Community Blueprint for Children

An Initiative of the Child Abuse Oversight Committee of the Santa Cruz County Children's Network

Report of Activities of Preplanning Phase

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Prepared by the
Santa Cruz County Child Abuse Prevention Council

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This report is available on the web at www.communitybridges.org/cbcreport.pdf

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Community Blueprint for Children Report

Section I. Introduction

This report exists as a resource for Santa Cruz County families and organizations sharing our vision of a comprehensive, systematic, countywide approach to child abuse prevention. The lasting, consequential effects of child abuse on individuals and on our community remain a significant problem for our county, in terms of both human suffering and economic cost. Even though the impact of abuse is severe, it is preventable. Child abuse prevention programs and practices take a number of forms in an effort to end the destructive abuse cycle. This document summarizes the work of the Preplanning Phase for Community Blueprint for Children, an initiative of the Child Abuse Oversight Committee of the County Children's Network. The lead agency for this effort is Santa Cruz County Child Abuse Prevention Council.

The report begins by providing basic information about child abuse: legal definitions, known incidence, estimated prevalence, consequences for abused individuals and society, and information on the costs to society associated with the abuse of children. The next section of the report gives an overview of Community Blueprint for Children: its history and reason for existence as well as a summary of Preplanning tasks completed to date and a discussion of research methods utilized in our original research into current local practices.

The following section outlines ten different child abuse prevention strategies that have proven effective in some applications at reducing abuse, reducing risk of abuse, and/or increasing protective factors. Following is the data from our local research, then preliminary findings and next steps. A thorough appendix includes documents associated with the preplanning phase as well as a list of references and works cited.

Section II. Child Abuse

Child abuse is an ever-present, pervasive aspect of American society, debilitating our community in broad and personal contexts.

What is Child Abuse?

The State of California, in supplemental compliance with Federal regulations, has established working definitions of child abuse as assuming four forms: physical abuse, emotional abuse, sexual abuse, and neglect. In an effort to elaborate on definitions supplied by California's penal code, we also reference non-governmental constructed meanings of child abuse.

Physical abuse has officially occurred in the instance that "(1) physical injury inflicted by other than accidental means upon a child by another person, (2) willful harming or injury of the child or the endangering of the person or health of the child, and/or (3) unlawful corporal punishment or injury. *Willful harming or injuring of a child or the endangering of the person or health of a child* means a situation in which any person willfully causes or permits any child to suffer, or inflicts thereon, unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of the child to be placed in a situation in which his or her person or health is endangered" (Child Welfare Information Gateway).

Emotional abuse is lawfully defined as causing *"serious emotional damage* [which] is evidenced by states of being or behavior including, but not limited to, severe anxiety, depression, withdrawal, or untoward aggressive behavior toward self or others" (Child Welfare Information Gateway).

Sexual abuse is legally defined in terms of sexual assault and exploitation: "*sexual assault* includes rape, statutory rape, rape in concert, incest, sodomy, lewd or lascivious acts upon a child, oral copulation, sexual penetration, or child molestation. *Sexual exploitation* refers to any of the following: (1) depicting a minor engaged in obscene acts; preparing, selling, or distributing obscene matter that depicts minors; employing a minor to perform obscene acts, and/or (2) knowingly permitting or encouraging a child to engage in, or assisting others to engage in, prostitution or a live performance involving obscene sexual conduct, or to either pose or model alone or with others for purposes of preparing a film, photograph, negative, slide, drawing, painting, or other pictorial depiction, involving obscene sexual conduct, and/or (3) depicting a child in, or knowingly developing, duplicating, printing, or exchanging any film, photograph, videotape, negative, or slide in which a child is engaged in an act of obscene sexual conduct" (Child Welfare Information Gateway).

Neglect is officially designated as severe or general, under the following California penal definitions: "*neglect* means the negligent treatment or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person. *Severe neglect* means the negligent failure of a person having the care or custody of a child to protect the child from severe malnutrition or medically diagnosed non-organic failure to thrive. *Severe neglect* also means those situations of neglect where any person having the care or custody of a child willfully causes or permits the person or health of the child to be placed in a situation such that his or her person or health is endangered, including the intentional

failure to provide adequate food, clothing, shelter, or medical care. *General neglect* means the negligent failure of a person having the care or custody of a child to provide adequate food, clothing, shelter, medical care, or supervision where no physical injury to the child has occurred" (Child Welfare Information Gateway).

Child Abuse: Known Incidence

Nation-wide in 2005, 3.3 million reports of child abuse were filed to child protective services indicating the likelihood of abuse for approximately 6 million children. About 899,000 of these cases were substantiated, with the following rates per form of abuse: "more than 60 percent were neglected, more than 15 percent were physically abused, less than 10 percent were sexually abused, and less than ten percent were emotionally maltreated" (Department of Health and Human Services). Approximately 1,460 child deaths were officially attributed to child abuse and neglect in the United States in 2005 (California Department of Public Health). This amounts to approximately four preventable deaths of children every day.

In California in 2006, reports of abuse were made regarding 48.3 in 1,000 children (University of California at Berkeley Center for Social Services Research, 2008). These cases were substantiated for 11.1 in 1,000 children (kidsdata.org). Comparably, in 2005 nearly half a million cases of child abuse were reported to child welfare services. Over 109,000 of these referrals were substantiated and legally recognized as child abuse (California Department of Public Health). In the state of California annually, between 300 and 400 children are hospitalized as a result of recognized maltreatment, and best estimates yield an annual death toll of around 140 children (California Department of Public Health). This means that every month in California, over eleven children lose their life to known incidences of abuse or neglect.

The total child population of Santa Cruz County has declined in the past decade from 63,969 children in 1998 to approximately 58,147 in 2006. In January through December, 2006, referrals were made for 3,120 children or for 53.7 children in every one thousand; of these referrals, substantiations were made for 788 children or for 13.6 children in every one thousand; of these substantiations, 266 children, or 4.2 children in every one thousand, entered the child welfare system. Approximately 300 children are in out-of-home care at any point in time in our county. For example on October 1, 2007, 310 children were in out-of-home care. Thirty-eight percent of these children were 0-5 years old. Referrals and substantiations are also disproportionately high for this age group. Thirty-six percent of referrals in 2006 were for 0-5 year olds, and 41% of substantiations were within this age range (University of California at Berkeley Center for Social Services Research, 2008).

Child Abuse: Underreported Epidemic

Though these numbers reveal a substantial problem, they do little to reflect the actual prevalence of child abuse, which remains a highly underreported and misunderstood issue. According to Dr. Jim Mercy, the Associated Director for Science at the Division of Violence Prevention of the Centers for Disease Control's National Center for Injury Prevention and Control, "Child maltreatment is a hidden problem. It's largely hidden from view. We know from data from child protective service agencies that in 2002 about eight hundred ninety six thousand children were confirmed as victims of child maltreatment.   But other data suggest that that may be an underestimate of a magnitude of ten (WABE radio interview)."

There are a number of reasons why cases of child abuse and neglect are not documented as often as they occur. Because child abuse and neglect most often occur inside the home at the hands of a parent, relative, or a person who is known to the child (US Department of Health and Human Services), the child is often dependent on the abuser and may therefore be too afraid or not have the necessary resources to report instances of abuse. The power differential between the abuser and victim also presents a strong barrier to disclosure by the child, as do the trauma bonds that often develop between a child and her/his abuser. Children naturally feel responsible for what is happening in their world, and may believe the abuse is their fault. Many bystanders, such as non-offending parents or other relatives, are also unlikely to confront the perpetrator or report the abuse due to fears of economic instability, violent reactions, or loss of family equilibrium. Shame also prevents a strong barrier to disclosure, for abused children, for perpetrators who might wish to seek help, and for relative bystanders.

An additional considerable aspect of child abuse that contributes to its underreporting, is the construct of the American "nuclear" family, existing privately and separate from the domain of the larger community. Many of us maintain a "behind closed doors" paradigm regarding family issues, and turn a blind eye to, for instance, a mother abusively reprimanding her son in a public setting because it is not our "business" to intervene.

When this point of view is compounded with limited and easy to misunderstand legal definitions of abuse, not to mention a lack of uniformity in child abuse legislation, the result is an impossible to identify statistical shadow of unreported and unsubstantiated cases of child abuse. While mandated reporters do play an important role in partially countering this effect, misconstrued meanings of child abuse and reporter obligations do not allow for the ensured legal reporting in all cases of child abuse.

Child Abuse: Other Ways of Estimating Prevalence

Since it is likely that a majority of cases of child abuse and neglect go unreported, there is a strong need for prevention in the community. In order to understand the true scope of the problem, we need to look at indicators of prevalence, versus known incidence. In the child abuse prevention field, the term "prevalence" is commonly used to refer to estimates of the number of people who have experienced child abuse in their lifetimes, whether or not the abuse was reported to authorities. The term "incidence" generally refers to the number of cases of maltreatment that do come to the attention of child welfare agencies. While it is not possible to provide precise statistics for prevalence, for obvious reasons, the literature includes several methods to estimate prevalence. The primary methods utilized for this purpose are to interview parents about their own parenting practices and to interview people retrospectively about their childhood experiences of abuse. Following are prevalence estimates utilizing these two methods.

A poll that interviewed parents was conducted Gallup in 1995. A representative sample of 1000 parents from around the country was asked how they handle a misbehaving child. The poll differentiated between abusive acts such as kicking, punching, throwing the child down, or hitting the child with a hard object, and other punitive practices such as yelling, spanking, and cursing. Five percent of parents admitted to using at least one of the abusive methods on their child(ren). This rate is sixteen times higher than federal statistics for substantiated cases of physical abuse from that time period. Parents also

reported that their children had been forced to engage in sexual activity by an adult or older child at rates 10 times the federal substantiations for the period.

George H. Gallup Jr., co-chairman of the Gallup Organization, hinted that the poll results, while much higher than substantiation rates, might still be underestimated. He said: "Our data are based on self-reporting, and some people probably did not report everything. In itself, the fact that so many parents were willing to admit using severe physical punishment shows something about social attitudes."

A number of retrospective studies of adults reporting about their own childhoods paint an even more alarming picture of the possible prevalence of child abuse and neglect. One of the most recent and conclusive studies is the Adverse Childhood Experience (ACE) Study, which effectively established a connection between adverse childhood experiences and mental and physical health issues in adults. This study revealed major discrepancies between the reported incidents of abuse and actual prevalence. 17,000 HMO patients participated in the study. The average age of participants was 57 years. They were middle class or above and 74% had attended college. Eighty percent were white (including Hispanic), 10% black, and 10% Asian. The ACE study found that adults reported forms of abuse and neglect at rates much higher than demonstrated by children's involvement in child welfare services. The following table illustrates the percentage of people who reported experiencing specific categories of abuse and neglect during their childhood. In many cases, people experienced more than one form of abuse, however for this exercise we will include discreet breakdown by type (Felitti).

ACE Study
Percentage of Adult HMO Patients Reporting Various Forms of Child Abuse

	Women	Men	Total
Physical Abuse	27%	29.9%	28%
Sexual Abuse	28%	16%	22%
Emotional Neglect	16.7%	12.4%	15%
Emotional Abuse	13.1%	7.6%	11%
Physical Neglect	9.2%	10.7%	10%

These figures and the Gallup numbers are obviously much higher than the reported and substantiated child abuse rates of 5.83% and 1.11% respectively for California and 5.37% and 1.36% respectively for Santa Cruz County. Given that the Santa Cruz County total child population in 2007 was slightly over 58,000, the ACE study calls into question the possibility that thousands of children in our county may be in jeopardy. The need for a strong child abuse prevention effort is clear.

Impact of Child Abuse on Individuals and Society

A major finding of the ACE study was the correlation between adverse childhood experiences and issues with mental and physical health in adulthood. The ACE study found that the risk of having the following conditions is increased for adults who had adverse childhood experiences: alcoholism and alcohol abuse, chronic obstructive pulmonary disease, depression, fetal death, health-related quality of life, illicit drug use, ischemic heart disease, liver disease, risk for intimate partner violence, multiple sex partners, sexually transmitted diseases, smoking, suicide attempts, and unintended

pregnancies. There was a strong, graded relationship between the number of ACEs, or categories of adverse childhood experience, a person had had in childhood, and the statistical risk of engaging in high-risk health behaviors such as smoking, substance abuse, overeating, or a sedentary lifestyle. There was also a strong correlation between the number of ACEs and the probability of suffering from chronic physical and/or mental health challenges (Felitti).

Many other studies have also demonstrated a link between child maltreatment and short and long term effects for abused individuals. The Centers for Disease Control cites a number of studies in a review of the literature (CDC – Scientific Information: Consequences). These studies link child abuse to such poor outcomes as head trauma, brain impairment, sleep disorders, panic disorder, ADHD, anxiety, PTSD, conduct disorder, learning difficulties, depression, suicide attempts, eating disorders, reactive attachment disorder, language delays, poor academic achievement, sexual promiscuity, juvenile delinquency, adult criminality, teen pregnancy, impaired interpersonal relationships, and substance abuse. Clearly the child abuse epidemic is creating an enormous amount of suffering for individuals and having a massive negative impact on our collective health, justice, and social infrastructures.

Child Abuse Costs

Prevent Child Abuse America completed a comprehensive analysis of the direct and indirect costs of child abuse in the United States in 2001. The organization came to the conclusion that we spend approximately $258 million dollars per day in our country, or almost $94 billion annually, to attend to the direct and indirect costs of child abuse. In every aspect of the economic analysis that went into the PCAA study, conservative estimates were used, so the annual figure could very possibly exceed $94 billon. Direct costs of $66.8 million per day included costs for health care (hospitalizations and chronic health problems), mental health care system, child welfare system, law enforcement, and the judicial system. Indirect costs amounted to almost $191 million per day for special education, mental health services, juvenile delinquency, lost productivity, and adult criminality. In fact the cost of child abuse for every family in the U.S. is $1461.66 per year (Prevent Child Abuse America).

By comparison, prevention is cost effective. Even a relatively expensive yet effective strategy, the Nurse Family Partnership program, a home visiting program for new families, when used with high-risk populations, has a 5.7% ratio of benefits to costs. The program costs $7271 per child to implement, however the gross savings for society as a result of the successful intervention amounts to $41,419 per child when used with high-risk populations (Rand Corporation).

