Program Standards Working Group. The Task Force was interested in advocating for the support and expansion of sound prevention programs in New Jersey. However, there seemed to be a lack of understanding as to what constitutes effective prevention programs. Thus, the Prevention Subcommittee of the Task Force formed a Prevention Program Standards Working Group charged with defining standards for programs intended to prevent child maltreatment. The members of the Task Force, Prevention Subcommitte, and Standards Working Group are noted in the appendix.

The Standards Working Group reviewed the literature on effective prevention programs from multiple fields including child welfare, public health, juvenile justice, substance abuse and mental health. Articles and books on this subject included theoretical information, research findings, and discussions of characteristics of effective programs. In order to provide a broad overview of standards rather than a critique of model programs, the working group organized the information under three headings: conceptual standards, practice standards, and administrative standards. This approach was used to provide the reader of this report with information that could be used to evaluate a variety of programs serving diverse populations. Since research and reports exist on specific program models, the working group encourages the reader to obtain additional information if interested in a particular program model. Writings on the evaluation of specific program models are included in the bibliography.

The full Task Force has reviewed and endorsed this report from the Standards Working Group. It is hoped that the report will be used to develop, identify, promote, monitor and fund effective prevention programs. Users of this report may include The Children's Trust Fund, the New Jersey Division of Youth and Family Services, and other offices within the Departments of Human Services, Health and Senior Services, Education and Corrections. Community planning groups such as Human Services Advisory Councils, Youth Services Commissions, Commissions on Child Abuse and Missing Children, Local Councils on Alcoholism and Drug Abuse, Municipal Alliances or other local organizations may find these standards useful when researching programs or selecting programs to be offered in their communities. It may be helpful to staff of private foundations, corporate giving officers and elected government officials. The standards can assist legislators and key decision makers in government as they seek to develop policies and provide support to prevention programs.

"Family Support America views the New Jersey experience of developing family-supportive guidelines as a catalyst for change in the rest of the country. By publishing Standards for Prevention Programs, Family Support America hopes to create greater discussion and dialogue among policy makers, community advocates, and parents about the benefits of prevention, the importance of operating from a family support philosophy and practice, and ways to implement real change at state and community levels to further strengthen families and prevent child abuse and neglect."

Virginia L. Mason,
President & CEO,
Family Support America

Service providers–community-based agencies, schools and organizations–may use the standards to help them select programs they want to offer, to develop new programs, or to strengthen existing programs. Individuals, families and community members who use prevention services can apply the standards to determine which services are most effective. To assist individuals and groups to use the standards, a guide has been provided at the end of the report.

The charge to articulate standards for programs that prevent child abuse and neglect reflects a growing acknowledgement of the desire and need for standards that can provide:

- Accountability for prevention programs;
- The ability to compare program to program;
- A common language for professionals to discuss effective prevention programs as well as a means to convey this information to key policy and decision makers and the general public; and
- Recognition of effective and well operated prevention programs.

There is increasing evidence in many fields of social services that **prevention** programs must play a more significant role in the full range of services. Karol L. Kumpfer and Rose Alvarado have written extensively for the field of juvenile delinquency prevention. They cite numerous studies (Kumpfer & Alvarado, 1998) documenting the relationship between social problems and the ability of families to care for their children. These etiological research studies "suggest parenting and family interventions that decrease family conflict and improve family involvement and parental monitoring should reduce problem behaviors" in children and youth. They conclude that, "strengthening the ability of families to raise children to be law-abiding and productive citizens should be a critical public policy issue in the United States."

Other professionals have cautioned that our current overemphasis on responding to maltreatment is an imbalanced approach. Efforts to prevent child abuse and neglect are not simultaneously occurring. In 1920, Christian Carl Carstens, the founder of the Child Welfare League of America, asserted that child protective agencies needed to work toward the prevention of cruelty and neglect, not merely preventing its recurrence. However, this advice has been largely ignored. (Schorr, 1997; Guterman, 1997) The child welfare system has continued to narrow its focus, restricting its resources to investigating alleged abuse and neglect incidents. Major risk factors such as poverty, inadequate parenting, helping families deal with transitions or stressors, substance abuse, and deteriorating neighborhoods cannot be addressed when protection and "moving children through the system" must take precedence. Yet, if these factors that might prevent child abuse, neglect or abandonment were addressed, there would be fewer children in need of out of home placements or adoptions.

Many have also questioned the effectiveness of our current child protection approach because it appears we are not making significant progress to reduce or eliminate child abuse and neglect. A cadre of child welfare professionals and related organizations formed the National Call to Action in 1999 to develop recommendations on how to improve results. In New Jersey, calls to the Division of Youth and Family Services (DYFS) to report alleged abuse or neglect jumped from an average of 50,000 in the early 1990s to over 70,000 in 1995. According to the Division, of the 82,800 calls to DYFS in 1999, 39,200 were considered child abuse and neglect referrals and 34,400 calls were regarding families "at risk" of child maltreatment. The number of children removed from home to protect them from further harm averaged 10,000 children annually.

Although effective prevention programs are not cheap, several studies have shown them to be cost-effective. A RAND Corporation study found that "programs that provide parental training and therapy for families whose children have shown aggressive behavior in their early school years avert almost three times as many serious crimes." (Kumpfer & Alvarado, 1998). The total cost of the violent criminal career of a young adult (18-23 years) is $1.1 million. In the field of substance abuse, the National Institute of Drug Abuse reports for every dollar spent on drug abuse prevention, communities can save $4 to $5 in costs for drug abuse treatment and counseling.

Most prevention programs, even those that are intense and comprehensive, are relatively less expensive than programs that intervene or treat children who have been abused. According to DYFS, foster care placement for one abused child in New Jersey in 2000 cost over $8,100 for the year. Should the child require residential care, the cost ranges from $65,000 to $78,000 for a year. In contrast, the Healthy Families America model home visitation program averages $3,500 per family per year. Prevention programs often provide immediate cost savings from reduced medical and social service costs and reductions in foster care placements.

This report provides:

- definitions of prevention;
- overarching standards that **address conceptual standards, practice standards, and administrative standards**; and
- comments on types of services or programs and use of critical elements.

The Prevention Program Standards Working Group of the New Jersey Task Force on Child Abuse and Neglect offers the following standards in order to advance the consistency, quality, and accountability of programs used in New Jersey for the purpose of preventing child maltreatment.

I. Defining Prevention

It is the intent of this report to particularly address standards for **primary and secondary** prevention programs. There is considerable consistency in the literature regarding the definitions of primary, secondary and tertiary prevention.

Primary prevention targets the general population and offers services and activities before any signs of undesired behaviors may be present; no screening occurs.

Secondary prevention is directed at those who are "at risk" of possibly maltreating or neglecting children. Determining who is at risk is based on etiological studies of why maltreatment may occur. Secondary prevention efforts and services are also provided before child abuse or neglect occur.

Tertiary prevention is provided after maltreatment has occurred with the goal of preventing continued abuse or neglect, to reduce the impact of maltreatment, and to avoid future abuse. Tertiary prevention is treatment, working with children who have been abused or working with families where abuse has occurred. Public resources have primarily gone into tertiary/treatment programs rather than primary or secondary prevention programs. Tertiary efforts are most often the focus of research efforts in child maltreatment.

In the field of substance abuse, there are similar definitions although the language differs. The three levels of prevention are: universal (for the general population), selected (for those at risk of substance abuse), and indicated (for those who already display signs of substance use or abuse but have not engaged in regular or heavy use.) Indicated prevention generally does not refer to treatment programs that would address detoxification or treatment for those in recovery.

Martin Bloom (1996) defines prevention as "coordinated actions seeking to prevent predictable problems, to protect existing states of health and health functioning, and to promote desired potentialities in individuals and groups in their physical and sociocultural settings over time." Although Bloom views promotion of well being as an aspect of preven-

tion, others have made a distinction between treatment, prevention and promotion service models. Prevention definitions and programs have evolved from traditional treatment approaches which attempt to remedy a problem by focusing on deficits, weaknesses, and characteristics of the target population or its environment that need to be changed. However, many professionals involved in prevention have moved towards a strengths-based approach, building on the assets and positive characteristics in the target population or environment that could be enhanced. This approach has become known as promotion. For example, Dunst (1995) summarizes that treatment is acting to eliminate or reduce the effects of an existing problem; prevention is deterring a potential problem whereby prevention programs are used before the onset of negative functioning in order to reduce the incidence or prevalence of poor outcomes; and promotion is enhancing and optimizing positive functioning which brings about results that develop and increase a person's or family's competencies and capabilities. It can be said that some prevention programs use a promotion approach.

The literature on family support programs is particularly useful in identifying basic goals of prevention and promotion programs that utilize a strengths-based approach. "Family support programs place primary emphasis on strengthening individual and family functioning in ways that empower people to act on their own behalf, especially enhancing parental child-rearing capabilities," Dunst,1995. Multiple authors describe family support programs as programs that:

- enable families to help themselves and their children;
- are services to families that empower and strengthen adults in their roles as parents, to enhance parental capacity and empowers parents to act on their own behalf;
- help prevent problems rather than correct them;
- encourage and enable families to solve their own problems;
- increase the stability of families;
- increase parents' confidence and competence in their parenting abilities especially contributing to maternal and infant health and development; and
- promote the flow of resources and supports to families.

FAMILY SUPPORT TOOLS

Magazine Helps Programs Adopt, Apply, Adhere

The literature on family support programs can help prevention programs and systems identify basics goals that utilize a strengths-based approach. Notes Carl Dunst in "Adopt, Apply, Adhere: Stay True to Family Support," an article appearing in the Spring/Summer 2003 issue of Family Support America's quarterly *America's Family Support Magazine*: "Family support programs place primary emphasis on strengthening individual and family functioning in ways that empower people to act on their own behalf, especially enhancing parental child-rearing capabilities."

To order a copy of the issue in which this article appears—or to join Family Support America and receive a yearly subscription—visit www.familysupportamerica.org or call 312/338-0900.

II. Overarching Standards

Family Support America, as the national organization dedicated to strengthening and promoting the field of family support, has developed a set of principles that are used to guide program development, implementation, and evaluation. These principles help to guide program practices and define expected staff behaviors. When adopted, applied, and adhered to, according to Dunst (2003), they form the basis for transforming programs, communities, and polices into ones that:

- Honor and respect families
- Recognize family strengths
- Build on informal and formal resources
- Promote and affirm culture, race, and linguistic identities
- Build strong communities

It is important to understand that prevention planning and implementation require numerous coordinated methods and approaches—not just programs. A comprehensive prevention plan would include changing laws, conducting media campaigns, mobilizing communities, using formal and informal settings and approaches that are not necessarily considered to be "programs." This is well illustrated in the field of substance abuse which has a rich history of support for studying prevention and disseminating its findings. Brounstein and Zweig (1999) elaborated on the six prevention strategies that the Center for Substance Abuse Prevention recommends be used by programs or by other approaches. These strategies include:

- dissemination of information and awareness;
- prevention education to learn specific life skills;
- alternative drug-free activities;
- problem identification, referrals, and counseling for early users;
- community-based interventions to organize the community and enhance its ability to address substance abuse; and
- environmental approaches that address standards, codes and laws in the community or state.

These strategies provided the structural core for the 1996 prevention plan developed by the New Jersey Department of Health and Senior Services Division of Addiction Services and the Governor's Council on Alcoholism and Drug Abuse.

The Standards Working Group recognized that prevention efforts need to be broad—impacting individuals, systems and environments. However, the charge to the Standards Working Group was limited to address standards for prevention programs. What makes prevention programs effective? Although there is a growing body of research of prevention programs and methods, many authors note that there is a great need for more evaluation and research to build solid evidence of the effectiveness of prevention programs (Reppucci, Britner & Woolard, 1997). Further, the effectiveness of a program is an interplay of several factors: What are the critical elements that must be used when imple-

menting the program components in order to produce the desired outcomes? What target population is the program best suited for? What are realistic and appropriate outcomes for the program, from both a short term and a long term perspective?

As the Standards Working Group began to look at specific types of programs, it became apparent that it would be an overwhelming task to review each type of program across multiple factors. The Subcommittee concluded that it did not have the time nor the

Table 1. Factors for Effective Prevention Programs

Conceptual Standards	Practice Standards	Administrative Standards	Other Considerations
a. Family centered	a. Flexible and responsive	a. Sound program structure, design and practices	a. Use of critical elements
b. Community based	b. Use of partnerships	b. Committed, caring staff	b. Types of services by method, activity or approach
c. Culturally sensitive and culturally competent	c. Links with informal and formal social supports	c. Data collection and documentation	c. Types of services by setting or target populations
d. An early start whenever possible	d. Universally available and voluntary	d. Measures outcomes and evaluation	d. Types of services by goals, content or focus
e. Developmentally appropriate	e. Comprehensive and integrated	e. Adequate funding and long range plans	
f. Participants as collaborators and partners with staff	f. Easily accessible	f. Use of advisory groups, collaborations, and input from participants	
g. Empowerment and strengths-based approaches	g. Long term and adequate intensity		

FAMILY SUPPORT TOOLS

How Are We Doing?
A Program Self-Assessment Toolkit

Family support principles are embedded into all three categories of effective program standards—conceptual, practices, and administrative. Program staff can use these principles to guide practices at multiple levels and to understand the ways in which the program and staff practices lead to desired results. For an additional resource in assessing how well your program applies the principles of family support practice, see Family Support America's publication *How Are We Doing? A Program Self-Assessment Toolkit for the Family Support Field*. This tool—recently re-released with new, easy-to-use software—helps programs assess practice in 10 areas, including: governance, outreach and engaging families, programs and activities, parent education and child development, working one-on-one with families, relationships with the community, center environment, home visiting, staff roles and capacities, and monitoring and evaluation.

For more information, or to order *How Are We Doing?*, visit www.familysupportamerica.org or call 312/338-0900.

resources to conduct a thorough analysis of program models. For example, examining parenting education programs would require looking at many different models that target different age and ethnic groups, address different child development stages, that vary in approach (i.e., didactic, support group, therapeutic), intensity and duration, and purport different outcomes (i.e., change in self-esteem and personal functioning of the parent, change in parent-child interactions, change in family's need for outside social supports, or change in ability to manage stressors). Further, what is the rate of successful replication of each model and what research has been conducted to verify the effectiveness of the program model. Some professionals have undertaken this work enlisting the expertise of many reviewers. See Alvarado & Kumpfer, 2000, and the "Strengthening America's Families" chart in the appendix.

Subsequently, the Working Group agreed to focus on identifying those factors that appeared to be present in various prevention programs that were considered to be effective according to the research or analytical studies reviewed. As illustrated below, these factors fall into three categories: conceptual, practice, and administrative standards. Conceptual standards are related to the theories and beliefs behind the programs, a framework for the approach. Practice standards are program design and implementation issues, specific elements that should be incorporated into the programs. Administrative standards are relative to the administration and management of the programs. Table I below illustrates the standards addressed in each category in the report that follows. "Other considerations" are provided to help differentiate standards from other descriptive program characteristics commonly used.

1. Conceptual Standards

Conceptual standards convey theories, values, and beliefs. These concepts reflect why a particular approach needs to be used for the prevention program to be effective. It is often these concepts that differentiate a primary or secondary prevention program from a treatment program. In other words, some concepts that are used when treating a family or child after abuse or neglect has already occurred are inappropriate when working with a family prior to problems arising.

a. Family Centered

Forces within and outside the family shape the development of children. Since the child is embedded in a family system, prevention services need to be family centered rather than child centered (Dunst, 1995; Hess, McGowan & Botsko, 2000). Family centered is synonymous with family focused, another term often used in the prevention literature. A review of effective approaches has indicated that child only, child centered, or parent centered approaches are not as effective as family focused prevention (Kumpfer & Alvarado, 1998; National Center for Missing & Exploited Children, 1999; National Institute on Drug Abuse, 1999). "Family" refers to the adults and other family members most intimately involved in raising the child, not just a conventional constellation of two, natural parents.

Family focused or centered does not mean that every program effort targets the whole family. Rather it means that sound prevention programs involve the parents and family members at some level. Some component should include parents and caregivers to help shape and reinforce the work that is being done. Kumpfer and Alvarado purport that the more problems the child and family are having, the more the intervention needs to be family focused.

As research has begun to help us understand why child abuse and neglect occur, it is widely believed that no one factor is the cause of maltreatment. Individual, social, and environmental factors are part of an ecological model used to understand why child maltreatment occurs and how to prevent it (Copeland, 1998; Harrington & Dubowitz, 1999; Reppucci, Britner & Woolard, 1997). Individual factors include a person's knowledge of child development and parenting skills, family history, abuse of substances; social factors refer to marital status, isolation, occurrence of family violence; and environmental factors involve economic conditions, society's tolerance of violence, and laws. (See Appendix, Figure 1.) Child maltreatment occurs within the context of the family, community and society. Although programs often focus on the individual and social factors, the complexity of the interactions that contribute to child maltreatment require prevention to address community and socio-economic conditions, also. Primary prevention efforts include development of sound policies and laws as well as addressing societal mores and values as expressed through community and family life.

The "Primary Prevention Pyramid" developed by Jack Pransky illustrates the potential impact of prevention efforts with individuals over various stages of the life span. (Appendix, Figure 2.) The larger the block in the pyramid, the greater the potential for prevention efforts to have an impact over one's lifetime. Within this representation, prevention efforts provided in early developmental stages are shown to present the greatest potential benefits. The gains made in the early stages become the foundation for later development with subsequent phases dependent on the integrity of the foundation. Yet, benefits can be gained at all stages, even during older adulthood. Prevention is a life long process, ideally, a recycling continuum rather than a response to a problem.

In substance abuse prevention literature, successful prevention programs work to decrease risk factors and increase protective factors. Researchers have found that the most crucial factors for drug abuse are those that influence a child's early development within the family. Risk factors include parents who suffer from substance abuse or mental illness, lack of strong parent-child attachments, poor parental monitoring and ineffective parenting. Protective factors include strong bonds and clear rules of conduct within a family and involvement of parents in their child's life. The notion of mediating the risk and protective factors is also supported in writings of James Garbarino, an eminent researcher on child maltreatment. Garbarino notes research that shows the detrimental affects of accumulating risk factors and the ameliorating benefit of opportunity factors (Garbarino, 1995).

"Prevention services need to be community based in order to access the formal and informal supports needed by the family."

Bernice Weissbourd and Heather Weiss (1992)

"... culture is not the only difference that matters; it is not the only important group affiliation or determinant of an individual's identity. Factors such as class, gender, religion, health status, and sexual orientation all contribute to the formation of identity."

Guidelines for Family Support Practice (Family Support America, 1996)

b. Community Based

Community based refers to understanding that preventing child maltreatment requires a broad societal commitment to children that involves seeking the ownership of all sectors of the community in prevention efforts (National Committee to Prevent Child Abuse, 1995.) Defined geographically, a community may be a neighborhood, municipality or region. All who receive services, reside or work in that defined community are to be invited to participate and, hopefully, will become involved in preventing child abuse. Programs that are community based are located in the communities where participants live, work or attend school.

Prevention services need to be community based in order to access the formal and informal supports needed by the family (Weissbourd & Weiss, 1992). Lisbeth Schorr (1997) states that children need to be seen in the context of their families and families within neighborhoods and communities. Programs should respond to the needs of local populations enabling the community to have a genuine sense of ownership that mobilizes the community. The community is an important contributor to effective childrearing. The community's workplaces and institutions (schools, organizations, religious groups) can provide support to the family to help the family carry out its parenting responsibilities. Or they can disrupt and even sabotage a family's functioning.