Section III. Community Blueprint for Children: Overview

The consistent presence of child abuse in our community is a clear indication that current beliefs and actions are not sufficient in reducing and preventing child abuse. The Community Blueprint for Children has taken a new ideological approach to thinking about child abuse, as it utilizes a proactive systems approach to this issue. In Santa Cruz County today, as in most communities, there is a systematic approach to intervening after a report of potential abuse is made, however activities to prevent abuse are implemented in a piecemeal fashion. The design of the collective group of prevention activities offered at any given time (and "design" is a word that overstates the actual condition) has for the most part been created through a complex series of non-related decisions made by individual agencies, programs, and funders, or some combination of the above groups. Although in our county there are some notable exceptions to this general rule, and there is also typically a high degree of collaboration between various governmental and non-governmental service providers, there is currently no systematic, comprehensive approach to preventing abuse for all children countywide. This is the niche that Community Blueprint for Children seeks to fill.

History

Community Blueprint for Children is an initiative of the Child Abuse Oversight Committee of the Santa Cruz County Children's Network. This committee formed in late 2005 in response to the revitalization of the Santa Cruz County Child Abuse Prevention Council (CAPC) and the recognition that a crucial component of this revitalization was the formation of a structure for collaboration between CAPC and the Children's Network. Initial steps for the new committee were to determine the committee's name, purpose, scope of work, and membership. Much of the early work was experimental, as participants in committee meetings struggled to define what purpose such a committee could have and how to best achieve these ends. The process was complicated by several factors. For example, the committee was initially open to anyone, including Children's Network Cabinet members and any interested member of the public. During this period, progress was hampered by the fact that decisions and directions of any meeting were subject to review and revision by a potentially new group at any subsequent meeting. Even among the group's most consistent attendees, there was a general lack of clarity about what the committee should focus on and how it would eventually make a meaningful contribution to the community.

Ultimately, in June, 2006, the committee adopted the following purpose statement:

The Child Abuse Oversight Committee's intent is to ensure that the issue of child abuse is consistently brought to the attention of the Children's Network and supports CAPC in fulfilling its core mandated functions.

At the same meeting, the committee accepted and endorsed a recommendation from the CAPC Board of Directors to primarily support the following two mandated CAPC functions:

- Provide a forum for interagency cooperation and coordination in the prevention, detection, treatment, and legal processing of child abuse cases

- Encourage and facilitate community support for child abuse and neglect prevention programs

This decision gave the Child Abuse Oversight Committee clearer direction about how to direct its efforts, and in July, 2006, the group made a decision to adopt a "project" in which committee members would identify a child abuse reduction goal for Santa Cruz County and create a plan for reaching that goal. This decision ultimately resulted in the Community Blueprint for Children planning process. In December, 2006, a Preplanning Team with a set composition of key representatives was chosen and in 2007, the Preplanning Team began to work to develop the plan and process for creating and reaching the long-term goal of reducing child abuse and neglect in our county. Members of the Preplanning Team are:

• Child Abuse Prevention Council	Beth Love
• CASA of Santa Cruz County	Nancy Sherrod
• First 5 of Santa Cruz County	Susan True
• County of Santa Cruz Health Services Agency	Lynn McKibbin
• County of Santa Cruz Human Resources Division	Sherra Clinton
• Family Resource Network	Erika Hearon

CBC Preplanning Phase

The initial task of the group was to review existing community collaborative efforts in other places that had shown effectiveness in reducing child abuse. A research effort was launched, which included extensive web research and phone and email requests for leads to a wide variety of regional, state, and national partners. Research criteria were that:

- the initiative had to have child abuse reduction as its intent,
- it had to be a collaborative, community effort, with multiple components and service delivery strategies (as opposed to a distinct program), and
- it had to have proven effective in reducing rates of abuse in the target area

The major finding of this aspect of the Preplanning Team's work was that there are very few successful community initiatives that have shown a reduction in child abuse rates over a geographic area anywhere in the US. At the time of the conclusion of the research, only two such programs had been identified: the Healthy Families Partnership in Hampton, Virginia, and the Vermont Partnership for an Abuse Free State. A third promising community initiative in the early stages that was identified was Strong Communities for Children in South Carolina. A summary of the research criteria and methods and the list of investigated initiatives and findings are attached to this document as Appendix A. Additionally, there is a sheet that summarizes the findings of the three successful or promising initiatives (Appendix B). These documents were presented to the Child Abuse Oversight Committee in October, 2006.

In November, 2006, the United Way put out a request for community organizations to take on the role of "champion" for a series of community goals that were articulated in the latest version of the Community Assessment Project (CAP). One such goal, "by the year 2010, children in Santa Cruz County will live in safer families and communities," was clearly in alignment with the goals of the Community Blueprint for Children initiative. At the suggestion of the Preplanning Team, CASA and CAPC jointly applied and were selected to be goal champions for this CAP goal. In December, 2007, the team formally recognized that work on Community Blueprint for Children and work done to reach the Community Assessment Project child safety goal were one and the same. A work plan was developed and adopted for a community planning process to develop the

community blueprint that would take the county from where we are to where we would like to be.

The next stage of the Preplanning Team's work was a period of great productivity, due largely to the support of consultant Nicole Young through an in-kind donation from First 5. Under the expert guidance of Ms. Young, the committee developed a number of structural tools to guide the planning process. Within the first half of 2007, the committee created and/or adopted the following documents:

- A statement of vision, values, and purpose
- A list of terms and definitions (taken from an existing Children's Network list and customized to suit our needs)
- An overview of the ecological theory of causation
- An agreement about possible risk and protective factors at the individual, family, and societal levels
- A continuum of child abuse prevention practices
- A matrix of best practice strategies with examples of effective programs
- A theory of change and logic model
- An updated roadmap of the planning process

All of these documents are included as Appendices C-J. It was also during this time that the group began to use terms like "systematic" and "comprehensive" to describe the approach to child abuse prevention that would be the ultimate result of the CBC efforts. An important value of the group that is reflected in the adoption of the ecological model of causation, the list of protective and risk factors, and the theory of change/logic model, is that child abuse has its causes in both individual and collective factors, and that any systematic approach to prevention will have to address both individual and community factors. The group also wanted to proceed mindfully around the issues of risk and protective factors, recognizing that characteristics of families involved with child welfare authorities are not necessarily accurate reflections of all families in which abuse is occurring. Some of the apparent protective factors for abuse (based on studies of families involved in the system), for example higher incomes and educational attainment, may protect a family from disclosure, rather than abuse. Equally, certain risk factors would tend to amplify the possibility of disclosure, and therefore reporting and substantiation of abuse. For these reasons, the CBC Preplanning Team was interested in insuring that elements of whatever plan was eventually adopted would be universally offered, and that strategies to reduce the stigmatization associated with help-seeking would be part of the plan.

It was also clear to the CBC Preplanning Team that any meaningful planning process to create a systematic approach to child abuse prevention would have to be based in an understanding of current practices in our county. A commitment to a countywide assessment of child abuse prevention practices was made. Although an assessment of this scope would necessarily be a fairly expensive proposition, there was consensus that the attempt be made and that data be collected to the extent possible given the resources.

In June, 2007, the Preplanning Team conducted an experiment in data collection by providing the matrix of best practices to the members of the Family Resource Network, along with a blank matrix for them to fill in with information about their programs. The results of this experiment gave direction to the assessment process. One key decision

was to get the information via telephone interview with informants, as opposed to mailed or emailed surveys.   The Preplanning Team felt that telephone interviews would increase the probability of getting sufficient, meaningful information from a wide variety of service providers, thereby insuring that the data collected would more fully represent the status of current efforts.

In September, 2007, a grant from the Community Foundation of Santa Cruz County was secured to aid in the CBC efforts. This funding allowed the CAPC Executive Director to dedicate additional hours to the initiative, primarily to the assessment efforts. A UCSC intern, Sarabeth Bavin, was also assigned to work on the assessment phase of CBC. With pro bono consulting from Applied Survey Research, an assessment process and two survey tools were designed and tested.   Key principles that were utilized in designing the survey process and tools included:

- *Basing our questionnaire on recognized best practices would facilitate the gathering of meaningful data.* The ecological model, the causal model of child abuse adopted by CBC, recognizes that child abuse occurs due to a complex set of interactions between a variety of risk and protective factors. Gathering data about all of the potential activities in the county that would increase protective factors or decrease risk factors would have been an insurmountable task, however. For instance we understand that economic stressors can be one factor in abuse, however we did not see a significant return on the efforts that would be needed to document every local practice that seeks to alleviate the impacts of poverty, given the specificity of our purpose. Therefore, our questionnaire was designed around the specific strategies that have proven to be best practices in the field of child abuse prevention.

- *Not all similar child abuse prevention programs deliver the same outcomes.* Therefore, we included questions to help us assess whether local programs matched critical elements of effective programs, were based on successful models, and/or had their own positive outcome data.

- *The interview process provided a wonderful opportunity to gather ideas from service providers about potential elements to include in the CBC plan.* Therefore, though the bulk of the questionnaire is related to current programs, we also included open-ended questions to solicit feedback for the later planning process.

- *For the purposes of our research, and for Community Blueprint for Children in general, we are concerned with primary and secondary prevention strategies, as defined in the CBC terms and definitions document.*

Local Assessment Research Methods

An early obstacle in our research presented itself as we attempted to discern the size and scope of our informant pool. Before we conducted our research, no comprehensive list of local child abuse prevention programs and practices existed as a resource from which to draw our information. Thus, we were left to rely on stakeholders known to us through participation in three county collaboratives, supplemented by our own investigations into our county hospitals, schools, and faith-based organizations. Our initial pool of CBC informants were individuals on the following rosters: Santa Cruz County Children's Network Cabinet, Santa Cruz County Family Resource Network, and County of Santa Cruz Child Welfare Services: System Improvement Plan Steering

Committee.   These lists are comprised of program directors and stakeholders from government-funded and non-profit organizations, as well as persons who (based on career or life experience) have a learned perspective on at least some aspect of the issue of child abuse in our county.   Sutter, Dominican, and Watsonville hospitals, the County Office of Education, individual school district offices, and various faith-based organizations (this category to a lesser extent) were also contacted in an effort to find programs matching our criterion, leading to valuable new leads and resources.

As we developed a list on which to base our informant pool, we realized that, depending on the role being played by our interviewee, two types of interviews would need to be conducted.   Some informants are stakeholders in child abuse prevention, but do not facilitate the practices of interest to our research.   These became the subjects of our type 1 interview: a request for leads survey plus two open-ended questions.   In the request for leads section of the interview, our informants were asked if they knew of practices or programs that matched our list of best practices in primary and secondary child abuse prevention.   From these interviews, a number of additional leads were established and resulted in subsequent interviews of both types.   Our two open-ended questions were intended to incite personal interpretations of child abuse prevention solutions, based on the subject's unique experience and expertise. We asked: (1) how would you approach designing a systematic, comprehensive approach to preventing child abuse in Santa Cruz County, and (2) are you aware of any unmet needs in terms of child abuse prevention programs in Santa Cruz County?   Our type 2 interview— limited to providers of services which appeared to match at least one strategy in our best practices profile—included the type 1 interview, along with specific questions related to program model, elements and strategies, intended and measured outcomes, populations served, and methods of assessment.   The type 1 interview questionnaire and a sample type 2 questionnaire (for the strategy parent education) are attached as Appendices K and L.

Our interview subjects were categorized and contacted with assistance from FileMaker Pro 6, which we also used to create an information database based on interview questions and responses.   We scheduled and conducted interviews from November 2007 through May 2008.   Twenty-one Type 1 interviews were conducted, thirty Type 2 interviews were conducted, and approximately three dozen more people were contacted as follow up on leads or in an effort to find additional relevant leads.   In an attempt to be as thorough as possible, we conducted a number of interviews regarding programs that only partially align with our best practice strategies.   For example, one of our best practice strategies was that of early care and education coupled with comprehensive family support.   Head Start is an iconic representation of this model.   While interviewing informants on our request for leads survey, a number of informants gave us leads to childcare and/or preschool programs which incorporate some family support component, however not to the degree that appears from research to be positively correlated with reductions in child abuse and neglect.   Nevertheless we included these in our research findings and will stipulate disclaimers as appropriate.

While our research was as extensive as our resources allowed, we would not be surprised to discover that there are more programs and practices relevant to this research that we failed to contact based on scheduling and staffing constraints.   We are also aware of additional programs that we attempted to contact, in some cases multiple times, without success.   In a few cases in which we were unable to make direct contact

with known programs, we included brief descriptions taken from secondary informants and/or program websites. In acknowledging that we could not have been as thorough as would have been most effective, we concede that our research may be incomplete. However, we do hope that any gaps in our research will be filled upon peer-review and publication. We therefore encourage persons with missing valuable information to contact and enlighten us.

For purposes of this report, we are including fairly extensive summaries of information we obtained about local practices, however due to time considerations, we are not including a compilation of answers to the open-ended questions. This data will be maintained in the database until needed to help shape the next phase of CBC.

Section IV. Best Practices in Child Abuse Prevention

Criteria for Community Blueprint for Children Research

A myriad of strategies have been employed in the hopes of preventing forms of abuse against children. In order to simplify our collection of data, the Community Blueprint for Children Preplanning Team, with the help of Nicole Young, has established a list of strategies deemed most effective in an ecological framework. We refer to these result-yielding programs as "best practices" in child abuse prevention. These are the particular strategies and practices that constitute the focal point of our investigations into Santa Cruz County's current child abuse prevention programs. Using definitions adopted by Community Blueprint for Children and consistent with much of the field, we categorized best practices as evidence-based, promising, or emerging. Evidence-based practices have demonstrated effectiveness through an experimental study design, i.e. randomized control trials. In most cases these practices have been subjected to multiple trials and have consistently shown positive outcomes. They are also published in peer review journals. Promising practices have proven effectiveness in quasi or non-experimental studies, e.g. there was no control group, and/or the intervention was not randomized. Nevertheless there is a sound theoretical basis for their effectiveness in preventing abuse, increasing protective factors, and/or decreasing risk factors. Emerging practices have not yet proven effective through research trials, and need further research to determine their effectiveness. All three levels of best practice strategies must have a book, manual and/or other written information that specifies the components of the practice protocol and describes how to implement it. Details about the three levels are included in the continuum of child abuse prevention practices, appendix G.