Community members need to be included in program development and administration activities (National Clearinghouse on Child Abuse and Neglect Information, 2000). The Office on Substance Abuse Prevention provides a model for this in the *Community Partnership Program Training Manual* (1991). When a community is empowered, its members share responsibility with professionals and are seen as experts, providing leadership and support. There is inclusive decision-making and an emphasis on cooperation and collaboration. (See Table 3 in the Appendix.)

Every program can incorporate community based strategies. Examples of how to do so are provided by three community involvement models noted in the bibliography.

c. Culturally Sensitive and Culturally Competent

Effective prevention programs affirm, promote and strengthen cultural identity and diversity. Whereas cultural sensitivity is an awareness of and tolerance for diversity, cultural competence goes further. Competency is knowledge about the culture that is used to assist participants in programs. It is showing respect for customs and practices, utilizing unique roles of family members and gaining the acceptance of the leaders within the cultural group. Cultural competence should be strengthened, not just tolerated (Chemers,

FAMILY SUPPORT TOOLS

Evaluations Show Success of Family Support

Findings on family support programs hint at the wealth of positive outcomes associated with high-quality, early intervention programs. In an l998 article published in Families in Society: The Journal of Contemporary Human Services, Comer and Fraser reviewed six family support program evaluations and concluded that "family support programs that attempt to control, ameliorate, and eradicate risk factors associated with socioeconomic, educational, and other disadvantages can be effective in strengthening families and increasing the well-being of children." The evaluations showed that the programs had contributed to a variety of positive outcomes, including gains in child development, language development, educational attainment, school achievement, supportive home environments, parent-child interaction, health outcomes, and adult development. Although sample sizes for the evaluations were small, Comer and Fraser found them to be convincing arguments "that well-conceptualized and implemented family-support services have the capacity to improve family functioning."

Arnold Reynolds's recent evaluation of the Chicago Child-Parent Centers, published in the Journal of the American Medical Association, also emphasized the key role of family support in effective early childhood interventions. His long-term study of the centers found that:

- Participating children had higher graduation rates and more years of completed education
- Participating children had lower drop-out rates and lower rates of juveniles arrest and violent crime arrests
- Paginating children were retained in their grade less often and used special education services less frequently
- Effects were stronger for boys and for children who had participated for more years of the program

Reynolds explicitly tied these positive finding to the family support components of the program.

—From Evidence along the Way—Issues in Family Support Evaluation: Report from a Meeting of National Thought Leaders (Chicago: Family Support America, 2002). To download the full report, visit www.familysupportamerica.org and click on "Evaluation" in the Learning Center.

1995; Dunst, 1995; Weissbourd & Weiss, 1992). When programs are tailored to the cultural traditions of the families, improvement is found in recruitment and retention of the families as well as overall outcomes (Kumpfer & Alvarado, 1998).

"Family support programs serve as models for a burgeoning movement to involve families not only as service recipients, but also in the design, delivery, and governance of services. Family support strategies create opportunities for the inclusion of family members in making decisions about the design and implementation of services, but also recognize parents as community leaders who can actively hold systems accountable to the needs of their families. At its core, family support is about a strong, authentic consumer voice."

Virginia Mason, President and CEO, Family Support America

d. An Early Start

In order to prevent child maltreatment, prevention programs need to work with caregivers and parents before negative patterns develop and produce unwanted or poor outcomes. The MacLeod and Nelson (2000) meta review found a strong indication that gains made through proactive interventions with families were better sustained and even increased over time. However, families that received help after maltreatment had already occurred tended to lose ground over time. Thus, it is imperative that programs begin working with parents at the time of the birth of their first child. (Guterman, 1997; Kumpfer & Alvarado, 1998). Other reviews of effective programs recommended that programs begin prenatally (Guterman, 1997; MacLeod & Nelson, 2000). Pregnancy is generally a time when many women are eager to learn about effective infant and toddler care and parenting. For substance abusing women, pregnancy is often a time they are willing to decrease drug use.

The greatest period of brain growth is between the ages of birth and 3 years. Early socialization patterns are established during the first years of life. The years from birth to six have great potential for enabling long lasting, healthy functioning. This is another reason why working with a family and caregivers from the birth of the child and on has great value.

e. Developmentally Appropriate for Families and Children

Understanding stages and developmental tasks is crucial to effectively responding to the needs of participants. There are developmental considerations for all participants, be they children, parents, other family members or caregivers. Child development refers to the ages and stages a child goes through physically, emotionally, socially, and intellectually. Parenting is a developmental process wherein the parents' skills and abilities change over time. Parents can become more competent and capable and skills can change and be more effective over time. And families go through various stages. Changes parents and families experience are related to the age and developmental stages of the child/ren, the transitions that families experience, and an individual's aging process. Thus, parent education, information about human development, and skill building for parents and caregivers are essential elements of effective prevention programs (Dunst, 1995; Kumpfer & Alvarado, 1998).

f. Participants as Collaborators and Partners with Staff

Partnering with parents is one of the most critical differences between prevention programs and traditional treatment programs. Involvement before abusive or negative acts occur shifts the focus to "educate, encourage, and prevent" rather than the emphasis of "mediate, monitor and protect" which are used after abuse has occurred. In this locus, prevention programs can allow participants to "drive" the service rather than insist that the provider or professional prescribe the services. The parents and family are held in respect and considered equal to staff. They should be involved in program planning and development, especially the planning of their own service goals. Parents are encouraged to serve on task forces, committees or boards (Dunst, 1995; National Clearinghouse of Child Abuse and Neglect Information, 2000). Often, participants who have received services evolve to become the provider of services—the home visitor, parent educator or group facilitator. This evolution promotes the use of paraprofessionals in prevention services.

Whether highly trained professionals or paraprofessionals are employed, they must be able to work with participants in a manner where power is shared and individuals, parents or families accomplish mastery of their skills. Expertise of the staff is shifted from "knowing what is best" to enabling the participants to become more self-reliant and less dependent. Partnerships with participants in the actual delivery of the services include techniques such as active listening, empathy, sincere caring, focusing on promotion of growth producing behaviors, and shared decision-making (Dunst, 1995). Paraprofessionals and professionals need to receive training, good supervision and experiences that support their ability to use these techniques.

g. Empowerment of Participants Using a Strengths-Based Approach

All persons have strengths. Empowerment of participants is identifying and building on the capabilities and competencies of program participants. When working with families, these approaches require positive, proactive work with the family, focusing on family strengths rather than limitations. Opportunities for competencies to be learned or displayed are created, taking advantage of resources and supports already utilized by the family (National Clearinghouse on Child Abuse and Neglect Information, 2000; Weissbourd & Weiss, 1992). Effort is made to build on the positive functioning of the parents and family rather than seeing the family as "broken" and "needing to be fixed." Participants and families become less dependent on professionals. Development is measured by self-efficacy, self-reliance, positive mental health, competency, and mastery of skills. Several of the authors found effective prevention programs utilize empowerment and strengths-based approaches (Dunst, 1995; Guterman, 1997; Kretzmann & McKnight, 1993; McLeod & Nelson, 2000).

This concept is also known as "asset building." Use of the asset building approach is demonstrated in the work of The Asset Based Community Development Institute and Search Institute. (See bibliography.)

2. Practice Standards for Program Implementation

Practice standards are related to a program's design and implementation. The practice standards portray strategies to be used to "get things done" in the program. Whereas conceptual standards address "why" a particular approach is used, practice standards

reflect "how" the program is to be implemented. For this report, distinctions between conceptual standards and practice standards are offered to help illustrate effective standards. At times, the same strategy may be employed to accomplish implementing concepts and practices.

a. Flexible and Responsive

The needs of participants differ due to their unique circumstances, cultural and ethnic background, or the unique characteristics of the communities in which they reside. Thus, programs need to utilize traditions, customs, practices, conditions and situations. Being flexible and responsive means tailoring program practices and ways staff interact (Dunst, 1995). For example, it appears that retention of families is improved when transportation, meals or snacks, and child care are provided (Kumpfer and Alvarado, 1998). When planning a parenting education class for working parents, supports are essential. Conducting the class at the child care center and providing the evening meal and child care makes it possible for parents to attend at the end of a busy day. It is unlikely that parents will go home, make dinner, get a babysitter and then return for a class.

Flexibility in planning services and in service delivery is considered one of four key preventive elements in prevention programs according to Hess, McGowan and Botsko (2000). This allows for the evolution of a program over time, improving its responsiveness to the changing needs of individuals, families and communities (Schorr, 1997). The challenge of providing services in a flexible and responsive manner is knowing the difference between flexibility and altering core elements that make a program successful. For example, intensive home visitation programs may require limiting caseloads to 15-25 families per home visitor. This is considered a core element and it is not something that staff should flex. The frequency and intensity of the visits (how often, when, where, for how long) may be flexed in response to the on-going needs of the family.

"The voices of parents-in particular, low-income parents—needs to be heard. Our social service agencies need to work in partnership with families for children's safety and well-being. Our educators, principals, and school boards need to work towards parents' hopes and dreams for their children's education. Our local government officials need to partner with families to make our communities stronger and safer. Our congress members at the federal and state levels need to response to families' concerns about childcare, education, health care, safety and many other issues that affect families every day."

Putting Parent Engagement into Action: A Practical Guide (Family Support America, 2002)

b. Partnership Approaches

There are two kinds of partnerships that are effective in prevention programs. The first kind, as noted above in conceptual standards, considers the participant as a partner and structures the administration of the program to allow participants to influence the policies and practices of the program and share in the power and decision-making.