As previously mentioned, for purposes of this initiative, we are focusing on primary and secondary child abuse prevention strategies. Primary prevention strategies, also called "universal prevention," target whole populations or segments of the population chosen without regard to risk. For example programs targeting all families in a geographic region or all first time pregnant women are examples of primary prevention programs. Secondary prevention programs, on the other hand, target specific groups of people based on distinguishing characteristics that may increase their risk for child abuse. Programs serving families enrolled after scoring at a certain threshold on a risk-based screening tool would be one example of secondary prevention programs. Some strategies selected for our research have applications as both secondary and primary prevention strategies. For example there are home visiting programs that are provided universally to all first time families, and there are also programs provided to families found to have risk factors for child abuse.

An important consideration in understanding the scope and effectiveness of child abuse prevention practices is to recognize that very few programs exist which meet the stringent research criteria to qualify as evidence-based practice. Few programs, even those that have effectively demonstrated positive outcomes in reducing abuse, increasing protective factors, and/or reducing risk factors have been subjected to the rigors of a randomized control trial (RCT). Prevention programs are often offered by nonprofit organizations with little to nothing in their budgets for evaluation, let alone replicable RCTs. Most of the research and practice in the field of child abuse has focused on intervention and treatment strategies. A huge need exists for a comprehensive investment into prevention research. Primary prevention strategies are

especially unlikely to have a very high level of evidence for their effectiveness. In fact, very few of the primary prevention strategies we found in our research meet the criteria for evidence-based practices. Therefore, we will include programs and practices with the highest available level of effectiveness, given the state of the field as a whole.

At this time, it is also important to note that the nature of child abuse *prevention* strategies, for the purposes of this research, require that they occur prior to an instance of known abuse. Regardless of this frame in our research, we do note the importance of responsive child abuse programs in terms of intervention, treatment, and tertiary prevention (defined as prevention of additional harm after abuse has occurred). Because the local Child Welfare Self Assessment and Systems Planning Process encompassed tertiary prevention as a part of its focus, Community Blueprint for Children is solely focused on primary and secondary prevention practices in the community.

Best Practice Strategies and Examples

Delving into an examination of our best practice primary and secondary prevention strategies is necessary to become familiarized with the basic practices and sample applications in the field. Following are sections for each of our ten targeted best practice prevention strategies: Public Education Campaign, Prenatal Screening for Risk Factors, Home Visitation, School-Based Prevention Programs, Parent Education, Community Engagement, Early Care and Education, Father Involvement Program, Differential Response, and Therapeutic Intervention.

Public Education Campaign

This primary prevention strategy relies on the relaying of positive childrearing information to the public, generally to parents and others who have an interest in promoting the optimal development of children. Public education campaigns operate under the belief that the proliferation of positive parenting knowledge will prevent child abuse by providing all parents and caregivers with increased child-rearing capacities and skills. Numerous pathways are utilized in transmittance of child abuse prevention information, such as the distribution of pamphlets or the publication of newsletters. Public speakers, through events or public service announcements, also offer an important medium of reproducing positive parenting skills in the wider community. Awareness is especially encouraged in April, designated as National Child Abuse Prevention Month. In many places in the US, blue ribbons are distributed and serve as a reminder and symbol of the negative affects produced by child abuse, alongside a positive vision for change through prevention. Public education campaigns also serve an important distributive function in terms of connecting parents, public service provides, and other organizations with important information regarding child abuse prevention strategies and resources.

While public education campaigns are very common as a prevention practice in the field, the researchers are unaware of any public education campaign that can be described as an evidenced-based best practice for child abuse prevention. The impact of such campaigns can be hard to measure. It is probable that these campaigns are most effective when used in conjunction with other strategies, for example as part of a comprehensive approach with a variety of direct service strategies as seen in Hampton Healthy Families, one of the effective community initiatives uncovered in our earlier research.

Although not a campaign, per se, an education program geared towards both parents to prevent Shaken Baby Syndrome for all children has been effective in reducing incidence of Shaken Baby Syndrome by 50% in eight counties in New York. Mark S. Dias concluded in his research study on the Upstate New York Shaken Baby Syndrome Education Program that a "coordinated, hospital-based, parent education program, targeting parents of all newborn infants, can reduce significantly the incidence of abusive head injuries among infants and children <36 months of age" (Dias, 2005). The researcher also concluded that additional studies would be needed to insure the replicability of his results. Currently several large randomized controlled trials are underway to test the effectiveness of Shaken Baby Syndrome education programs. One of these is replicating the model used by Mark Dias. The other two, one in Canada and one in the U.S. are testing the effectiveness of a model called "The Period of PURPLE Crying." These trials are concluding and results are expected to be published by the end of the year.

Prenatal Screening for Risk Factors
This primary prevention strategy is used to assess the child abuse risk potential of pregnant women and their families, for instance utilizing a screening tool to determine the presence of risk factors such as substance abuse, depression, unrealistic developmental expectations for children, or a parent's history of abuse as a child. In some cases, the programs subsequently provide or refer positively screened candidates for in-depth assessment and monitoring, or for treatment or other services. The assessment of all pregnant women and their partners, if possible, to determine the presence of risk factors, followed by referrals to appropriate treatment, serves to decrease risk factors, thereby contributing to child abuse prevention.

An evidence-based program that fits the mold for this category is the *4P's Plus* program, which screens all pregnant women for several factors that could lead to child abuse: substance abuse, depression, and domestic violence. The women who positively screen receive in depth assessment, referrals, and monitoring (Chasnoff).

Home Visitation

Home visiting is a child abuse prevention practice that can be both primary and secondary. A wide variety of home visiting programs exist, with varied intended outcomes, target audiences, and staffing levels. Some effective programs utilize paraprofessionals, often people who share similar cultural backgrounds with the program participants, and other programs use professionals such as nurses or therapists. Still others incorporate professionals and paraprofessionals in a multi-disciplinary team approach. One example of a primary prevention application would be a program that offers in-home services to all first time families around the time of birth. In secondary form, the families receiving services are targeted based on risk. One practice is to couple a universal screening program, for example for all first time parents, with a home visitation program that has both universal and targeted elements. Families whose assessment indicates a low risk of abuse may get 1-2 visits, and families found to be at higher risk may get visited for as long as five years.

The *Nurse Family Partnership* (NFP) is an evidence-based Home Visiting practice offered to first time mothers from pregnancy through age two. The model was developed by David Olds and has been found effective in a number of trials. NFP is a voluntary program that targets first time parents with low incomes. Mothers can enroll

prenatally, and early enrollment does improve outcomes. Registered nurse home visitors form powerful therapeutic relationships with clients, support clients in building supportive parenting skills, foster attachment between the client and the client's baby, and support the development of clients support system and sense of self-efficacy (Nurse Family Partnership).

The program results are exemplified by improved pregnancy outcomes; decreased substance abuse and arrests; improved child health, development, and safety; and enhanced parent life-course development. (Nurse Family Partnership).

A promising home visiting program utilizing paraprofessionals is *Healthy Families America*. The target population may vary by community/state, as programs are implemented in 450 communities nationwide. Prenatal screening is offered universally with a standardized risk assessment tool. Services support the parent, parent-child interaction and child development. Indicators of effectiveness include improved parent-child interactions and the utilization of formal and informal social supports (Research Findings: Healthy Families America).

School-Based Prevention Programs
Our focus in this section is on models that operate through the public education system to provide school-age children with information and skills to prevent perpetration of abuse. For instance, some programs increase understanding of social and emotional competencies, while teaching students about child development and effective parenting practices. Because all children are enrolled in some form of education, schools are an important outlet for reaching out to children. *Roots of Empathy* is an evidence-based school based violence prevention program that has effectively worked to reduce aggression in children through increasing their mental and emotional competencies. The Roots of Empathy curriculum requires 27 classroom visits, 3 with a parent and child, and these correlate with nine themes. The purpose of the parent/child visits is to model positive techniques for parent-child interaction, while educating students about child development. Roots of Empathy qualifies as a child abuse prevention program because it considerably reduces risk factors and increases protective factors for child abuse (Program Reach and Effectiveness: Roots of Empathy).

Parent Education
Parent education provides important instruction for various target audiences including young adults, parents, and other caregivers, with a goal of improving parenting skills. Parent Education programs encourage increased knowledge of child development and nurturing parenting skills. Effective programs are typically offered in a series, with opportunities for parents to practice what they learn between class sessions. *Positive Discipline* is an example of a promising primary child abuse prevention practice that teaches children and adults the resources and skills needed to be responsible and respectful community members. The program focuses on effective disciplinary skills, mutual respect, encouragement, and problem-solving skills (Nelsen, 2008). *The Incredible Years* is an evidence-based secondary child abuse prevention practice that trains parents, teachers and children to effectively respond to social and emotional challenges. The Incredible Years has a goal of preventing delinquency, drug abuse and violence, as well as child abuse. There is an intervention version of the program for use with child welfare populations, and a prevention version designed for use with high-risk populations (CEBC). *Triple P Positive Parenting Program* is a parent education program designed to be delivered in varying intensities according to need. The

California Evidence-Based Clearinghouse (CEBC) has recognized it as an evidence-based strategy for child welfare populations and as a secondary prevention practice with at-risk populations (CEBC). A randomized controlled study utilizing the model in a very comprehensive fashion in nine South Carolina counties is in process with funding from the Centers for Disease Control and Prevention. Results from the first two years of the trial are expected to be published by the end of the year.

Community Engagement
A community engagement program utilizes community concern, neighborhood involvement, and institutional and organizational support to universally prevent child abuse. An emerging Community Engagement practice in South Carolina is called *Strong Communities* for Children, which operates on the premise of strong families building strong communities, and vice versa. The program encourages a collective goal of establishing a strong sense of community and promoting the safety and well-being of all children (Strong Communities).

Early Care and Education Coupled with Comprehensive Family Support
This practice is offered in 38 states, D.C., and Canada. *Head Start* is a prominent evidence-based early care and education prevention practice, targeting low-income pregnant women and families with children from birth to five. Its outcomes include improved prenatal health, child development, and family functioning. Additionally, the child is prepared for school. An emerging primary prevention practice utilizing this strategy is *Strengthening Families Through Early Care and Education.* This program is currently being utilized in early care and education settings in over 30 states. The intent of the program is to prevent child abuse and other poor outcomes for families by training and utilizing early care and education staff to promote research-based protective factors in the families they serve (CEBC).

Father Involvement Programs
In the past, mothers were regarded as the primary or even sole target for most parent support and education programs. In recent years there has been an awakening to the importance of a father's involvement in the life his child. Studies have linked father involvement with young children to improved cognitive development, a greater sense of mastery, increased empathy, a reduction in challenging behavior, and enhanced social development (Child Trends). There has been a growing trend in family serving agencies and schools to develop and implement specific outreach and engagement strategies geared toward increased involvement by fathers. There are also a number of emerging programs and research trials focused primarily on father engagement. One such randomized control trial funded by the Office of Child Abuse Prevention in California is a fatherhood involvement study with sites around the state. The local fatherhood program, *PAPÁS: Supporting Father Involvement*, is a part of this study. More information will be included about the model in the section about PAPÁS.

Differential Response
Traditionally, child welfare services have investigated allegations of maltreatment and only provided services after substantiated that abuse has occurred. In recent years, child welfare reform has resulted in a additional component for child welfare agencies, a proactive approach called "alternative response," or "differential response." Differential response (DR) allows agencies to intervene before substantiations in an attempt to prevent the family from entering the system. Many such programs focus on building family strengths, and may have alternative pathways for families with high versus low

risk. DR is often offered through collaboration with community-based agencies. There are a variety of models throughout California and the US. Each DR program develops its own program strategies based on intended outcomes specific to their effort .

Therapeutic Intervention

This secondary child abuse prevention practice involves parent and child therapy sessions to reduce the risk of child abuse, improve parenting skills and attitudes, and improve child behavior. An evidence-based example is *Parent-Child Interaction Therapy*, which targets children ages 2-7 with behavioral problems and physically abusive parents with children four to twelve. Critical program elements include 14-20 one-hour sessions in which the therapist discusses concepts with parents and provides coaching based on parent-child interactions. There is an initial focus on securing a nurturing relationship, followed by establishing a consistent approach to discipline (CEBC)

Section V. Local Assessment Results

General Comments on Assessment Results

FORMAT FOR PRESENTATION: The results of our assessment into current local child abuse prevention practices follow.   Results are grouped according to best practice strategy. In some cases, a local program has elements that fit more than one category, for example Families Together is a differential response program that utilizes a home-based service delivery strategy for most program services. In cases such as these, we include the program under the category that is most closely aligned with the overall design of the program, even though we realize this reductionist perspective may understate the reach and intent of the program.   Even though the categorization scheme will result in such effects, we will do our best to counter this effect within the text for each program.

Under each strategy, we include first those local programs that closely align with a model program, have outcomes that prove alignment with a best practice strategy, or sufficiently match critical elements of a model program so that a reasonable investigator would conclude that the program would result in similar outcomes to the model. After that, we include other services (under the rubric "Related Local Efforts") that have some critical elements in common with model programs, utilize some evidence or research base for their program design, and/or appear to be relevant to our research as potential programs upon which to build in designing our systematic approach to prevention.

STATISTICS: In deciding to assess current community practices in child abuse prevention, it was the hope of the Preplanning Team to get a sense of how many people were being served, who was being served, and who wasn't (in terms of demographic characteristics, geography, etc.).   Unfortunately there were many impediments to determining this information with any degree of accuracy. We were initially cognizant of the fact that without a shared community-wide database there would be no way to understand and report on the total number of unduplicated individuals receiving prevention services in Santa Cruz County. We quickly found other obstacles to meaningful data collection and reporting. One obstacle is that agencies have differing ways of counting data, for example some agencies count the family as the client, some count the child, and some count the parent. Another example is that different programs have reporting requirements for different funding streams, and that these funders do not all use consistent categorization schemes. Another common barrier to our attempt to get a picture of the number and demographics of people receiving prevention services is that agencies with multiple programs do not all track participant demographics separately by program.   So if we were interested in the characteristics of families enrolled in a home visitation program that was one of several programs offered by one agency, for example, the program staff could probably tell us about how many families were served in the last year, but could not tell us precisely what their income was, or their race, or their area of residency.

As a result, we have asked agencies to give us their best estimates, and will include program demographics when possible, however we provide them with the following important disclaimers:

- that all client numbers and demographic information in this report should be assumed to be gross estimates of program-by-program data only, unless otherwise stipulated, and

- that we make no claim to have information about the number of unduplicated individuals served across programs.

ADDITIONAL ACTIVITIES: It is also important to note at this time that there were limitations in our capacity to conduct this research that may have resulted in the absence of important local programs from this assessment. This is not a reflection of a bias or intentional judgment against any program or organization, but a reflection of our available resources. In some cases we made multiple attempts to contact known providers and never managed to schedule an interview. In some cases, we received solid leads to programs too late in the process for adequate follow-up, however we at least made an attempt to make contact in almost every case for apparently appropriate leads. In other cases, we made judgment calls as to how to use our limited time to best ferret out the programs that would most likely match our model strategies. For example we have anecdotal information that several faith-based organizations in our community provide programs for parents, however we only attempted to contact those for which we received a lead from an informant or from our own internal knowledge base. We simply did not have the resources to call and follow up on calls to all the faith-based organizations in the county, and we also reasoned that although parenting programs provided in faith-based organizations were undoubtedly helpful to parents, we hoped that any such programs that matched best practices strategies would come to our attention through the informant interviews.

Local Child Abuse Practices

Following are the results of our assessment into local child abuse prevention practices, again arranged in our ten best practice categories: Public Education Campaign, Prenatal Screening for Risk Factors, Home Visitation, School-Based Prevention Programs, Parent Education, Community Engagement, Early Care and Education, Father Involvement Program, Differential Response, and Therapeutic Intervention.

Public Education Campaign
LOCAL BEST PRACTICE PROGRAMS: None.

Not surprisingly, as noted above, the impact of public education campaigns can be difficult to measure. There are no public education campaigns in our county that meet our research criteria for evidence-based, promising, or emerging practices.

PUBLIC EDUCATION CAMPAIGN: RELATED LOCAL EFFORTS: Two.

Expect Respect: This program is based on an effective model and offered locally by Walnut Avenue Women's Center. Although the model is a school-based program, the program is utilized as a public education campaign in local practice. WAWC sends program staff to places where teens congregate, for example teen concerts at the Catalyst and community events geared toward teens, and talks with young people one-on-one and in small groups. They also provide teens with printed materials containing information about such topics as healthy relationships and strategies for avoiding dating violence. The organization also utilizes outreach through print and radio media to teach teens about these same topics. The intent of the school-based model program is to

prevent sexual and relationship violence, and the model has demonstrated outcomes in increased understanding of healthy relationships and nonviolent interpersonal skills. These outcomes could translate into nonviolent practices in later child rearing, however it is not clear if the effects would generalize to a public education service delivery strategy.

Participant Demographics: Not available for this program.

It Takes a Community to Raise a Child: This campaign is a month-long collaborative effort led by the Santa Cruz County Child Abuse Prevention Council. Planning team partners are CASA of Santa Cruz County, Live Oak Family Resource Center (a program of Community Bridges), and the County of Santa Cruz. Dozens of additional agencies join the campaign as collaborators. The campaign includes a kickoff event, distribution of educational materials, media coverage, and a series of varied community events. In 2008 the kickoff event was a family celebration with a variety of positive, educational activities for children and parents to do together as well as booths providing parenting information. Community events included such educational offerings as workshops for parents, presentations and trainings for staff of family-serving agencies, and a film festival. Although general child abuse prevention public awareness campaigns such as this do not have a research base to prove their effectiveness, the designers of the local campaign have drawn on recent public opinion research into effective child abuse prevention messages in developing the theme and talking points for the campaign. The resources allocated for the campaign have not allowed for comprehensive distribution of the campaign message or evaluation into changed knowledge or attitudes in the general public. However, post tests among people participating in trainings and workshops indicate increased knowledge of presented topics.

Participant Demographics: The total number of people reached through public awareness messaging is unknown. In 2008, over 300 people attended the kickoff, almost 300 people attended trainings or workshops, and over 5000 pieces of literature were distributed in the community.

Prenatal Screening for Risk Factors
LOCAL BEST PRACTICE PROGRAMS: One

4P's Plus Screen for Perinatal Substance Abuse, Depression, and Domestic Violence: Santa Cruz County Health Services Agency Maternal Child and Adolescent Health is working collaboratively with Human Services Department and Santa Cruz Community Counseling Center in a Federal Abandoned Infants Act grant in this countywide effort to screen all pregnant women for specific risk factors, which if unaddressed, could lead to child abuse and other poor outcomes for children. The program trains staff in OB/GYN clinics and private practices to use an evidence-based screening tool, then provides ongoing support for implementation of screenings, interventions, and referrals. The tool is based on the 4Ps screening tool that is available for use in the public domain. Dr. Ira Chasnoff improved upon the tool by reframing the way the two questions related to alcohol and tobacco use were asked. By framing the two questions about the use of cigarettes and alcohol with the prefix "in the month before you knew you were pregnant..." Dr. Chasnoff was able to get a much higher percentage of women admitting to cigarette and/or alcohol use. Follow-up questions for positive answers ferret out additional information about substance use.

Currently the screening tool is being administered to all pregnant women receiving prenatal care in the community clinics in the county (Planned Parenthood – north and south, Salud Para la Gente, the Santa Cruz Women's Health Center, Watsonville Community Hospital, and Dominican Hospital). Three private OB/GYN practices in the county have also joined the effort. In addition to providing training for all the people doing the screening in the clinics, the program provides a curriculum to screeners with responses to the common answers women give to the screening tool. Depending on what women say, the provider has ways to address it that will support further disclosure and use of treatment. Once a person is found to be using, screeners provide appropriate referrals to inpatient or outpatient treatment, depending on the woman's need, insurance, and eligibility for various treatment programs, such as Primeros Pasos (summarized later in this report).

Due to extensive attention given to developing and maintaining a valid, live resource list, many pregnant women are able to access needed treatment fairly quickly after a positive screen. One success story is that a doctor screening one of his patients got a disclosure from the patient that both she and her partner were currently using. The doctor used his resource list and called someone from Mondanaro Baskin. The Mondanaro Baskin staff member came to pick the mom up and got her immediately into treatment.

Currently most pregnant women in South County are being screened. Outreach is now being planned to private OB/GYN practices in North County to recruit more providers into the program.

Intended Outcomes: The ultimate outcomes for 4P's Plus are that all pregnant women in Santa Cruz County are screened with the tool and all women identified with need have easy access to inpatient or outpatient treatment.

Observed Changes: Clinics feel like they have the support and resources to make referrals and screen thoroughly, therefore pregnant women are being screened.

Although there were things in place to address heavy substance use in pregnant women before 4P's Plus, the community was not consistent in addressing light users of alcohol. Providers now know how to frame questions in a way that helps identify light users in order to be able to do education. Since the impact of even a small amount of alcohol on a developing fetus can be extensive, identifying these users and supporting them in quitting can reduce the number of children born with Fetal Alcohol Spectrum Disorder. Children with any condition that increases their physical or mental vulnerability are at a greater risk of abuse.

Results: From the start of the program in November, 2006, until March, 2008, 1117 women were screened. Of these, 351 (31%) had positive screens for substance use before pregnant, and 151 of these admitted to ongoing use during pregnancy in the follow up questions.

PRENATAL SCREENING: RELATED LOCAL EFFORTS: One

Women, Infants and Children (WIC) *– a Program of Community Bridges:* WIC is a federal nutrition program targeting low income women who are pregnant or breastfeeding and children through age 5. Although it is not a child abuse prevention program, an intake interview is administered to all mothers at entry into the program,

and this interview includes questions that provide information about one risk factor for abuse, the mother's use of alcohol and drugs. Employees are also trained to understand issues such as domestic violence and child abuse, and will flag the mother's folder if any of the above issues are found. The WIC service provider gives support to help resolve the issue and referrals to appropriate services are made. It is worthwhile to note that WIC also gives extensive support for breastfeeding, including a lactation consultant, outreach to local hospitals, awareness of images within the WIC office (no images of bottle-feeding), and a Promotora Program in which women from the community learn about breastfeeding then tell their sisters and friends what they have learned. Although the CBC research did not find any evidence-based child abuse prevention practices that focused entirely on breastfeeding, successful attachment is definitely linked with a reduction in child abuse in the literature, and breastfeeding promotes successful attachment.

Follow-Up: Interviews are conducted at six month intervals for recertification; the substance abuse issue is reviewed in the recertification conversation and a determination made regarding the need for further support.

Intended Outcomes: The program's intent is to identify moms that need extra resources and/or extra support and refer them to services.

Participants Served: The number of WIC participants in the last year was approximately 9000, so that many women participated in the screening with the questions on one risk factor. All people served had incomes below 185% of poverty level. Approximately 90% were Latino/a and approximately 75% live in the City of Watsonville.

Home Visitation
LOCAL BEST PRACTICE PROGRAMS: Five

Dominican Hospital Home Health Mother Baby Home Visit Program: This program is a primary prevention strategy in that it is offered to parents of newborns without consideration of risk. Only families with appropriate insurance are eligible, however, so it is not completely universal. Families come into the program via a verbal invitation at discharge, followed with a phone call by the home visiting nurse. (Families without appropriate insurance also receive a phone call, however it is from a postpartum nurse and they are offered a referral to Visiting Nurses Association rather than a visit from the Home Health nurse.)

Dominican Home Health has one home visit nurse who visits each eligible family that has requested the service. Most of the families only have one visit, however some have two. The intensive care babies get one to five visits and may be provided with more than one visit per week, depending on need.

The home visit nurse makes referrals to resources, examines the mother and baby, weighs the baby, provides lactation consultation and home safety information, reviews post partum and newborn care, answers the concerns of the family, provides instruction in infection prevention and in the care and feeding of the baby. The nurse also asks about depression and anxiety. If there are concerns, a referral will be made to the public health nurse. There is no routine screening for risks; and the home visiting nurse was not aware of any screening tools.

Intended Outcomes: Intended outcomes of the program include healthy mothers and babies who are breastfeeding for one year or more, insuring mother's understanding of proper storage and pumping techniques for breast milk, connecting families with community resources, insuring a safe home environment, and connecting people to positive parenting classes.

Results and Evaluation: No system of evaluating program effectiveness is in place.

Demographics: Approximately 158 mothers were visiting in the last fiscal year. About 55% of them were Caucasian and 40% Latina. About 40% were living on less than 100% of the poverty level. Most of the clients live in the unincorporated mid-county area or in the City of Santa Cruz.

High Risk Perinatal Program: Santa Cruz County Health Services Agency Maternal, Child, and Adolescent Health provides three secondary prevention home visitation programs for different at-risk populations. The program for high-risk pregnant women utilizes public health nurses to provide services. The target population for this particular program is pregnant women utilizing the methadone clinic to deal with their addictions. The program can serve 30 clients annually, and would like to be able to serve 20 more. Services provided include case management, case coordination, intervention, and referrals. Services are provided in the home by people with one of the following levels of education: RN, BS in nursing, or PHN. All providers have training in child abuse prevention and reporting. The caseload size varies, averaging about 30-35 cases. The frequency of the visits also varies, depending on need. Women receive services for 1-6 months.

Intended Outcomes: Two outcomes are intended, a healthy baby and the mother going into treatment.

Results and Evaluation: Program effectiveness is evaluated via tracking outcome data. The intervention results in positive individual birth outcomes.

High Risk Infant Program: The High Risk Infant Program is also a secondary prevention strategy of Maternal, Child, and Adolescent Health in which public health nurse case management is utilized to provide support to high-risk families. Infants with health challenges are at increased risk for abuse, and these infants and their families are the target of the program. The agency partners with staff at Dominican and Watsonville Hospitals and with child welfare services to implement the program. In the last fiscal year, 183 infants were served by the program.

Public health nurses provide skilled medical care, assessments, professional interventions, and referrals. Visits take place weekly to semi-monthly, and the average number of visits per client is 3.1. Of 111 clients whose cases closed in 2006/07, the client profile included:

- 3 Premature infants, <31 weeks gestational age
- 28 Premature infants, 31-36 weeks gestational age
- 23 drug-exposed infants
- 41 other infants who had been admitted to the Neonatal Intensive Care Unit
- 6 mothers with mental health limitation
- 10 other infants with various risk factors

Intended Outcomes: Goals of the program include improved health and development and increased child safety.

Results: A sample of client process and outcome measures reported in FY 2006/07 include:

- 59% of eligible infants received formal developmental assessment per protocol.
- 98% of mothers had a post partum depression assessment and interventions where needed.
- 98% had a child abuse/neglect assessment and interventions where needed.
- 97% had a domestic violence assessment and interventions where needed.
- 99% had a safety assessment and interventions where needed.
- 90% of the infants have nutrients and fluids to meet physical/developmental/nutritional needs.
- 90% are sleeping on their back.
- 68% of the infant's activities contributed to their physical, social and cognitive growth.
- 87% of the infants received health care, immunizations, and health screening to meet acute and preventative health care needs for age.
- 95% of the infants' immunizations are up to date.
- 63% of the infant's physical environment offers opportunities for successful healthy development.
- 95% use car seat correctly.
- 68% of the infants have a social environment that offers opportunities for successful healthy development.
- 9% have open CPS case at closure.
- 95% of the mothers are clean and sober at closure.
- 99% of the mothers avoided a repeat pregnancy.
- 90% of mothers were breastfeeding for any length of time.

Demographics: 183 new clients had cases opened in 2006/07. Of 111 cases which closed within the fiscal year, 70% resided within the 95076 zip code (Watsonville and surrounding areas), 72% were Medi-Cal clients, and 36% were receiving government aid.

Early Start: This secondary prevention strategy for children with disabilities is mandated by State and federal law under IDEA (Individuals with Disabilities Educational Act), and is provided locally by Pajaro Valley Unified School District. In order to be eligible, children must meet age requirement (0-3 years old), live within school district boundaries, and must qualify for special education, based on assessment results. While technically not intended to be a child abuse prevention program, the extensive level of support for this at-risk population could decrease risk factors and increase protective factors.

An Individual Family Service Plan (IFSP) based on family needs is drafted and implemented in collaboration with the family. Goals are reviewed every six months and changed as needed. Services are home and center-based. Program staff help families access community services, transportation, and other supports. Services provided at

the center include a support group with parents and children separately. Another component offers twice weekly opportunities to gather together in the park. Home visit frequency depends on needs of child, and ranges from 2 visits per week to 1 per month. Children are served from 0-3 years old or until services are no longer needed. Home visitors and other parent-serving staff have Early Childhood Education credentials or the equivalent at minimum, some staff are credentialed or licensed therapists, or other professional staff.

Intended Outcomes: These are individualized according to the IFSP.

Results and Evaluation: Each family is tracked in their goals against their baselines. Goals with the 0-3 population are in the areas of language, fine motor, gross motor, and early academic goals. The program outcomes are tracked via a variety of child development tools including the Baby Bergantz, a developmental checklist.