The second kind of partnership refers to how the program interacts with other agencies to maximize coordination of services and cooperation (Weissbourd & Weiss, 1992). Effective prevention programs do not operate in isolation. They need to be integrated into the continuum of services. The approach must involve the building of partnerships with other agencies. Over time, prevention programs need to become "institutionalized," that is, recognized as a core part of the service delivery system. Referrals would be routinely made for prevention services and financial support would be on-going.

c. Linkages with Informal and Formal Social Supports

Formal supports are the more traditional linkages with other social services or institutions. Informal supports refer to connections that are fostered with peers, extended family members, volunteers, paraprofessionals, groups and informal organizations. Providing support through these linkages nurtures a family as well as reduces isolation and loneliness (Dunst, 1995; Guterman, 1997, Weissbourd & Weiss, 1992). The National Institute on Drug Abuse reported that substance abuse prevention strategies that involved many components of the community (parents, schools, mass media, community, and health policymakers) had greater success in reducing substance abuse. When social norms and expectations are changed there is a greater impact on behavior (NIDA Notes, 14, No. 5, 1999).

Developing these linkages may be a function of building the capacity of the community. The Search Institute focuses on healthy youth development and emphasizes the importance of bringing families, neighborhoods, schools, religious communities, peers and non-related adults to work together. Healthy community development is seen as an integral part of providing support to youth (Search Institute, 1998).

d. Universally Available and Voluntary

Prevention programs are to be offered to the broad community, not just to persons or families with "problems." Services are seen as ways to strengthen and improve functioning rather than something a participant or family must do to address its dysfunction. Guterman (1997) noted that there appears to be a clinical advantage for programs that do not target services based on "psychosocial risk." MacLeod and Nelson (2000) found in their review of prevention programs that there was a higher likelihood of success when working with families of mixed incomes instead of just targeting low socio-economic status families. There is an adage that has developed: "Programs for poor families tend to become poor programs." Although funders may require that services be limited to children or families experiencing poverty or to "problem families," when the general public does not benefit from these programs, over time the programs tend to have inadequate resources invested in them.

Related to offering the program on a universal basis, prevention programs are also more effective when participation is voluntary (Guterman, 1997; Weissbourd and Weiss, 1992).

e. Comprehensive, Integrated Services

"…there are no simple short-term solutions. The most effective prevention approaches involve complex and multi-component programs that address early precursors of problem behaviors in youth. The most effective approaches often are those that change the family, school, or community environment in long-lasting and positive ways." (Kumpfer &

Alvarado, 1998) In 1991, the Office on Substance Abuse Prevention stressed that quick, one-shot interventions or overly simplistic approaches for prevention programs do not work. The need for comprehensive prevention services that are integrated into a service system is emphasized over and over again in the literature: Chemers, 1995; Hess, McGowan and Botsko, 2000; Schorr, 1997; Weissbourd and Weiss, 1992.

Child advocates at the 1995 Wingspread Conference envisioned a comprehensive array of health, educational and social services and supports for families that would include: supportive programs for all new parents starting prenatally and continuing until the child enters school; child health and development services with adequate access to health care; an educational system that effectively prepares children for successful adulthood; human relationship developmental skills for school age children; services that help parents to safely raise and nurture their children; housing policies and community development efforts that support families; economic opportunities to provide above-poverty standards of living; access to parenting information and parenting skill development; a crisis intervention system that responds to protect children in danger of abuse or neglect; access to therapeutic services for all abused children; and a justice and legal system that aggressively pursues the best interests of children and families. When it is accepted that prevention efforts must be comprehensive, it is also more acceptable to work across various systems and disciplines. The fields of child welfare, health, education, mental health and juvenile justice can unite and look for ways to optimize their resources. Successful prevention efforts result in deterring many different social problems. Avoiding child abuse, substance abuse, problems in school, delinquency, risky sexual behaviors and too early pregnancies, all benefit from healthy family, community and societal functioning.

f. Easily Accessible

Prevention services should be provided in non-threatening environments that are safe and convenient (Kumpfer & Alvarado, 1998). Services should be offered as much as possible with a "public face," that is, in a place that is acceptable to all such as at home, a school, a library, or at a place of worship instead of a place that may have a stigma attached to it or a social services facility where someone must go to "fix a problem."

Easy access to staff is also considered important (Hess, McGowan and Botsko, 2000). Easy access refers to the staff encouraging participants to contact them when and as often as needed rather than restricting access to an appointment at a fixed time or delaying until a crisis is imminent. This does not mean that the program encourages over reliance on staff. Rather, as participants are supported to act and advocate on their own behalf, it means practicing it within the context

of the program as well. Helping the participants to know early on when they need to ask for help teaches them act proactively instead of waiting until situations become problems.

Accessing the service during the recruitment period should also be easy. Primary prevention services have few eligibility requirements. Secondary programs may be offered to specific at risk populations but once it is determined who is eligible, obtaining the services should be easy. Recruitment should occur through organizations that serve families and children—such as schools, places of worship, other social service providers, hospitals and healthcare clinics, and recreational groups.

Aggressive outreach to first engage participants and then maintain the relationship is critical. In prevention programs, staff need to reach out to participants to invite, engage and encourage participation. Contact by telephone, mailings, or personal visits may be used to support their participation. "Creative outreach" may need to continue for three to four months in order to engage the participant. Once engaged, incentives to participate may be provided such as food, coupons, "gifts," providing childcare during the program and transportation to the program.

g. Long Term and Adequate Intensity

Quick, one-shot programs interventions do not work in primary or secondary prevention programs. For example, when advertising a public education message, it has been determined that the message must be heard by the consumer nine or more times for it to be acknowledged and remembered when competing with the multitude of messages received through media. The message should also be provided through multiple contexts. For example, hearing the same message through public media, school, business and a place of worship is far more effective than having the message delivered to just one of those audiences.

Lisbeth Schorr states that successful programs have a long-term, persevering approach (Schorr, 1997). The relationships among length, intensity, type of skills being addressed, short-term success and maintaining positive outcomes over time are being studied. Although some short-term interventions are effective, a greater intensity of services over an extended period of time seems most effective for families at high risk (Guterman, 1997; Kumpfer & Alvarado, 1998; MacLeod & Nelson, 2000). Efforts that are too short may produce temporary reductions of symptoms rather than long term effects. Time is needed to modify dysfunctional processes. It takes time to develop trust, to locate all of the needed services and to comprehensively address needs. Time is also needed to help an individual or family master new skills in daily living. Although there is agreement that prevention programs should be intense and long-term, how intense and how long is still being debated.

3. Administrative Standards

Administrative standards address ways to effectively administer and manage programs. Programs are provided by agencies and organizations. Unless the organization offers only one program, there are two layers of administrative standards to consider—administrative practices for the program and administrative practices for the organization. The comments below summarize key concepts on administrative standards for programs.

Administrative practices and standards that are conducted by the organization (rather than the program) include:

- Administrative structure (e.g., as expressed by the "Organizational Chart")
- Budgetary and financial management
- Funding and overall resource development
- Board of Directors
- Human resources and personnel management issues
- Facility operations
- Organizational policies and procedures
- Quality assurance and outcome measures
- Long term and strategic planning
- Public relations and marketing
- Community support and collaboration

Administrative practices and standards for a program include:

- Program's structure, components, design and procedures
- Practices related to interaction with the persons served
- Funding of the program
- Supervision, staff development and training
- Pertinent certifications and licenses
- Annual program workplan and long range plans for the program
- Record keeping
- Evaluation and reporting
- Use of program advisory groups
- Cooperative and collaborative relationships with other programs and groups

The development of accreditation or certification practices for prevention services or licenses for prevention staff is limited at this time. The Council on Accreditation of Services to Children and Families conducts reviews on a myriad of services regarding their use of effective standards and provision of quality services. This process usually results in granting the agencies and/or programs reviewed a "certification status" which may be used to verify the soundness of the organization to the public and/or funding sources.

Licensure for individuals who specialize in prevention is even less common. In the field of substance abuse, some states such as New Jersey have developed a certification process for substance abuse prevention specialists. Other states such as Illinois have developed prevention specialist licenses that are broader than just substance abuse. Even less available are college degrees at either the undergraduate or graduate level in the area of prevention. This raises significant questions about the ability to continuously improve prevention efforts if individuals are not encouraged or rewarded to pursue careers that specialize in prevention.

a. Sound Program Structure, Design and Practices

Standards applying to the program's structure, components, design, practices and procedures are addressed in the conceptual and practice standards noted above. Programs have many different forms and approaches. The components and approaches should be reviewed as to whether or not they reflect sound standards for being family centered; community based; culturally competent; address an appropriate target population; if the approaches are developmentally appropriate for the participants; how participants are treated as collaborators and partners; if a strength-based approach is being used. Is the design flexible and responsive to participant needs; are linkages made with formal and informal community supports; are services universally available, voluntary, comprehensive and integrated into a broader service's system; are they easily accessed and of a sufficient intensity and duration.

The design, procedures, and timeframes for implementation should be documented and understandable for staff and participants. Ideally, a program manual should be developed that reflects the concepts, practices, and administrative standards of the program.

b. Committed and Caring Staff

Research is bearing out that the quality of staff in prevention programs is a key factor for how successful the program is at reaching the intended outcomes for participants. Kumpfer and Alvarado (1998) noted from the literature nine staff characteristics and skills that are needed for program effectiveness: warmth, genuineness and empathy; communication skills in presenting and listening; openness and willingness to share; sensitivity to family and group processes; dedication to, care for, and concern about families; flexibility; humor; credibility; and personal experience with children as a parent or childcare provider.