This program has been recognized by the state as a SEEDS programs, Supporting Early Educational Delivery Systems. SEEDS is a project of the California Department Education of that offers training and technical assistance to special education programs for children 0-5 throughout the state. As a SEEDS project, the local agency is a demonstrate site for the state government. Other districts have sent people to PVUSD to train.

Demographics: The program can serve 40 clients at a time. Federal law mandates that all eligible children be served, so the program is not allowed to maintain a waiting list. If capacity is met, the client will be served by SARC (San Andreas Regional Center).

LOFRC Home Visiting Program: This secondary prevention program is modeled after Healthy Families America. Target families are challenged, at-risk families. One half-time home visitor sees thirty parents per year. The caseload is 10-12 parents at once. About 50% are self-referred through word-of-mouth, about 25% are internally referred, and the rest are from various social and health service providers, such as HSA Public Health Nursing, Dominican Home Health, and local schools. Screening is done with a basic needs assessment that includes questions regarding risk factors. Home visitors see families for 3-12 months. Families often present in crisis; the vast majority present with either domestic violence, substance abuse or mental health issues.. Workers support the families to take care of immediate needs, then get them connected to resources to address the presenting crisis (i.e. for domestic or mental health issues). Visits are weekly initially, then decrease to bi-monthly as family strength increases. Home visitors develop case plans with the families, use Positive Discipline curriculum with families in their homes, build on strengths and decrease risk factors. The visitors are paraprofessional home visitors with extensive training, support, and professional development.

The program uses five areas of the California Family Development matrix both for evaluation and supporting families in assessing their own strengths. The five areas are: parent child relations, social/emotional health, child care and safety, community relations, family relations.

Intended Short Term Outcomes: Participating families physical, mental, behavioral and special needs are identified and met, as observed by:

- Families establish and maintain stability.

- Parents have increased knowledge of positive parenting practices.

- Families have access to family support services.

- Families have access to and utilize information and referral and site-based partner services.

Long Term Outcomes include:

- Families live in violence-free homes.

- Families exhibit strong protective factors that promote violence-free homes.

- Parents are successful advocates for themselves and their children, aware of how to thrive and where to get support.

Results and Evaluation: 84% of clients showed a significant increase in scores over the baseline assessment. On a five-point scale, there was an average of more than a two-point increase from initial measurements, from "in-crisis" or "at-risk" to "stable" or "safe."

Demographics: Thirty clients can receive services in a year. In FY 2006/07, about 27 clients were Latino/a and the rest Caucasian. All clients had incomes at or less than 200% of the poverty level. Most of the families had at least one child in the 0-5 age group. Families all lived in the unincorporated mid-county area. Twenty-eight participating parents were female and the other two male.

HOME VISITATION: RELATED LOCAL EFFORTS: Four

Adolescent Family Life: The third home visitation program provided by Maternal, Child, and Adolescent Health public health nurses targets pregnant or parenting teens and their babies. In order to be eligible, teen mothers and fathers need to be less than 21 years old. At the time of this interview, there was a waiting list of 12 people for this program. Strategies employed include parenting education, health assessments, nutrition assessments, child safety instruction, vocational assessments, postpartum depression support, case management, skilled intervention and teaching. Caseloads average 30 clients and visits are weekly or monthly until family goals are achieved.

Intended Outcomes: The program goals include improved parent/child relationships, increase in feeding skills, and increased parent/child attachment. The NCAST (Nursing Child Assessment Satellite Training) evaluation tool is utilized to measure indicators of improved parent functioning.

Results: Client changes are more pronounced when families are visited by skilled medical professionals.

Demographics: In fiscal year 2006/07, 108 people were served by the program. Of these, 90% were Latina/o and the rest Caucasian. Eighty-five percent lived in the 95076 zip code area.

Additional Home Visiting Programs: Two additional agencies have home visiting programs that provide support to families as at least one of the target populations. None of these programs provides the level of intensity associated with positive outcomes in child abuse prevention through home visitation. Mountain Community Resources offers 1-2 visits to people living in the San Lorenzo Valley or Scotts Valley if

the presenting issues cannot be met with a brief intervention. Davenport Resource Service Center utilizes home visits as one strategy in a program intended to improve health for families in the north coast area. Families get visited for 10 hours total per year per family for up to five years. Services include referrals, literacy support, and center-based group activities, including festivals and twice monthly single topic classes. Most families are monolingual Spanish speakers, and all have incomes at or below 200% of the poverty level.

School Based Prevention Programs
LOCAL BEST PRACTICE PROGRAMS: None found

A number of local organizations implement programs within local schools. Some of these utilize various curricula for which there is evidence of effectiveness in producing intended outcomes. None of the organizations we found in our research were utilizing a best practice curriculum in its entirety, and none of the school-based programs discovered in our research were specifically geared toward child abuse prevention. We include in the following section programs that could potentially increase protective factors or decrease risk factors for the youth participants if the skills and knowledge imparted by the programs are maintained into parenthood. We also acknowledge that this proved to be one of our most challenging categories for data collection. We are aware of the existence of additional programs, but were unable to gather necessary data to include these in our report.

SCHOOL BASED PREVENTION PROGRAMS: RELATED LOCAL EFFORTS: Three informants with various programs.

Barrios Unidos: This organization offers groups in partnership with Santa Cruz High School, Pajaro Valley High School, and Scotts Valley Middle School. They use a curriculum in the groups that includes elements from two recognized models. One of these models, the FLY (Fresh Lifelines for Youth) Law Program, is designed to "teach at-risk youth about the law and consequences of crime, while building important life skills such as empathy, problem solving, and anger management." (FLY Law Program) Although the focus is crime prevention, the life skills components could potentially be related to the focus of this report. The second model cited by Barrios Unidos staff is Joven Noble, which translates into "The Noble Young Man," a curriculum developed by Jerry Tello of the National Latino Fatherhood and Family Institute. Joven Noble is an indigenous based, youth leadership development program for adolescent males (Curriculum – Tello).

The target population for Barrios Unidos' school-based efforts is middle and high school students, aged 10-18. Topics covered in the groups include anger management, effective communication, and conflict resolution. The groups are voluntary and held during lunch time, once per week during the school year, depending on the needs of the school. During the groups, youth talk about issues and learn skills. At Pajaro Valley High School, there are several groups going, including separate groups for males and females. At all schools many of the participants come regularly and also bring in friends who want to participate. The group size varies from 2-30 students, and the facilitators create smaller break out groups when there is a large number of students. Barrios Unidos generally brings one man and one woman facilitator for each group, except in the case of the young women's group, which is facilitated by a female only.

The intended outcomes are to reduce youth violence, increase conflict management skills, and enhance positive life skills. Observed results included a decrease in conflict in the schools, better relationships between students and teachers, and reduced behavioral problems. The programs served 200 students in the previous fiscal year; 80% were Latino/a and about 18% were Caucasian.

Walnut Avenue Women's Center: This organization runs several school-based programs. The programs are geared toward middle and high school students attending Shoreline Middle School, San Lorenzo Valley schools, Aptos High School, and youth in a group home in Watsonville. Programs include "I Decide," "Healthy Relationships," and "The Friendship Workshop." Models which have influenced the curricula for these programs include Girl's Circle, the Developmental Assets Model from Search Institute, and a domestic violence prevention curriculum from Duluth, Minnesota. Although a relationship may exist between the outcomes of these programs and the prevention of child abuse, the models are not specifically designed to prevent child abuse. A research study of the Girl's Circle program demonstrated a significant increase in social support, body image, and self-efficacy among program participants upon completion. Increased social support and self-efficacy could potentially lead to non-violent, supportive parenting (Dollete and Steese). Similarly, the Search Institute has found a direct correlation between the level of developmental assets in youth and the likelihood of high-risk behaviors including substance use, violence and anti-social behavior. The more assets a young person has, the less likely they are to engage in high-risk behaviors (Search Institute). While there certainly appear to be implications of this research that might translate to child abuse prevention for these youth as they move into parenting, again, child abuse prevention is not the focus of the research base.

One WAWC program for youth is the "I Decide" program, provided for all 7th grade students at Shoreline Middle School. The eight-hour curriculum is administered during every session of the students' health class for three weeks. This program, as well as other Walnut Avenue Women's Center programming for young people, focuses on the development of healthy interpersonal relationships. The intended outcomes are for participants to be their own advocates, to know what is okay and not okay in their life, to make decisions for their own bodies, and to be able to get help if necessary. The programs are evaluated via pre and post-surveys and open-ended questionnaires.

Mountain Community Resources: MCR collaborates with a number of different partners, including Barrios Unidos, Walnut Avenue Women's Center, Planned Parenthood, and Youth Services to provide various programs to middle school and high school students in the San Lorenzo Valley. MCR provides the venue and sometimes facilitators. Their collaborators provide the program and whether or not the program is based on a model depends on the collaborator.

Parent Education
LOCAL BEST PRACTICE PROGRAMS: Three

These best practice parent education models are being offered at over a dozen sites in the county by over a dozen different organizations. Two of the models, Positive Discipline and Cara y Corazon, are being implemented in a way that fits clearly within the parameters of this research, i.e. they are being used as primary and/or secondary prevention models, and at least in some incidences are being delivered in a way that is consistent with the model program approach. One additional best practice model

included in this section, PRIDE, may not be a precise fit for this body of research, however the rationale for its inclusion in this report is included in the write-up for the program. This "Local Best Practice" section will include only those programs that fit the following criteria:

- Are primarily delivered as primary and/or secondary prevention strategies in local application

- Are being implemented in a manner that is fairly consistent with the best practices model, including hours of training, instructor qualifications, materials used, etc.

- The model is a parent education program

There are many fine parent education programs in our county that do not match all of the above criteria. For example some programs are combinations of several different approaches, including some that are best practice parent education programs and other elements which certainly have a research-base, however since they do not closely conform to the model, they are included in the section entitled "Related Local Efforts," which follows this section. The "Local Best Practices" section is arranged by model program; the following section is arranged by agency or category of agencies, e.g. "faith-based organizations."

Positive Discipline: This model is being used extensively in a wide number of settings throughout the county. Positive Discipline is a nationally recognized approach to working with children for parents and educators. It has applications as a primary prevention strategy, a secondary prevention strategy, and a tertiary prevention strategy, and local applications include all three levels. Although the model has been evaluated in a number of studies, there are no randomized controlled trials. The model has been in use for almost three decades, and continues to evolve in response to the experience of trainers and participants. For example, the method's developer, Jane Nelson, is now steering parents and teachers away from the use of "logical consequences," and toward a focus on solutions.

Many of the Positive Discipline classes are taught locally by Jane Weed-Pomerantz, or by people she has trained. The five family resource center hubs are all utilizing Positive Discipline as part of a Parent Education Collaborative being funded by First 5. The program is also being offered through adult education classes and in treatment facilities and locked institutions. In some applications throughout Santa Cruz County, Positive Discipline is being implemented in a manner that is a fairly close match to the model program implementation, and in other cases it is used as a component of a more eclectic approach. Sites and organizations summarized in this section are fairly to fully comprehensive implementations of the program. Less comprehensive applications will be mentioned in the "Related Local Practices" section that follows.

Santa Cruz Adult School: Positive Discipline is offered to parents in sixteen-hour classes (eight week series of two hour classes). The following classes are offered annually: two classes for parents of children of all ages, two for parents of teens, and one class for parenting in recovery. The classes are experiential, participatory, and contain very little lecturing. Positive Discipline textbooks for each age bracket (and one for parenting in recovery) are used to guide the class. Every class provides opportunities for parents to develop tools. One type of role-play and parent problem-

solving exercise is as follows: A parent shares about a challenging incident with her/his child, then the situation is enacted with the parent playing the child and someone else playing the parent. The group then makes suggestions about other ways the situation could have been handled. The parent maintains a "child mind" and listens to the suggestions, then chooses one of the ideas. That new way of handling the situation is then acted out, and the parent plays him/herself. The focus is on the parent's thoughts and feelings, and on decisions that the parent is making.

Intended Outcomes: One outcome is to support families in developing relationships built on mutual respect and dignity. Other goals include improved communication and problem solving skills, and increased empathy. Finally, the implementers intend for both parents and children to have a well-developed feelings vocabulary and utilize appropriate ways to express feelings

Results: Because the class is taught experientially, there are lots of paradigm shifts. For example, parents begin to reframe their requests to children in a positive way. Parents use the tools and see changes in their child's responsiveness and behavior. Class effectiveness is evaluated via instructor observation and a parent self-evaluation via a pre/post test.

Demographics: About 60 people participated in the classes offered through SC City Schools Adult Education in the previous fiscal year. Most of these clients were female, residents of the City of Santa Cruz, Caucasian, and had incomes between 100 and 200% of the poverty level.

Watsonville/Aptos Adult School: The Positive Discipline classes offered through Watsonville/Aptos Adult School utilize a very similar approach. Their classes are in six to eight week sessions, and currently two series are offered each year. One of the current classes is a collaboration with Head Start, so all the participants have at least one preschooler. The other class is open to parents with any age child. The ultimate goal is to increase the number of classes offered.

Intended Outcomes: Similar to Santa Cruz City Schools' program.

Results: The program staff reported that families exhibit very powerful changes. For example, after taking the class, parents see their children and themselves in a new way. Parents have also reported breaking cycles of verbal abuse.

Demographics: Sixty families were served in the previous fiscal year. Of these, all were residents of the City of Watsonville, about 70% were Latino/a and 30% Caucasian, about one third were living below 100% of the poverty level and the other two thirds had incomes of between 100 and 200% of the poverty level.

Parent Education Collaborative: The five family resource centers (FRCs) that comprise the Parent Education Collaborative are Live Oak Family Resource Center and La Manzana Community Resources (both programs of Community Bridges), Mountain Community Resources, La Familia Center, and Davenport Resource Service Center (a program of the Community Action Board). All five of the FRCs in the collaborative are utilizing Positive Discipline in a way that matches the best practice application of the model, in that parents enroll for a series of seven or eight classes, a Positive Discipline trained instructor facilitates the classes, and the nationally recognized curriculum is utilized. All participate in joint trainings and planning, and trained Positive Discipline

instructors are available to teach classes through any of the organizations. Data for the classes is tracked collectively in the SUN database that has been set up for all First 5 grantees. Because of the shared database, unduplicated client demographics can be generated for the Positive Discipline program, excluding data from Davenport Resource Service Center. In the first three quarters of fiscal year 2007/08, 218 parents participated in at least one Positive Discipline series from one of the four centers tracking data collectively. The collaborative is clearly on track for its intended outcome of 251 for the entire fiscal year. Summaries for the individual centers' classes are below.

The Parent Education Collaborative is taking part in a large scale Positive Discipline study. Although this study, the PEEP (Parent Education Effectiveness Project) survey, is currently in the data gathering phase and publishing is pending completion, the researchers are sharing data from the pre and post-screening tool with LOFRC. To date, changes have been measured that indicate a decrease in violence in the families, and an increase in understanding of child development and behavioral norms.

Outcomes are also evaluated via a telephone family survey funded by First 5. Applied Survey Research (ASR) gathers and compiles data from the survey tool, and reports back to First 5 and the agencies twice per year.

In addition to Positive Discipline, some of these centers offer other parent education components, including some additional offerings as part of the collaborative. Information about these programs is included, when available and relevant, under the "Related Local Efforts" section.

Live Oak Family Resource Center: Live Oak Family Resource Center (LOFRC) is the lead agency for the Parent Education Collaborative. LOFRC offers a number of eight week Positive Discipline series each year, and in addition includes techniques from Positive Discipline in other parent education offerings including drop in groups and Together in the Park, which are summarized in the "Related Local Practice" section. Santa Cruz Adult School is an important partner in providing both Positive Discipline and other parent education classes in collaboration with LOFRC. By partnering with the Adult School, more classes are offered and more people can be served, since leveraging of school Average Daily Attendance funds stretches available dollars for parent education. Other partnerships for the Positive Discipline classes include Live Oak Child Development, which has provided a site for some classes, and Cabrillo College, where Positive Discipline classes were offered in partnership for students enrolled in EOPs. While LOFRC Positive Discipline classes are predominantly for parents with children 0-5, one new class is targeting parents of school-age children, and a class that is not part of the Parent Education Collaborative targets teens and parents of teens.

There are no eligibility criteria for participation in Positive Discipline and the classes are free. Since the class is universally offered, it fits into the CBC matrix as a primary prevention practice. However the agency has a philosophical value of mixing families of differing risk levels in its classes in order to enhance modeling and peer support. Therefore, classes may include people who have open cases with child welfare services, people whose families have risks for abuse, and people with healthy families, all combined in one class. The center offers five series of eight week Positive Discipline classes per year. One targets parents in recovery; of the others, two are in English, and

two in Spanish. There is also one ongoing weekly Positive Discipline workshop for parents of school age children.

Intended Outcomes: Parent education is part of a LOFRC strategy called Strong Families, which includes home visiting and resource referral in addition to parent education. The short and intermediate outcomes intended for the Strong Families strategy are that parents will exhibit an increase in knowledge of effective parenting practices, and that parents will have access to appropriate support services.

Results and Evaluation: PEEP results for LOFRC Positive Discipline offerings indicate 100% of participants show an increase in positive parenting knowledge and behaviors and a decrease in inappropriate parenting behavior.

Demographics: LOFRC served 82 parents during FY 2006-07. Sixty percent were Caucasian, 35% Hispanic and the remainder Asian, African-American or multi-racial. The vast majority of clients are female and live in mid-county.

Mountain Community Resources: The primary target for MCR's Positive Discipline series is parents with children 0-5, however they will take parents with any age children. The organization targets people whose income is equal to or less than 200% of the federal poverty line for all of its programs, however no one is turned away. The agency holds Positive Discipline classes in the evenings. Classes are two hours long and run in 8 week sessions. Classes run back to back, with four series per year in English and 1 series in Spanish. The organization utilizes instructors from the Positive Discipline collaborative and handouts developed for the Positive Discipline curriculum. MCR provides free childcare so parents have access to the classes, and the childcare workers are trained in Positive Discipline.

Results: The following changes have been observed: Parents are more comfortable and less fearful of parenting; parents gain helpful parenting tools.

La Manzana Community Resources (a program of Community Bridges): La Manzana is a participant in the Parent Education Collaborative. The target of parent education classes is low income families with children zero to five living in South County. The classes are built on the principles of Positive Discipline, however to quote the former Program Director, Albert Maldonado, "because these programs are not designed with low-income Latino populations in mind…(the program)…needs to be altered so it is culturally appropriate." Adaptations in implementation include making the classes into a more social event including sharing of food. The actual parent education curriculum is followed as intended. Laura Garcia, a parent educator on the staff of La Manzana is a trained Positive Discipline instructor, and has now become a trainer of trainers.

Familia Center: Familia Center is also a participant in the Parent Education Collaborative. Familia Center is utilizing the model provided by Live Oak Family Resource Center and an instructor from Santa Cruz Adult School for their Positive Discipline program. Familia Center conducts outreach to bring parents into the class. The target population is Latinos with low incomes and at least one child under five in the home. In the current fiscal year the agency implemented one 8 week series in Spanish. The intended outcome is to reduce and prevent child abuse.

Davenport Resource Service Center (a program of Community Action Board): The target for DRSC's Positive Discipline program is the same families that are served by

the agency's home visiting program. Most are farmworker families, however the programs are open to any family with a child 0-5 living in the North Coast area or on the Westside of Santa Cruz. According to the class instructor, Positive Discipline is being implemented at the center with approximately 80% fidelity to the model. Outreach is conducted to get a minimum of ten or more of the home visited families enrolled into the program. A series of seven classes is conducted bilingually, once a week for two hours. Program staff teach new skills and parents share what has been working. Free on-site childcare is provided. The intended outcome is to help the parents achieve skills to use nonviolent discipline. Fifteen participants were served in the last fiscal year.

Other "Best Practice" Applications of Positive Discipline: Jane Weed-Pomerantz is teaching parents the techniques of Positive Discipline in two additional institutional settings. The class in Blaine Street Jail is for incarcerated women who want to have a better relationship with their children. There is also a class (in collaboration with LOFRC) for women participating in the Mondanaro Baskin Center, an inpatient substance abuse recovery facility for pregnant women and women with young children operated by Janus of Santa Cruz. Some women in both institutions may already have open child welfare caseloads, and in these instances the intervention would fit our CBC definition of tertiary prevention, and therefore be outside the scope of this report. Women who do not have open child welfare cases would be receiving secondary prevention services, however, according to our definition. For that reason, we believe it is important to capture these Positive Discipline classes as part of our assessment.

Ms. Weed-Pomerantz is also teaching continuous back-to-back eight-week sessions of Positive Discipline for Parents in Recovery at various locations in the community through a collaboration with the county Health Service Agency's Drug and Alcohol Services. HSA pays the cost for parents involved in family preservation court to attend these Positive Discipline classes. For those families, it's a tertiary prevention strategy and outside of the parameters for this report, however the family preservation clients do not fill the classes, so Ms Weed-Pomerantz distributes flyers widely among treatment providers and via other means to the general community. The class is open to anyone in recovery, so for people joining the class who are not involved in the child welfare system, it is a secondary prevention strategy.

Cara y Corazon: Cara y Corazon is a culturally based family-strengthening and community mobilization program, geared primarily toward Latino and bicultural families. It was developed by Jerry Tello of the National Latino Fatherhood and Family Institute, and is implemented locally in a number of diverse settings. Although no research data is currently available, a researcher at UCSF is helping to develop an evaluation of the curriculum's impact on families. In Santa Cruz County, Jaime Molina of the Health Services Agency is one of the people who is both teaching Cara y Corazon and overseeing fidelity to the model program. In has been implemented locally for 13 years. Approximately thirty clinicians, teachers, and counselors have been trained to administer the program locally. The model is based in a philosophical idea called "cultura cura," which translates into "culture heals" in English. Trainers embody the idea that families have answers to their questions and challenges within themselves and within their cultural traditions. A phrase used to describe the approach is "I'm not here to teach you; I'm here to help you remember."

Although the curriculum is somewhat Latino focused, it has been used successfully with people of any culture or race. Locally the program targets any families that want to

improve their relationship with their children. Cara y Corazon is offered through various collaborative efforts in a number of different settings. In South County, Pajaro Valley Unified School District Adult Education is providing the program at Alianza School. Santa Cruz City Schools Adult School is providing Cara y Corazon at Bayview Elementary and in the Live Oak School District there are classes at Del Mar Elementary. According to Jaime Molina, there will soon be 10 more school sites in the county. Additionally there are programs at Hermanas Recovery Center and Santa Cruz Residential Recovery through the Reclaiming Futures grant, a collaborative effort of the Probation Department and Children's Mental Health. Parents attending groups offered in Watsonville have access to the programs via free childcare, courtesy of First 5. Additionally, with sufficient attendance, childcare can be paid for via Adult Education. The program is also offered in Santa Cruz at the Beach Flats Community Center through a collaboration with Health Services Agency and Santa Cruz Adult School (see details below).

Cara y Corazon can be offered as an eight or twelve week curriculum. The final four weeks, weeks 9-12, are optional and require child participation. The curriculum is designed for families with preadolescent children, however families with younger children also attend. Classes are one to one and a half hours per week. Groups include between 10-15 couples and some single parents. Traditionally more moms participate, but that is shifting currently. Groups are dynamic and interactive. Topics throughout the series include an acknowledgment process and trust-building process, acceptance and recognition of strengths and positive characteristics in every family member, family structure, the cycle of life (including healthy transitions, child development, emotional/psychological development, effects of trauma, and unrealistic expectations of children and parents), living beyond survival, acting in the best interests of the whole family, and ceremonies and traditions.

Post Cara y Corazon is an ongoing support group for graduates. Locally program organizers are supporting parent leadership development so parent can begin facilitating their own groups. Beach Flats and Watsonville/Aptos Adult Education are both providing Post Cara y Corazon.

Intended Outcomes: Program developers intend for the program to result in healthier families, stronger relationships between parents, and parental community leadership/community voice.

Results: Parents have connected with their inner strength, increased their self esteem, and improved communication in families, according to the results of pre and post tests.

Demographics: Jaime Molina estimates that approximately 200 families participated in Cara y Corazon through the various venues in which it was offered last year. Approximately 85% were Latino/a and about 15% were Caucasian. About 80% were living with incomes less than 100% of the poverty level, and the remaining participants were at or under 200% of the poverty level. About 60% reside in South County and 40% in North County.

Beach Flats Community Center: The Cara y Corazon program offered at the Beach Flats Community Center (BFCC) targets Spanish speaking Latino families. The primary geographic targets are Beach Flats and Lower Ocean, however families from the rest of

the City of Santa Cruz are accepted on a space available basis. Instructors are bilingual, and outreach is conducted in a culturally competent manner.

Intended Outcomes: The organizers intend to strengthen families, to insure that people understand that their families and extended families are their own resource, to build on family values to support parents in guiding and supporting their own children, and to raise consciousness about the gifts and baggage that parents are giving to their children.

Results: Mothers who report sadness or depression in the pretest believe they have to carry the whole load. In the post test there is a shift; the same mothers know that there are other members of the family who can lend support. In the beginning families feel hopeless and don't know how they will meet their challenges, then afterwards they perceive themselves to be more hopeful and have more of a sense of their own efficacy as parents.

Demographics: Approximately 16 clients participated in Cara y Corazon through BFCC in the last fiscal year. More participants were females than males. One hundred participants were Latino/a and residents of the City of Santa Cruz. About half had incomes below 100% of the poverty level, and the other half had incomes between 100% and 200% of the poverty level.

PRIDE (Parent Resources for Information, Development, and Education): The PRIDE program was developed by the California Welfare League of America (CWLA) in collaboration with fourteen state child welfare agencies, and other key national partners including stakeholders from higher education and service delivery organizations. The program was designed specifically to train foster parents, adoptive parents and kinship caregivers to strengthen the quality of family foster care and adoption services (CEBC). The curriculum includes specific competencies and an approach to training which are consistent with the CWLA Standards of Excellence for Family Foster Care, so although the model does not fit our best practices definition precisely, it is indeed research-based. Locally the program is offered by Cabrillo College in collaboration with Santa Cruz County Human Services Department.

A large focus of the PRIDE curriculum is on the effects of trauma and abuse on kids, with the intent of insuring that caregivers can understand the behavior and the underlying cause. The training also places a large emphasis on Positive Discipline techniques. There is also teaching on normal child development and how that can be delayed by abuse, to insure that people's expectations are reasonable.

PRIDE is offered as a twenty-seven hour series in nine three hour sessions. It is offered at Cabrillo College four times per year (3 in English, 1 in Spanish). It is taught by a Cabrillo instructor, Deborah Helms, in collaboration with a foster parent. The bulk of the training is geared toward helping people develop a realistic picture of what it will be like to have a child who is traumatized or abused in their home, so people can either be more effective or can opt out before taking in a child. In addition to the Positive Discipline component, participants are also taught about attachment parenting and the work of experts in the field of childhood trauma such as Bruce Perry and Bryan Post.

Since the children who will be the beneficiaries of the PRIDE training are already in the child welfare system and in out of home placement, clearly PRIDE is tertiary prevention for these children and therefore not a subject for this research. However we are

including it here because the caretakers who are taking the training are not abusive. For purposes of this research, we are considering PRIDE a secondary prevention strategy for caregivers, since it is targeted, as opposed to universal, and since there are increased risks of abuse for children who have already been abused and for families in which there are children acting out the impact of severe trauma.

Intended Outcomes: The intent is for people to get a good picture of what the children are facing and what they will be facing as caregivers, so they will either opt out or, if they do stay in they will have clearer expectations.

Results and Evaluation: The program is not evaluated for effectiveness locally, however participants fill out satisfaction surveys after receiving the training.

PARENT EDUCATION: RELATED LOCAL EFFORTS:

Live Oak Family Resource Center: LOFRC offers a number of less formal parent education programs in addition to the various Positive Discipline series described in the previous section. While not comprehensive Positive Discipline classes, nevertheless the techniques of this model are woven into the offerings. Free drop-in parent/child classes include four weekly classes:

- in English for parents with 9-18 month olds

- in English for parents with 18-30 month olds

- in Spanish for parents of 0-2 year olds

- in Spanish for parents of 0-5 year olds

These classes are not simply playgroups, but opportunities for parents to learn from each other and the instructor. Each class has time for parents and children to interact together while engaged in a variety of age-appropriate activities, and time for parents to engage in a lecture/discussion component while their children are supervised in another space. Teaching modalities include modeling, suggestions, discussion, role-plays, etc. Although the instructors are prepared with curriculum topics for discussion, there is also space for emergent issues presented by parents. The classes have a drop in format, and many people come fairly regularly. Others just come a few times.