When Lisbeth Schorr reviewed various programs for her book, *Common Purpose*, she found that successful programs encouraged practitioners to build strong relationships based on mutual trust and respect. It was the quality of these relationships that most profoundly differentiated effective from ineffective programs. Staff persons need to be there long enough, close enough and persevering enough to forge authentic relationships that help to turn lives around. Successful programs are managed by competent and committed individuals willing to: experiment and take risks; manage by "groping around;" tolerate ambiguity; win the trust of line workers, politicians and the public; responsive to the demands for prompt, tangible evidence of results; collaborative; and managers who allow for discretion of staff on the front lines. Staff on the front lines receive the same respect, nurturing, and support from their managers that they are expected to extend to those they serve.

Adequate training of staff is needed. Although the warmth and empathy of a staff person is most likely brought to the job, training in listening, how to use a strength-based approach, how to determine service priorities and how to treat participants as partners are skills that can be taught. As previously noted, with the lack of academic education in prevention, effective standards in prevention programs need to be taught on-the-job. Supervision that is frequent enough and by someone who understands effective prevention practices is needed.

c. Data Collection and Documentation

It is essential from the start of the program to articulate anticipated levels of service and to devise forms that will collect information necessary to determine if the levels of service and outcomes are being met. Records usually collect descriptive information at the onset of service, amounts of service received throughout the duration of the participant's involvement, and data that reflects the changes that are occurring for the participant comparing certain behaviors, knowledge or circumstances at the beginning and at the end of the service period. When conducting parenting programs, Daro (1990) suggests gathering data as follows:

- **At intake:** source of referral; family structure; major strengths and/or presenting problem; and if family/individual voluntarily agreed to participate;
- **Service summary:** Units of service over each week/month; number of families receiving services; and
- **Descriptive Data:** Length of time of service, level of family's participation, per centage of goals achieved, reason for termination of service.

The types of data to be collected should reflect the anticipated needs for descriptive and quantitative information. Staff should be trained in record keeping and in report preparation. Some organizations prepare an annual "workplan" that articulates the expected levels of service for the program. The levels of service are targets for staff to achieve during the coming year.

d. Measuring Outcomes and Evaluation

Programs must have an evaluation component that gathers quantitative and qualitative data to determine if the program is achieving anticipated outcomes and to what extent. The National Clearinghouse on Child Abuse and Neglect Information recommends that funding be provided only to those programs that have some evidence of effectiveness.

In addition to descriptive information about the participant and levels of service, the program should gather information that indicates whether or not the program is achieving the outcomes intended for the participants. Outcome information is different from levels of service data. Outcomes measure some type of change—circumstances, knowledge, skills, behaviors, or attitudes. Outcome measures need to be used at the onset and at the end of the duration of the service. Some measures are also used intermittently throughout the time of service.

In the *Parenting Program Evaluation Manual*, Second Edition, Daro (1990) recommends the following factors be considered when selecting an evaluation tool:

- **Program Relevance:** The instrument should address appropriate values, attitudes, or knowledge areas as defined by the program's goals and objectives.
- **Client Relevance:** The instrument should be relevant to the cultural and racial groups represented within the client population and at a reading level and in a language comprehensible to the participant.
- **Research Relevance:** The instrument should have high reliability and validity for the constructs under consideration and have been standardized on a population similar to that of the client population.
- **Normative Relevance:** The instrument should be reviewed in light of present day parenting norms;
- **Staff Relevance:** Careful attention should be paid to the skills required to implement the instrument. Special training might need to occur regarding administration, scoring and interpretation of the instrument and data collected.
- **Fiscal Relevance:** The cost of purchasing and administering the instrument must fit your program's budget, including the amount of staff time allocated to evaluation.

Many different valid and reliable tests and measurements are available for evaluation purposes. (See examples in Daro, 1990; Repucci, Britner & Woolard, 1997; Strube & Test, 1996.) Some of these instruments can be scored by the organization; others can be sent "outside" to be scored and analyzed. Programs may also establish their own measurements. However, evaluation expertise is needed to determine the reliability of new instruments.

The sophistication of the program evaluation will be dependent on the resources for the program. The strongest type of evaluation uses random assignment of participants, includes a sufficiently large sample size, includes both short-term and long-term follow up, measures behaviors rather than just attitudes or beliefs, involves proper statistical analyses, has both positive and negative results published, includes replication of successful programs and uses independent evaluators (Kirby, 1997). However, few prevention programs have adequate resources to pay for independent evaluators and a control group, let alone funds over time to look at long-term outcomes and success in replicating the program. Thus, the more common approach to evaluation is to select one or more standard measurements, to conduct measurements on the participants in the program, to have the participants or staff administer the measurements, and to analyze the information "inside." At a minimum, pre and post tests should be used to determine if the program is at least achieving the desired outcomes for the participants in that specific program at that period in time.

FAMILY SUPPORT TOOLS

Working to Capture Programs' Progress

Over the past several years, Family Support America has worked to improve evaluation practice in the family support field. Crucial to these efforts has been an emphasis on "family-supportive" evaluations, conducted in alignment with the principles of family support practice. It is crucial that evaluations not only capture program and community progress in meaningful ways, but also that they are done in ways that uphold the principles that guide the field. To be aligned to the principles, families need to be involved in selecting outcomes to be achieved, in collecting data to measure success, and in interpreting data.

Through it Evidence Along the Way project, Family Support America has been working to develop and pilot a participatory evaluation framework for use by family support programs nationwide. This framework is characterized by three major qualities. It is:

- Participatory in its process, involving multiple stakeholders, including participants, staff, and other key decision makers
- Focused on promotional indicators of family support, which highlight positive development, growth, and capacity within children and families
- Based on adherence to family support principles, with the idea that the ways in which staff members interact with participants and the ways in which participants actively engage in the program and with each other affect family outcomes

To learn more about Family Support America's evaluation work and resources, visit www.familysupportamerica.org and click on "Evaluation" in the Learning Center.

Determining appropriate outcomes can be one of the most difficult tasks of evaluation. If the prevention program is based on avoiding the occurrence of certain behaviors or problems, it is difficult to verify that the efforts of a program resulted in such an outcome never occurring. Subsequently, prevention programs that intend to reduce child abuse might not use the outcome of a decreased rate of child abuse since it is difficult to prove that the program produced behaviors that did not occur. Rather, prevention programs have moved to evaluating benefits gained by participants such as evidence of more effective parenting knowledge, attitudes, skills and behaviors or ability to cope with the stress of child care; improved parent-child communication or parent-child bonding; enhancing a parent's ability to care for the child's physical and developmental needs; and increased social supports or decreased risk indices.

e. Adequate Funding and Long Range Plans

There do not appear to be any studies that specifically look at the impact of the level of funding as it relates to program effectiveness. Other information (already noted above) does point to the need for comprehensive, long-term, and intense services which suggest that sound prevention programs need adequate funding and are not inexpensive.

Elements of effective programs do include financial accountability and addressing the need for adequate funding not only for start up but for on-going implementation. Sound prevention programs should prepare annual and long term plans for program implementation, how to change in response to participant feedback, and address resource development needs. Organizations that house the prevention program must meet accreditation and licensure requirements or other governmental regulations such as a non-profit properly conducting itself to maintain its tax exempt status.

"Partnering with parents is a bedrock belief of family support. This partnership takes many forms but is consistently done with full respect and a deep desire to work with parents and family members on service planning, delivery, and evaluation. The test of time has shown that the engagement and support of parents is key to sustaining family support programs and funding for them. Many state and local programs are now striving to embed parent leadership and engagement into their philosophy and practice. The question among program staff is no longer, 'Why engage parents?' but is instead, 'How can we engage parents most productively and respectfully?'"

The State of Family Support: Seven-Year Gains from the Family Support America States Initiative (Family Support America, 2002)

f. Advisory Groups, Collaborations, and Input from Participants Served

Administrative practices need to provide for participant and community participation. This can take many forms. Consumer focus groups can be conducted as well as participant surveys or follow up questionnaires. Advisory groups can be established. Partnerships among organizations can take the form of cooperation or collaboration and can be informal or formalized with written letters of agreement. Based on the conceptual and practice standards noted above, effective prevention programs should evidence forms of participant and community participation throughout.

III. Types of Services and Critical Elements

There is no one best program. Communities and service providers must carefully select the best program for their target population. In addition to knowing the principles for effective programs, the provider must understand the target population and its needs and capabilities in order to match the approach with the target population (Kumpfer & Alvarado, 1998).

Participants, families, service providers, funders, legislators and other key policy makers want to know which program type is effective—which program should be promoted, funded, and used. Service providers want to know what are the critical elements of effective prevention programs, which elements should be included in new models that are being developed, or how to strengthen existing programs. This final section of the report discusses types of programs and critical elements.

Programs vary greatly. Characteristics of programs may be described by methods or approaches; auspices (public or private); by funding sources; by the host or sponsor or setting of the program; by goals, content or focus; by activities; by duration; by intensity or even size of the program; by staff characteristics; or by participant characteristics (target population). "Types" of programs are categories that use certain characteristics to identify the program.

It is important not to confuse these characteristics of programs with program standards. In other words, effective programs may vary greatly in their dimensions or characteristics and still be effective. As research has increased on effective prevention programs, critical elements are emerging that identify characteristics as well as standards of effective programs.

a. Use of Critical Elements

Critical elements refer to a cluster of characteristics of a particular program model that must be replicated if the desired outcomes for that program model are to be obtained. The critical elements vary widely from one program model or type to another. The elements may include components, procedures and practices, particular qualities of staff especially as they may impact how well staff relate to the target population, and other characteristics. These characteristics differ from standards. Critical elements are characteristics that apply to a specific type of program used in a specific way rather than standards that should apply to all programs.

It has been found that programs have certain characteristics that must be adhered to in order to achieve the intended goals. When a program is implemented, it is essential to know which parts of the program must be used without deviation and which parts of the program may be adapted to meet unique needs of the persons to be served. Determining critical elements is not always easy. The critical elements are usually identified through research and/or years of use of the program wherein attention is paid to even modest changes.

Critical elements may address types of staff. For example, it has been found that training former teenage mothers to facilitate parenting groups for teenage mothers is very effective or using men as facilitators for programs involving teenage boys in pregnancy prevention or young fathers in parenting groups. Other critical elements may require a limited ratio of participants to be served per staff person, may address intensity and duration of program use by the participants, or may denote key components of the programs. Two examples of how critical

elements are used with a particular program model follow.

In *Guidelines for Programs to Reduce Child Victimization* (1999), essential elements when implementing these types of programs include: addressing protection as well as risk factors for children in information provided and skills taught; using a combination of observing modeled behavior, active rehearsal, and reinforcement of the desired behavior to achieve positive behavioral change with children; using a developmentally appropriate curriculum; and containing skills training in the following areas: teaching children to recognize dangerous and abusive situations, to distinguish between appropriate and inappropriate touch, to say "no" to unwanted overtures, to avoid dangerous situations, encouraging children to tell an adult about such episodes, and assuring children that such incidents are never the fault of the child. Characteristics that may be modified include program length and duration and varying modes of presentation so long as they allow the active participation of the child.

In the Healthy Families America home visiting program model, there are twelve critical elements. Some of them are: initiate the service prenatally or at the time of the baby's birth; services need to be intensive (at least once a week) with well-defined criteria for increasing or decreasing the service intensity; low caseloads of no more than 15 to 25 families per home visitor; and staff should be selected on the basis of their ability to demonstrate a combination of the requisite personal characteristics and knowledge base as represented by specific academic degrees or employment backgrounds. Recent additional research is beginning to show that retaining families in this program model is related to staff characteristics whereby the home visitor is a parent, is someone who lives in the community of the families being served and is someone who is "older."

b. Types of Services by Methodology, Activities, or Approach

The list below portrays types of services known by the approach or activity used to deliver the service:

- Home Visitation
- Parenting Education using Groups, Workshops or Seminars
- Mentoring
- Self-help Support Groups
- Child Care and After School Care
- Case Management
- Respite Care
- Community Organization and Empowerment

Increasingly, studies are being conducted on types of services. Some studies may compare outcomes using one approach compared to another. Other studies look at various components within one approach. An example of each is provided.

In the November 1998 Bulletin of the Office of Juvenile Justice and Delinquency Prevention, three program types were reviewed for evidence of effectiveness. "The three family intervention strategies effective in reducing risk factors and increasing protective factors are behavior parent training, family therapy, and family skills training or behavioral family therapy. Behavior parent training means teaching parents effective discipline techniques to reduce a child's conduct disorder. Family therapy interventions refer to family therapy programs such as Structural Family Therapy used when preteen or teens already have behavioral problems and the family needs to improve communication, parental control, and parent-child relationships. Family skills training/behavior family therapy target high-risk groups and have multi-component interventions which include behavioral parent training, family therapy, and children's social skills training such as the Strengthening Families Program and Bavolek's Nurturing Program."

This study concluded that outcomes differed based on the type of family intervention approach. For example:

- Training in parenting skills often reduces negative behavior problems by improving parental monitoring and supervision but only indirectly improves family relationships.
- Family interventions do a better job of improving family relations, support, and communication and reduce family conflict.
- In-home family or parent support programs help build a more supportive environment which improves the family's ability to access information, services and social networks.
- Case management increases the family's access to services.
- Parent education improves parents' knowledge but doesn't necessarily change behavior.

Another example in the same article concluded that skills training approaches for parents are more effective than didactic, lecture-style programs to change behavior. Thus, information needs to be combined with discussion time, experiential practice, role-playing and homework.

Home visiting is another type of program approach where an increasing amount of research is being conducted to determine which program characteristics are more critical. Following the David and Lucille Packard Foundation report entitled, "The Future of Children," (1999) the Packard Foundation has funded additional research of the leading home visiting programs to assess which characteristics are essential and which ones appear less significant to impact desired program outcomes. Their overall goal is to look at which factors impact not just changes in parental knowledge and attitude but changes in parent-child interactions that are of functional importance (not just statistical significance) and to determine which characteristics could result in designing programs that produce cost savings adequate to justify changes in policy.

c. Types of Services by the Setting or Target Population

Another way to group programs is by the setting. Programs may be: home-based, school-based, neighborhood-based, faith-based, or in the workplace. There do not appear to be any studies recommending one setting over another. However, the setting must support the practice of easy accessibility. When working with high-risk families, it is important to engage other family-serving agencies such as schools, local churches, drug treatment agencies, housing authorities, mental health centers, youth and social service agencies in order to contact and attract hard-to-reach families.

Programs may also be grouped by target population. Programs may target infants and toddlers, young children, ages 2-5, teens, parents, pregnant women, teen parents, children with disabilities and their families, at-risk parents, and so on.

One comprehensive comparison of effective prevention programs groups the recommendations using a matrix of families having children between the ages of Birth (including prenatal efforts) to 5 years, 6-10 years, 11-18, or Birth to 18 years cross referenced against whether or not the families might be considered part of the "general population," a "high-risk population," or an "in-crisis population." (See Table 4 in the Appendix.) It was prepared by the *Strengthening America's Families Initiative* under the auspices of the U.S. Office of Juvenile Justice and Delinquency Prevention (OJJDP), the Center for Substance Abuse Prevention (CSAP) and the University of Utah (Alvarado and Kumpfer, 2000). The initiative began in the mid-1980's with the purpose of identifying best practices that could meet the diverse needs of communities and to disseminate the findings to practitioners. Model programs were identified in 1989, 1994 and 1999.

In order to consider review of a model program, the comparison noted above required the program meet the standards of: an experimental design with random assignment or matched control group; statistically significant outcomes; replication in at least one additional site with demonstrated effects; and evidence that the outcomes were sustained for at least one year following. Then each program was rated based upon theory, fidelity of the intervention, sampling strategy and implementation, attrition, measures used, data collection, missing data, analysis, ability to replicate, dissemination capability, cultural and age appropriateness, program integrity and utility. The list of "exemplary, model and promising" programs was developed through a search of the scientific literature and from recommendations from program developers who had to provide detail on the programs.

d. Types of Services by Goals, Content or Focus

Another typology notes the goal, focus or intended outcomes of the program such as teen pregnancy prevention programs, programs to prevent child sexual abuse, or school-readiness programs. When these phrases are used, no one approach, target population, or setting for the program tends to come to mind. For example, teen pregnancy prevention programs may target pre-adolescents, young teens, or even older teens—if hoping to impact the large number of 19 year olds that become new teen mothers. Teen pregnancy prevention programs may be school based, community based, or faith based. They may use mentoring, family therapy, case management, or recreational types of approaches. They may emphasize one-on-one, family or group methods. A comparison of program effectiveness to address teen pregnancy prevention is illustrated in *"No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy."* (Kirby, 1997) There is much in the literature that points to the disadvantages of babies born to mothers between ages 15-17. These babies have less supportive and stimulating home environments, poorer health, lower cognitive development, poor education outcomes, high rates of behavior problems, and higher rates of teen childbearing themselves. Key findings on effective teen pregnancy prevention programs suggest:

- no single or simple approach is effective; the approach must address both postponing sex and using contraception as well as factors such as poverty, lack of opportunity, family dysfunction,and social disorganization more generally;
- multi-component programs in schools and communities appear to work better to increase the use of contraceptives and decrease pregnancy rates than single components; and
- some youth development programs as an approach look promising but more research needs to be done.

Since the phrase, "child abuse prevention program," is general and unable to convey the various characteristics of the many different and effective programs that are used, it is important to continue research on specific program characteristics as they relate to outcomes, target populations, and approaches.

IV. Conclusions

As outlined above, significant factors to consider when developing or selecting an effective prevention program include:

conceptual soundness as evidenced by how well the program is family centered and community based, culturally sensitive and competent, engages families prenatally, at birth, or within the first six years of the birth of their first child, treats family participants as partners and empowers them by building on their strengths, and meets the developmental needs of the parent, children, and family;

best practices evidenced by how flexible and responsive the program is to a family's and community's changing needs, how well it works in partnership with participants and the community, its ability to link families with formal and informal social supports, if services are offered voluntarily and universally, if they are comprehensive and integrated into broader service systems, easily accessible and of sufficient duration and intensity; and

sound administrative standards that are reflected in the program's structure, design, and practices, through a committed staff, having adequate documentation of levels of service and outcomes, incorporates evaluation methods, obtains adequate funding, plans for the future, and makes good use of advisory groups and input from the families and communities it serves. In addition, the program must fit the target population and the community.

Although the Prevention Program Standards Working Group sought to highlight standards for programs that prevent child maltreatment, information was gathered across disciplines. Sound prevention programs often produce desirable outcomes across the fields of health, substance abuse prevention, juvenile delinquency prevention and education as well as in child welfare. Information in this report can be used to assess a program's soundness when a program is being developed or to strengthen an existing program.

It is intended that the information in this report might provide providers, communities, funders, and policy makers the information they need to determine which programs deserve promotion and support. It is hoped that legislators at the state level as well as the Governor and other cabinet officers will find this information useful as New Jersey pursues prevention focused policies and programs to better serve individuals, families, parents, and children who deserve brighter futures.