In addition to the parent/child classes, LOFRC also offers weekly childbirth preparation classes in four-week sessions, alternating between an English series and a Spanish series. Finally, the center also offers two "Together in the Park" drop-in groups weekly for families with children 0-5, in collaboration with Santa Cruz Adult School. Together in the Park offers parent education and support with age appropriate activities for children.

LOFRC served approximately 700 people in these parent education programs in the last fiscal year. Of these, a little over 20% were Latino/a and most of the rest were Caucasian. The vast majority of adults served are female, though approximately 12% are male. About 40% reside in the unincorporated mid-county area; about 40% reside in the City of Santa Cruz. The rest live in various places around the county. Over a third of center clients have incomes less than 100% of the poverty level. Almost half have incomes above 200%. Evaluation of all of the drop-in offerings is done via quarterly surveys administered internally. One hundred percent of the internal quarterly surveys

have indicated that parents have increased knowledge and skills. Other changes noted include positive changes in parental beliefs and increased community connection.

Parent Center: The Parent Center utilizes a mix of strategies, rather than a discreet model, in its parenting classes, including some that are evidence-based and some that have a sufficient level of evidence to be considered best practices for the purpose of this report. For example, the Parent Center instructors participated in a Positive Discipline training and incorporate that work into the classes. They also utilize an evidence-based therapeutic model, Cognitive Behavior Therapy (CBT), a practice that supports people in making links between what they think, feel, and do.

The target populations include people with open child welfare cases, incarcerated fathers, women with substance abuse issues, and people that want to attend. The Parent Center prioritizes people with open child welfare cases, and indeed most clients are currently involved with child welfare.

Classes are offered in 10 week cycles. Instructors teach parents to deal with their own emotions first. In addition to the models previously mentioned, they incorporate anger management, positive affirmations, and affect-regulation work as class topics. Both homework and in-class participation are included. There is also instruction about child development, i.e. "ages and stages." There is a big safety component, which includes information about child abuse laws.

Intended Outcomes: Two major outcomes are hoped for: improved family functioning and preventing and treating child abuse.

Our rationale for placement in this section follows: While Trauma Focused CBT is listed as an evidence-based practice for child welfare populations, for purposes of this research, CBT will not be considered a best practice in <u>parent education</u> for primary or secondary prevention populations, based on the fact that a review of the literature failed to turn up a best practice model using CBT in this manner. While the practice is undoubtedly helpful to program participants, it doesn't fit our research criteria for this section of the report. Another source of techniques used in parent classes at the Parent Center is the work of B. Bryan Post, PhD, LCSW. Dr. Post specializes in treating trauma and attachment disorders in children and families, and is the founder of the Post Institute for Family-Centered Therapy. While his work appears to be revolutionary, and there are many testimonials as to its effectiveness, we could find no documentation of studies to demonstrate the effectiveness of the work.

We also recognize that some participants of the classes are individuals from the public interested in becoming more effective in their parenting, however for the majority of clients, the preventative aspects of the intervention are tertiary.

Walnut Avenue Women's Center (WAWC): WAWC offers parenting classes to mothers who come to the agency for domestic violence services. The focus of the classes is on the domestic violence that has occurred and how that has effected their parenting. Moms learn a new set of healthy parenting skills after leaving a violent situation. A ten week parenting series is offered twice per year. The intended outcomes are for the mothers to learn and use healthy parenting tools, and to increase parental responsibility for keeping children safe. The types of indicators which are tracked via pre and post-test, observation, and client testimony include the number of arguments between parent and child there were in a week and how they were handled,

whether or not a parent took time to respond instead of reacting, and how stressors were handled. Most of the participants' children are in the Youth Program and these young people do report positive changes in family functioning. In the last fiscal year, approximately twenty clients, all female, participated in the parenting classes. About 60% were Caucasian and 40% Latina. About 50% live in the City of Santa Cruz and the rest are spread around the county; all are living with incomes equal to or less than 200% of the poverty level and about 50% have incomes less than 100% of poverty level.

Watsonville/Aptos Adult School: In addition to Positive Discipline classes, this adult school also offers a primary prevention parent education program called Families in Control, a program based on Back in Control, a book by Gregory Bodenhammer. The adult school offers an eight week class for parents and adolescents. Conflict resolution, listening, and role-plays help parents see the perspective of the child and the teens to see the perspective of the parents. Parents and teens are together for part of the time and also have segregated processing time.

Pajaro Valley Unified School District SELPA/Special Services Department: This department provides parent education as part of its Early Start program, a state and federally mandated program for children 0-3 with disabilities. The program is outlined more fully in the "Home Visiting" section of this report. Parent education is provided in a group setting via semi-weekly meetings at the Early Start center or at a park. The children, parents, and staff are all together for part of the meeting and teachers model an activity. Afterwards parents are separated from the children and receive formal parent education, for instance information on child development or topics of relevance to children with special needs. During this time, children are with their teachers working on such things as feeding, mobility, or other skills in according with the child's needs.

Special Parents Information Network (SPIN): SPIN is another entity that targets families coping with a disability, either of the parent or the child. SPIN's Mentor Parents Program is loosely based on a model program that utilizes mentor parents to support parents of developmentally delayed children. The model program has demonstrated a positive impact on children and parents. SPIN also provides monthly parent groups in which workshops on various topics are provided. The themes of the workshops are based on parent requests. The agency also provides a resource guide that outlines services and systems for disabled parents and children in our area. Intended outcomes include for parents to be able to navigate the system to serve their children and for children to be able to achieve their potential by empowering families through information, support, and resources.

Cabrillo College Early Childhood Education Department: Cabrillo College ECE has offered parent education programs for the community in the past. The classes covered communication and Positive Discipline. Classes were apparently well received, but did not fill; hence they were eliminated from the course offerings.   The programs are not offered currently, nor is there a plan to offer them in the near future.   There are mandatory parenting classes, however, for parents with children in the Cabrillo College Children's Center, an on-campus childcare center for children that provides a learning environment for the College's ECE students. This program is reviewed in the "Early Care and Education with Comprehensive Family Support section of this report.

Hospital Based Parent Education Programs: All three of the hospitals in the county offer parent education classes or related parent groups.

Lactation Center of Sutter Maternity and Surgery: The New Parent Support Groups offered by this hospital do not follow one best practice model, but incorporate information and research from such fields as family development, child development, attachment theory, etc. The groups are facilitated by Maggie Muir, LMFT, IBCLC, and Lilly Beggs, PHN, IBCLC. Weekly drop-in parenting groups include one for parents and their children birth-4 months, one for parents and children 4-9 months, a prenatal care class, a breastfeeding class, and a postpartum wellness support group. The postpartum wellness group started as a group for women healing from postpartum depression, but now it is for women with any postpartum challenges. Women can self refer to the groups, and referrals for the wellness group also come from OB/GYNs and midwives. Most of the classes fit into our primary prevention category; the postpartum wellness group is more of a secondary prevention strategy, since postpartum depression and other complications can certainly increase the risk of child maltreatment. There is a small fee for groups, however no one is turned away if they can't pay.

The classes provide a forum for people to share, receive referrals and education, and give and receive peer emotional support. There is a lot of education in all the groups on infant development, communication in families, and safe sleeping. The wellness group also covers perinatal mood disorders, since there is a 4-5% rate of infanticide and maternal suicide among women with postpartum psychosis, which most commonly happens shortly after birth. Because sleep deprivation in a depressed mom can also trigger postpartum psychosis, sleeping information shared with families includes information on safe co-sleeping. Facilitators encourage each family to do whatever works best for their family so that everyone can get sufficient sleep.

Intended Outcomes: Outcomes intended for Sutter's parenting education classes include supporting families' healthy adjustment to new parenthood, child abuse prevention, maternal and family wellness, SIDS reduction, child safety, reduction of baby stress (for instance though baby wearing techniques), information about creating and utilizing community support systems, and the provision of tools and skills for parenting, especially for baby calming.

Results: An example of observed changes in families include fathers' use of skills from the Happiest Baby on the Block (effective baby calming techniques), mothers exhibiting greater confidence and developing a support network, women in the wellness group exhibiting an increase in connection with their babies and speaking more positively about them, and in response to this the babies showing increased responsiveness. Exact program demographics are unknown, however hundreds of parents participate in the classes each year, some on a long term basis, and others just a few times.

Watsonville Community Hospital also has an ongoing weekly drop-in group for new moms and their infants. The group is free and is facilitated by an OB nurse and lactation consultant. Further information was not available.

Dominican Hospital also offers a variety of parent education offerings that have relevance to this research. For example a breastfeeding class and a drop-in weekly breastfeeding support group can enhance the possibility of successful breastfeeding, an

activity which positively correlates with secure attachment, and therefore reduced risk of abuse. Dominican PEP also offers childbirth preparation classes, classes for new dads, and classes to help people parent through challenging times.

Nonviolent Communication Santa Cruz: This center offers a variety of workshops and classes on applying the principles and techniques of Nonviolent Communication (NVC) to the role of parenting. Nonviolent communication utilizes the language of observations, feelings, needs, and requests rather than judgment, blame, criticism, and demands. The intent of parent education utilizing NVC is to foster connection between parents and children, to increase empathy, to insure mutual understanding, to provide tools that will support the emergence of effective communications and synergistic solutions in which everyone's needs are met, and to make life more wonderful for all members of the family.

Faith-Based Organizations: One of the limitations of this body of research is that we had a fairly limited capacity to investigate possible child abuse prevention strategies, including parent education, being offered by other than traditional service providers known to our original list of informants or secondary informants revealed through the interviews. Certainly the limited information we have regarding parent education or other forms of parent support provided by faith-based organizations is a reflection of that study limitation. We did engage in limited outreach to faith-based organizations; however we make no claim as to the thoroughness of corresponding information in this report. Through personal contacts and through outreach to faith-based organizations as part of our public awareness campaign, we have become aware of at least three faith-based organizations providing some level of support and education to parents. Two of these organizations, Twin Lakes Church and the Center for Conscious Living, are utilizing, at least in part, Love and Logic, a parent education curriculum that is given a rating of 4 on the prevention section of the CEBC website. A 4 on the CEBC website is similar to an "emerging practice" for purposes of Community Blueprint for Children.

Parent Education as Program Component: Many programs include parent education as a component of a larger strategy. For example parent education is practiced as part of home visitation programs, father involvement programs, and early care and education programs. In our county, the following organizations include at least some parent education in their work with families: PAPÁS, Early Start, Even Start, Head Start, the State Preschools, and the cooperative preschools. Some of these organizations are utilizing principles and practices from Positive Discipline in their parent education offerings.

Community Engagement
LOCAL BEST PRACTICE PROGRAMS: None.

RELATED LOCAL EFFORTS: None.

Early Care and Education with Comprehensive Family Support
LOCAL BEST PRACTICE PROGRAMS: Three (Head Start, Migrant Head Start, Even Start)

Head Start (and Early Head Start): Locally, Head Start is a program of Santa Cruz Community Counseling Center. The program utilizes the federal Head Start model and meets all of the model's performance measures. The targets for the program are low income families with 0-5 year olds and children with special needs. Families with

infants, toddlers, or pregnant women are enrolled in Early Head Start, and those with 3 and 4 year olds are enrolled in Head Start. Program guidelines require that at least 90% of families have very low incomes. Ten percent of families can have income higher than the designated cut off. These slots are typically reserved for children with special needs or for families with high need and low (but not low enough) income.

The model has two main categories of service strategies: the early childhood education piece and parent support. For purposes of this report, we will focus on the parent support component of all programs in this category. Families enrolled in Head Start may be assigned to the home-based or the center-based track. For those participating in home-based services, one worker provides both the early childhood education and the parent support component. For those with center-based services, case managers provide family support and teachers teach the children, however there is some overlap. Additional components include mental health and disabilities support, health and nutrition. Parent involvement is mandatory.

Within the first 45 days of enrollment there is a comprehensive assessment of the family development and needs. The program utilizes a whole child/whole family approach. The eligible individual is the child who is 0-5 years old, however the program serves the family as a whole. For example in one family the mom needed a mammogram and a teenager needed glasses; Head Start staff supported the family in accessing these resources even though neither individual was the eligible child.

Every family receives some level of home visiting. Those enrolled in the center-based program get 2-4 visits per year from the teacher or case manager. In the home-based program, most of the education and support is delivered in home, with a minimum of 32 visits per year for Head Start and 45 visits annually for Early Start. (This amounts to weekly visits, since Head Start takes a break during the summer.) Those receiving the home-based services are also encouraged to participate in group activities. At least two such group activities are offered each month for home visited families. Group activities include a nutritious meal, a fun activity, and an educational piece. Parent leadership is an important aspect of the Head Start Model. Parents are in leadership positions and make decisions about the program.

Each Head Start family works with staff to create a family partnership agreement including the development of goals. Staff and family work together to design strategies to meet goals and track progress. Goals common to many parents include adult education, parenting information, participating in counseling, and learning English. Every child's file is reviewed by a multidisciplinary team every six weeks.

Intended Outcomes: Following are some of the intended outcomes of the program:

- increased literacy for children and families

- improved social/emotional development

- children ready for kindergarten

- health improvements: every family connected to a medical home, up-to-date immunizations, health issues improved

Results: The local Head Start program has documented the following changes as a result of interventions and ongoing efforts to improve outcomes and program functioning:

- Services are more integrated as a result of restructuring the program's approach to decision-making and management. A team model allows each site to make day-to-day decisions with management support to implement.

- Parents exhibit less stress due to support.

- Improvements are noted in family development, parenting, and health.

- A Positive Discipline train-the-trainers was offered for Head Start parents. Those that participated demonstrated increased enthusiasm and confidence.

Evaluation: The federal government performs a complete audit of every Head Start program every three years. There are over 1700 performance standards for programs to meet. Many are process outcomes such as completion of a family partnership plan, completed immunizations, and connection to medical homes. The program also does a complete self assessment every year. Community partners, parents, and staff participate in the annual evaluation. The program also administers parent satisfaction surveys and uses the results as part of the program improvement plan.

Demographics: Early Head Start has a capacity of 42 families at a time and served 72 families in the last fiscal year. The Head Start capacity is 421 families at a time; that program served 478 in fiscal year 2006/07. Of all families enrolled, 95% had incomes less than 100% of the poverty level; five percent had between 100-200% of the poverty level. There is a waiting list.