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Factors Influencing the Occurrence of Child Abuse and Neglect

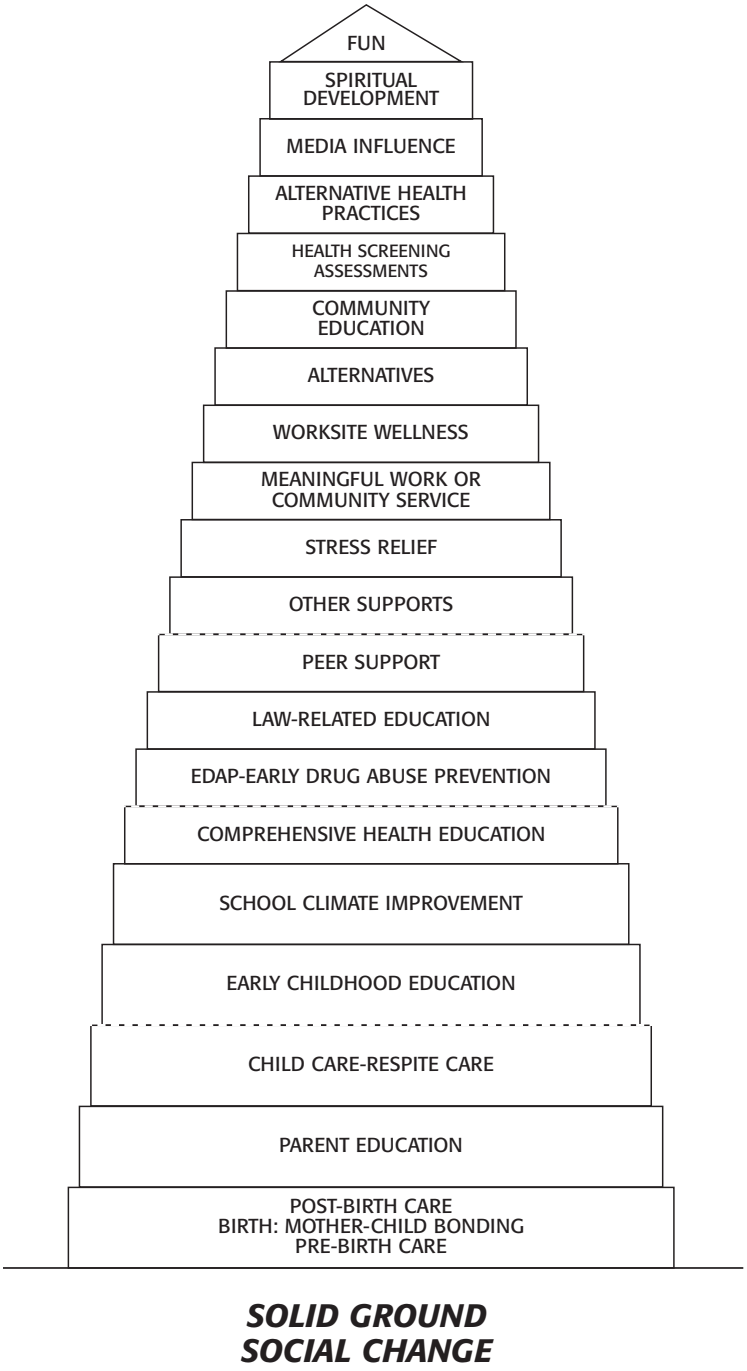
Figure 1

Prepared by
Sharon Copeland
Figure 1.

Source: Copeland, S. *Prevention: Has its time come to the field of child protection services?* NJ Advisor (The American Professional Society on the Abuse of Children-New Jersey Chapter Newsletter), Fall 1998, Volume 3, No. 2, pp 3-8.

Figure 2

Primary Prevention Pyramid



Source: Reprinted with permission from author Jack Pransky as printed in *Prevention: The Critical Need*, page 40.

Community Empowerment

Delivery of Services (the dominant paradigm)	Community Empowerment (the alternative paradigm)
• Professional responsibility (doing for the community) • Power vested in agencies • Professionals seen as experts • Planning and services responsive to each agency s mission	• Shared responsibility (doing with the community) • Power residing in the community • Community seen as the expert • Services and activities planned and implemented on the basis of community needs and priorities
• Fragmentation of planning and service delivery • External leadership based on authority, position and title • Denial of ethnic and cultural differences • External linkages limited to networking and coordination • Closed decision-making process	• Interdependency and integration of planning and services • Community-based leadership that develops shared vision, broad support, and management of community problem solving • Appreciation of ethnic diversity • Emphasis on cooperation and collaboration • Inclusive decision making
• Accountability to the agency • Evaluation primarily to determine funding • Categorical funding • Community participation limited to providing feedback and input	• Accountability to the community • Evaluation to check program development and decision making • Funding based on critical health issues • Maximal community involvement at all levels

Source: ***Office of Substance Abuse Prevention***, OSAP Community Partnership Program Training Manual, 1991.

Table 4

Strengthening America's Families Program Matrix

Ratings: Exemplary I, Exemplary II, Model, Promising (Highest to Lowest)

	Universal (General Population)	**Selected** (High Risk Population)	**Indicated** (In-Crisis Population)
Age 0 – 5	HIPPY (Model) 3 – 5 New York, NY Make Parenting A Pleasure (Promising) 0 – 8, Eugene, OR MELD (Model) 0 – 5 Minneapolis, MN Parents As Teachers (Model) 0 – 5 St. Louis, MO Raising a Thinking Child: I Can Problem Solve for Families (Exemplary II) 4 –7 Philadelphia, PA	Dare to be You (Model) 2 –5 Cortez, CO Healthy Families America (Model) 0 – 5 Indianapolis, IN Prenatal and Early Childhood Nurse Home Visiting Program (Exemplary II) 0 – 5Denver, CO	Healthy and Fair Start/CEDEN (Model) 0 – 5, Austin, TX Helping the Noncompliant Child (Exemplary I) 3 – 7 Seattle, WA
Age 6 – 10	Preparing for the Drug Free Years (Exemplary I) 8 – 14 Seattle, WA	The Incredible Years: Parents and Children's Training Series (Exemplary I) 3 – 10 Seattle, WA Strengthening Families Program (Exemplary I) 6–10, Salt Lake City, UT Strengthening Hawai'i Families (Model) 5 – 12, Honolulu, HI Families and Schools Together (Model) 3 –14, Madison, WI	Focus on Families (Model) 3 – 14 Seattle, WA
Age 11– 18	Parents Who Care (Model) 12 – 16 Seattle, WA Strengthening Families Program: For Parents and Youth 10 – 14 (Exemplary II) 10 –14, Ames, IA	Adolescent Transitions Program (Exemplary II) 11–18, Eugene, OR Creating Lasting Family Connections (Model)9 – 17, Louisville, KY	Bethesda Day Treatment (Promising)10 – 18, Milton, PA Brief Strategy Family Therapy (Exemplary II) 8–17, Miami, FL Functional Family Therapy (Exemplary I) 6–18, Salt Lake City, UT Multidimensional Family Therapy (Exemplary II) 11 – 18, Miami, FL Multisystemic Therapy (Exemplary I) 10 – 18, Charleston, SC Treatment Foster Care (Exemplary I) 12 –18, Eugene, OR
Age 0 – 18	NICASA Parent Project (Model) 0 – 18, Round Lake, IL Parents Anonymous (Promising) 0 –18, Compton, CA	Effective Black Parenting (Model) 2 –18, Studio City, CA Nurturing Parenting Program (Model) 1 – 18, Park City, UT Strengthening Multi-Ethnic Families andCommunities Program (Promising) 3 –18, Los Angeles, CA	HOMEBUILDERS (Model) 0 – 18Federal Way, WA Parenting Wisely (Exemplary II) 6 –18, Athens, OH Project Seek (Model) 0 – 18, Lansing, MI Nurturing Program for Families in Substance Abuse Treatment and Recovery (Promising) 0 – 18, Cambridge, MA

Source: *Strengthening Americaís Families: Model Family Programs for Substance Abuse and Delinquency Prevention,* Alvarado, R., Kendall, K., Beesley, S., Lee-Cavaness, C. (eds). University of Utah, Depart. of Health Promotion and Education, April 2000, p. ix.

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Donna M. Pincavage, *Executive Director*
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Prevention Subcommittee Members

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Division of Family Guidance

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Division of Youth & Family Services

Tina Minnis Williams
Division of Youth and Family Services

Prevention Program Standards Working Group Members

CHAIRPERSON

Sharon J.B. Copeland, M.S.W., L.S.W.
Prevent Child Abuse-New Jersey

MEMBERS

Catherine Bender, R.N.
Nancy Murphy, R.N., M.A.
Child and Adolescent Health
New Jersey Department of Health and Senior Services

Clete Davis
Office of Program Development and Prevention Services
Juvenile Justice Commission
NJ Department of Law and Public Safety

Glenna Gundell, Chairperson
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New Jersey Task Force on Child Abuse and Neglect

Roy G. Perham, Ph.D.
Office of Assemblywoman Rose Heck

Donna Pincavage, M.S.W., M.P.A., L.S.W.
New Jersey Task Force on Child Abuse and Neglect

Isabel Wolock, Ph.D.
Professor Emerita
Rutgers, The State University of New Jersey

Standards for Prevention Programs: Abridged Overview

Factors that are present in effective prevention programs fall into three categories:

Conceptual Standards (Theories and beliefs behind effective prevention programs)

- Family Centered – See children in context of families and communities; avoid child only or parent only approaches.
- Community Based – Locate programs locally where participants live, work or attend school.
- Culturally Sensitive and Culturally Competent – Affirm, strengthen cultural identity and diversity.
- Begin Early – Work with target population before negative or abuse patterns are established.
- Developmentally Appropriate – Relevant to the ages and developmental stages of participants.
- Regard Participants as Partners with Staff – Participants "drive" the service.
- Uses Empowerment and Strengths-Based Approaches – Build on capabilities and competences of program participants rather than problems or deficits.

Practice Standards (Approaches to program design and implementation)

- Flexible and Responsive – Tailor practices to the needs of the participants.
- Partnership Approach with Participants and Coordination of Services – Enable participants to influence policies and practices; maximize coordination/collaboration among service providers.
- Linkages with Informal and Formal Supports – Connect participants with multiple supports.
- Universally Available and Voluntary Participation – Programs are offered to broad community and seen as an opportunity to enhance the participant, attracting voluntary participation.
- Comprehensive and Integrated Services – Use multiple supports to reinforce positive outcomes.
- Easily Accessible for Participants – Easy engagement, integration and use of program services.
- Long Term and Adequate Intensity – Combines length of service and intensity to maintain positive outcomes over time.

Administrative Standards (How programs are administered and managed)

- Use of Sound Program Structures, Designs, and Practices – These reflect the conceptual and practice standards noted above.
- Committed and Caring Staff – Quality of staff and their interactive ability is a key factor.
- Collects and Documents Data – Collect and report service level and outcome data.
- Measures Outcomes and Conducts Evaluation – Use of quantitative and qualitative data to evaluate if anticipated outcomes are being achieved.
- Adequate Funding and Long Term Plans – Need for stable and long-term funding.
- Use of Advisory Groups, Collaborations and Input from Participants – Foster participant and community participation.

When considering which prevention program model to promote or use, the more factors noted above that are present in the model, the more likely the program will be effective. An effective program produces the intended goals and outcomes purported by the model.

Although these standards were developed based on literature and research from multiple fields, they are especially intended for use to promote the well-being of children and to prevent child maltreatment. The standards focus on program approaches that address the general population or those individuals who may be at greater risk of being abusive or abused based on etiological studies of why maltreatment occurs. Sound prevention programs strengthen the ability of families and communities to effectively raise children.

A Guide for Using the "Standards for Prevention Programs"

The terms and concepts used in this guide are based on the report. Before using the guide, it is necessary to read the report and become familiar with the definitions for terms and the background for the concepts.

Planning and Preparation

The checklists below will guide you when preparing to conduct a prevention program in your community. Good planning will help ensure that you are selecting the most effective means to reach your goals. Check off each item as it is accomplished.

Who Will Be Included in the Process

Effective prevention programs involve a broad base of individuals and groups from your community.

Item	Check
1. Parents and youth are involved.	❑
2. Potential participants are included.	❑
3. Professionals and representatives from key organizations are involved.	❑
4. Members from the community reflect broad representation.	❑

Effective prevention programs involve individuals and groups from your community throughout the planning, implementing and evaluating stages of your prevention program efforts.

Item	Check
1. Focus groups, open meetings or forums, planning committees and groups were used to obtain the input of many individuals and groups.	❑
2. An on-going Advisory Board is part of the plan.	❑
3. We plan to use surveys, outcome measures and evaluation processes to continue to obtain input and feedback once the program has begun.	❑

Identifying the Outcomes You Want

Deciding on your goals and outcomes is a very important first step. The goals can help mobilize key persons and participants. The outcomes will set the stage for measuring whether or not you will reach your goals.

	Item	Check
1.	We have 1 to 2 major, written goals.	❑
2.	We have 2 to 4 written outcomes for each goal.	❑
3.	Each of the outcomes is measurable.	❑
4.	Timeframes have been established.	❑

Who Will Participate in the Program

Clear identification of your target population is a key to successful program focus and development.

	Item	Check
1.	We consulted with individuals, families, key organizations and community leaders to learn about who can benefit.	❑
2.	We selected a target population that attempts to maximize participation without diluting the services.	❑
3.	We considered how all individuals or families might receive at least some services.	❑
4.	The prevention services will be provided as early as possible, before unwanted behaviors or outcomes occur.	❑

Access to the Program

Effective prevention programs are easily accessed by the participants.

	Item	Check
1.	The services will be offered in a place that is considered safe, easy to reach, and positive such as at home, school, the workplace or a public place such as a library.	❑
2.	The program hours are convenient for the participants.	❑
3.	Instead of waiting for the participants to come to the program, we have found various ways to bring the program to the participants.	❑
4.	Participant supports and incentives such as transportation, meals and baby-sitting will be offered to encourage participation.	❑
5.	The program embraces diversity and is culturally sensitive and respectful of the customs and traditions of the participants and the community.	❑

Selecting an Effective Prevention Program

Informed choices improve the likelihood of selecting an effective prevention program.

	Item	Check
1.	We reviewed research, books, articles and audio-visual materials about potential prevention programs we wanted to consider.	❑
2.	We carefully examined at least 2-3 models of a particular program and we understand the critical elements for the program we selected.	❑
3.	We selected a program that has already been researched and evaluated and shows evidence of successfully replicating the outcomes.	❑

Identifying and Effectively Using the Community's Resources

Knowledge of community resources improves program selection and reduces the likelihood of program redundancy and competition.*

	Item	Check
1.	We assessed the strengths of potential participants.	❑
2.	We assessed the strengths of our community, including the location where the services will be provided.	❑
3.	We have listed informal and formal supports to be used by participants.	❑
4.	We have a plan for accessing immediate in-kind and financial support for the program, volunteer help, and expertise.	❑
5.	We have a plan for the long-term financial support of the program.	❑

*See listing of "community involvement models" in bibliography for assistance in how to mobilize community resources and how to conduct strength-based assessments.

Measuring a Program Against the Standards

Some programs will be more effective than others to help you meet your goals. The charts below will help you determine how well the program you are most interested in will help you reach your goals and how well it meets criteria for effective prevention programs. Score each section to determine the strengths of the program.

Conceptual Standards:

Measuring the Ideas Behind the Program Does the prevention program you plan to implement:	How Well It Meets the Criteria				
	Does not 0	Unsure 1	Partially 2	Good 3	Excellent 4
1. Family centered: Involve all possible participants such as the child, parents, family members, and caregivers?					
2a. Community-based: Reinforce desired outcomes through the home and in the community (through the organizations with whom the participant is involved)?					
2b. Engage community members in program development, implementation and ownership?					
2c. Recognize the role community members play in supporting families and participants in their success?					
2d. Use informal and formal supports needed by the participant and/or family?					
3. Culturally competent: Promote and strengthen cultural identity and diversity?					
4. Early start: Work with participants BEFORE unwanted behaviors develop (beginning prenatally if appropriate)?					
5. Developmentally appropriate: Meet the developmentally appropriate needs of the participants, be they children, parents, other family members or caregivers?					
6. Participants as partners: Treat the participant as partner and collaborator, evidenced by involving the participant in planning and decision-making and promoting self-reliance?					
7. Strengths-based approach: Assess the strengths and capabilities of the participants and build upon them?					

Practice Standards:

Measuring the Approaches to Be Used Does the prevention program you plan to implement:	How Well It Meets the Criteria				
	Does not 0	Unsure 1	Partially 2	Good 3	Excellent 4
1a. Flexible and responsive: Allow for flexibility to meet the unique needs or circumstances of the participants such as increasing the intensity of the service in times of greater need?					
1b. Offer the service(s) at a time convenient to the participant?					
1c. Provide incentives to help engage participants such as providing an evening meal or child care for families?					
2a. Partnership approaches: Fit into a continuum of services, maximizing coordination of services with other providers?					
2b. Link participants with other needed services?					
3. Uses formal and informal supports: Link participants with informal supports such as friends, mentors, role models, or community organizations?					
4a. Universal availability: Offer services to a broad range of participants, not just persons or families with problems?					
4b. Voluntary: Accept most participants who come voluntarily?					
5. Comprehensive and integrated: Involve multiple service components and/or comprehensive types of services?					
6a. Easily accessible: Provide the service in a non-threatening environment such as a public place that is safe and convenient (a school, library, place of worship, recreational site, or workplace)?					
6b. Allow the participant to easily access staff?					
7. Length and intensity of services: Have a frequency, intensity and length of service sufficient to produce and maintain the desired outcome(s)?					

Administrative Standards:

Measuring the Capacity of the Organization(s) Implementing the Program and Management of the Program When the program is being implemented:	How Well It Meets the Criteria				
	Does not 0	Unsure 1	Partially 2	Good 3	Excellent 4
1. Sound organization: Will the agency or organization conducting the program be strong and stable, evidenced by past success?					
2a. Sound program structure, design and practices: Will the agency or organization have documented program, management, and fiscal procedures in place?					
2b. Are written and realistic timeframes to be used?					
2c. Will the necessary critical elements be properly used?					
2d. Will it follow an already established and researched model?					
2e. Will it be a good fit for the intended target population?					
3a. Committed staff: Is there evidence that direct service staff are caring, empathetic, sensitive, and dedicated as well as strong, credible, experienced and credentialed?					
3b. Will adequate training and supervision be provided at the onset and on-going?					
4a. Data collection and documentation: Will record keeping documents be in place and ready for use in a timely fashion?					
4b. Will the infrastructure be adequate to manage data collection and preparation of reports?					
5a. Measuring outcomes: Will well-defined and quantified levels of service be routinely recorded?					

Administrative Standards: continued

Measuring the Capacity of the Organization(s) Implementing the Program and Management of the Program When the program is being implemented:	How Well It Meets the Criteria				
	Does not 0	Unsure 1	Partially 2	Good 3	Excellent 4
5b. Will outcomes be measured and is a process in place for them to be routinely analyzed?					
6a. Long range plan: Will it be in line with the long range plan?					
6b. Are adequate funds available for current and long-term provision of prevention services?					
7a. Gathering input: Will participant involvement be evident through the use of advisory groups, participant feedback surveys or other means?					
7b. Will continued involvement by community leaders be welcomed and used?					

Additional comments you may want to add:

1. What else do you know that makes you think the prevention program you have selected will meet the goals and outcomes you want?

2 What aspects of the program or its implementation are you still concerned about?

We hope the information provided to you in this report leads to the successful implementation of effective prevention programs. For more information, please contact the New Jersey Task Force on Child Abuse and Neglect, 222 So. Warren Street, P. O. Box 700, Trenton, NJ 08625-0700 or call 609-292-0888.