Migrant Head Start: Pajaro Valley Unified School District Migrant and Seasonal Head Start utilizes the Head Start model adapted to a migrant population. It is a fairly close match to the model program in terms of service delivery, training, parent opportunities, and record keeping. The target is migrant farmworker families residing in PVUSD boundaries with children 2 months through transition into Kindergarten. The same income guidelines apply as for Head Start; in addition, 10% of children have disabilities.

The program treats every family individually. Assessment of each family includes legal status, health, economic situation, etc. The intent is to provide support that is relevant to the family's situation. Family service staff carry 45-50 children in their caseloads (average 1.2 children per family). Staff visit each family at least once in the first 30 days, then will do more if necessary. Involvement with families matches need; there is more involvement with the families who have multiple problems and/or don't have transportation. Children in the program attend one of about 70 family childcare homes (503 slots) or 5 daycare centers (10 classrooms). The program has a parent educator to work with families with children with behavior challenges. Families also receive visits from family service staff. A couple of therapists (MFTs) work under contract to the program, observing all of the childcare settings and making observations of children identified as having high needs. Family service staff look for various risk factors, e.g. domestic violence, children with special needs, isolated families, issues with transportation, etc. Support is given as necessary and beneficial. The program implements a standard practice of educating families new to the country about legal issues regarding corporal punishment.

The families participate in monthly committee meetings, trainings, and workshops. Topics change from year to year; parent need influences topic selection. For example parents may want parent education or information on domestic violence.

Intended Outcomes: Intended outcomes include:

- to provide education and strategies for parents to support positive relationships with their children

- to let parents new to the country know what the expectations are

- to help parents understand appropriate development

- to support parents in accessing resources for individual needs

- in some cases, to help parents connect with other parents for mutual support

Evaluations: Parents participating in trainings complete a written evaluation.

Demographics: The program can serve 750 annually; they served 735 in the last fiscal year. One hundred percent were Latino. Ninety-five percent had incomes less than 100% of poverty; five percent had incomes between 100-200% of poverty. Most clients were Watsonville residents.

Even Start: Even Start is a family literacy program that utilizes home visitors, offered locally by the Walnut Avenue Women's Center (WAWC). The target population is families with literacy issues and low incomes. People in the program are primarily English language learners, but some program participants have English as their first language. Although the program focuses on improving literacy, program interventions would tend to enhance protective factors and reduce risk factors for abuse.

The program includes home and center-based services and utilizes a team approach to supporting families' learning and growth. The members of the team include, at minimum, a home visitor assigned to the family and childcare providers who work with the child. Collaboration between home visitors, childcare providers, and others is crucial. Staff qualifications include a bachelor's degree, Even Start intensive training, domestic violence training, and early childhood education. There are two home visitors: one for teen parents, one for community families.

People generally enter the program via referral from a childcare center. Women entering prenatally are screened via home visitor observation, and noted risk factors, if any, are brought into consultation with the other members of the team, then addressed.

Families are required to spend a certain amount of time each week in each of four program components: some type of adult education, weekly parenting classes in English or Spanish, the children enrolled in and attending the childcare component, and working one-on-one with their home visitor at home or at the center. Members of the team model how to work with the child, build literacy skills, support parents in understanding what their infant is "saying," and promote healthy interactions between the parent and the child. Families stay in the program until the child is in kindergarten or first grade. The program includes a focus on fathering. Teen moms are taught about healthy relationships. Additionally, home visitors work a lot with parents, especially the

teen parents, around natural child development and appropriate ideation of child/parent roles.

Intended Outcomes and Results: Not available for this program.

Evaluation: The program is evaluated via participant self reports, various evaluation tools administered by the home visitors and childcare providers, twice annual literacy tests, and weekly observations.

Demographics: In the last fiscal year, 31 families were served. Most clients last year were Latino/a and living below 100% of the poverty level. Approximately 25% of the participants were male last year, and the rest female.

RELATED LOCAL EFFORTS: Eight

Watsonville/Aptos Adult Education: Two cooperative preschools are operated under the auspices of Watsonville/Aptos Adult Education: 1) Watsonville Cooperative Preschool and 2) El Jardin Bilingual Cooperative Preschool. The program borrows from a couple of different model programs including the Epstein model of Family Partnerships, and Cabrillo ECE program, in the case of El Jardin. The schools target Watsonville-based parents of 3-4 year olds who are able to work at least once per week in the classroom. El Jardin conducts outreach to monolingual Spanish speakers. Although the geographic target is Watsonville, people have come from other areas such as Aptos and Soquel.

At the beginning of each school year the parents give input on topics of interest. The parent board and teachers schedule monthly parent education meetings based on this input. For example, there was a huge amount of interest this year in conflict resolution and discipline, so multiple meetings focused on these. Parents also receive education during their workdays at the school. Each workday includes a seminar during lunchtime for parents who worked with the children that day to debrief about what happened during the morning session. The teacher also introduces materials focused on best practices with young children.

Intended Outcomes: The school intends to foster the following intended outcomes for families and children:

- increased community involvement

- closer connection between parents and their children in school

- parents continued involvement in child's education (long term)

- increased parental confidence in their roles as teacher and parents

- children ready for school

Results: The following changes have been observed:

- Parents display more confidence in parenting.

- Parents are more comfortable seeking help.

- Parents talk about feeling isolated upon entry; that shifts over time in the school.

Evaluation: Each parent fills out a program survey to rate how the program has met goals. Twice yearly parent/child conferences are held in which staff and parents discuss parent and child goals.

Demographics: The program can serve 50 families at one time and served 75 families in the last fiscal year. The racial breakdown follows: 45% Caucasian, 50% Latino, 2% African American, 3% Asian. Most families live at or below 200% of the poverty level. Most parent participants are female. There is a small waiting list.

Santa Cruz City Schools Adult Education: Santa Cruz City Schools Adult Education (Santa Cruz Adult School) runs three parent cooperative daycare programs which are similar in design to the two Watsonville/Aptos Adult Education coop preschools. The Three schools are the Westside, Soquel, and Santa Cruz Parent Education Nursery Schools. The schools serve students in half-day programs, 2 or 3 days per week. Parents must work in the classroom and also contribute in other ways, for instance helping with yard work, maintenance, or fundraising. Teachers support parents in learning supportive, effective parenting techniques through monthly workshops, discussions, and modeling in the classroom. Intended outcomes for parents include increased knowledge of child development, increased skills in working with young children, and enhanced capacity to understand children's behavior.

Beach Flats Community Center: The early care and education program offered by Beach Flats Community Center is based on the parent cooperative preschool model. It adds a bilingual community liaison and is adapted to be culturally appropriate for the target population: primarily Spanish-speaking families living in Beach Flats and Lower Ocean. The community liaison helps parents with school-related paper work, resource referral, service hours, etc. The program staff model interactive, hands-on, child-centered programming for the parents. The family's language is respected, however the program has a goal of introducing English as a second language where applicable.

Parents are required to do 16 hours of parent participation activities per week. The organization insures access by having many different options for parent participation. For example, since one goal of the program is to support families in increased postive interaction with their children, reading to a child counts toward participation hours. Each parent also must work directly with the children in the classroom for 4 hours each week. The parents learn through the modeling of the teacher. There is also a monthly seminar for parents; sample seminar topics include nutrition, raising a reader, and making choices for kindergarten. The program is free for participating families.

Intended outcomes for the parent component include enhancing parents' knowledge of school expectations, supporting parents in developing a repertoire of activities and resources that support children's academic achievement; increasing supportive parenting and effective communication between parents and children, and providing a forum for parents to develop a mutual support system. The program serves 33 children and their parents, all residents of the City of Santa Cruz, all Latino/a, and all from families with incomes at or below 200% of the poverty level.

Santa Cruz Toddler Care Center: The Santa Cruz Toddler Care Center uses "RIE inspired" practice and philosophy. RIE (Resources for Infant Educarers) is an institute founded by infant specialist Magda Gerber. The organization's purpose is to support, train, and mentor parents and caregivers to improve infant care. The Toddler Care

Center has adapted the RIE philosophy for use in a center-based program. Central to RIE philosophy is supporting parents and caregivers in learning to observe, understand, and follow infant cues, and to empower children through supporting their self-initiated activities (Gerber).

The Toddler Center serves children aged twelve months to three years, and serves sixteen children per day. Parent education is currently offered through approximately 6-8 events per year. About half of the events are workshops or meetings (with onsite childcare) focused on parent-driven topics, e.g. RIE philosophy, moving to preschool, alternative health, napping, eating, conflict resolution. The other meetings are social gatherings for informal networking. At these gatherings, staff are there and can mingle and model. The Toddler Center does administer post tests after parent workshops and utilizes the responses for program improvement.

Cabrillo College Children's Center: The Cabrillo College Children's Center includes mandatory parent participation as a requirement for children's enrollment in the program. Parent participation includes taking a parenting class, taking part in parent conferences and a home visit from the child's teacher, working eight hours per semester (for instance on cleaning or materials repair), and attending four parent meetings. Parents also have access to materials such as books and tapes to support them in their parenting.

Children may be enrolled in half or full day options geared toward specific toddler and preschool age groupings. In general the program schedules match the college's academic calendar, however childcare is sometimes available through the summer for 2-5 year olds. A State-funded preschool program is available to eligible families.

State Preschools: The other three related local programs for this strategy area are all state preschools. State preschools receive subsidies to provide quality childcare programs for children from families with low incomes. One of the requirements for state preschools is to survey parents to determine their needs on an annual basis, then to design parent education and support components to meet identified needs. All three of the local organizations that provide state preschools offer parent meetings on a variety of topics and also provide resource referral. Following are brief summaries of each.

Campus Kids Connection: This preschool targets families with low incomes who experience barriers to preschool due to costs. The preschool is located at Gault Elementary, and most students come from the general area of the school, however children can come from anywhere in the county. The preschool conducts a semi-annual parent survey and creates three parent nights per year based on the survey results. Topics of interest to parents in the recent past include Positive Discipline, literacy, special needs, and attention issues. If the staff does not have the necessary expertise to provide education on parent-driven topics in-house, they will collaborate with other agencies to insure the parents' needs are met. The school also holds parent conferences with families. If a family needs additional resources, the school makes the referral and follows up. An important intended outcome of the program is to be a resource for families so children can grow up and thrive in a healthy environment. There is no formal tracking of indicators, however the following changes have been observed among parents: improved communication, feeling confident asking for help, understanding there is a partnership between providers and parents that positively impacts parent and child development. The preschool serves 24 families. Ninety

percent are Latino/a, and the remaining 10% are Caucasian. All are residents of the City of Santa Cruz.

Go Kids: Go Kids has multiple sites in Santa Cruz County. We only interviewed a representative for one site (in Soquel). Go Kids integrates full fee students with subsidized students. Since the subsidized students are served through the State Preschool program, parent education is mandated. Because the school is integrated, all families benefit by the parent support component. Although there may be differences from site-to-site with regard to target age ranges, numbers served, etc., the model is the same at all sites in terms of the requirement for specific parent components. Content of parent education varies from site-to-site in order to insure a match for needs of parents at that site. Topics for parent education nights in the recent past at the Soquel site include autism, substance abuse, nutrition, parenting, etc. Intended outcomes for the parent component include the provision of parent education and giving information about how parents can better support their child's development.

Community Bridges Child Development Division: This division of Community Bridges provides childcare at several sites in the county. As State Preschool programs, these programs provide parent support and education through the provision of written resources, parent/teacher conferences, and quarterly parent meetings and parenting education nights. The intended outcomes for the parent components include increased parenting skills and an understanding of the link between children's diet and dental health. The organization has provided services to approximately 105 families per year. Ninety-eight percent are families with low incomes, parents working or enrolled in school, and Latino. Approximately 66% reside in the City of Santa Cruz and 33% reside in Watsonville.

Father Involvement Programs
LOCAL BEST PRACTICE PROGRAMS: One

**PAPÁS: Supporting Father Involvement:** This program is part of a statewide research project funded by the Office of Child Abuse Prevention. The local effort is a program of the Family and Child Development Division of the Santa Cruz Community Counseling Center. The statewide research project is a randomized control trial intended to find effective ways to support fathers in being involved in their families and communities. The program targets families with children 0-11. The primary target is Latino families, however families from other racial or ethnic groups are also served. The geographic target is the entire county, with an emphasis on South County. For purposes of the CBC research, PAPÁS is a primary prevention strategy, since the selection of participants screens out families with common risks for abuse. In order to participate in the study, both parents must actively want to co-parent, and must be interested in and able to participate for the full 18 months. Additionally, families are not accepted into the study if they have current child welfare involvement, severe substance abuse problems, severe mental health problems, or domestic violence.

The model utilizes a holistic approach to prevent child abuse. Families are assigned randomly to the intervention group or the control group. Program staff evaluate participants of both groups at entry, then post intervention, in five domains:

- Parents as individuals, including mental health, parenting skills, self esteem

- The couple relationship, including problem solving, role assignment, shared responsibility, stressors, and support system

- The parent/child relationship (both parents individually and as a couple), including delegation of parenting responsibilities, parenting style, strengths and challenges

- Family of origin, looking at a three generational pattern, for example how the parents' parents' parenting style influences parenting of the next generation

- Community supports and stressors, for instance social support networks, work support and/or stress, neighborhood factors, formal support.

The intervention group receives a parenting workshop series totaling 32 hours over twelve weeks. The workshop curriculum is based on the above five domains. Parenting workshops are free and also include the provision of food and childcare. Workshops are co-facilitated by one female and one male for role modeling, and at least one facilitator is a clinician. There are three sessions on each day of the workshop: information, open discussion, and a kinesthetic session (e.g. journaling to reinforce information). There is also a socialization component (eating).

Midway through the twelve weeks the mothers and fathers are separated. During these segregated sessions, the mothers are interviewed about changes in the men, and the men interact with their children. A peer-to-peer support group is held quarterly to encourage mutual support.

In addition to the parent education component and support group, families also receive case management services, and the needs of the family drive the level of case management. The range of possible support strategies utilized by case managers includes resource referral, home visits, and referrals to long-term therapy. Families have access to the case manager for 18 months.

The control families receive a three-hour informational session about father involvement instead of the 32 hour intervention. Controls also have access to 18 months of case management. Both groups are tracked over eighteen months and receive two follow-up assessments.

PAPÁS is currently being offered at three sites in Santa Cruz County, in Watsonville near La Manzana Community Resources, at Live Oak Family Resource Center in mid-county, and in the Beach Flats area through a collaboration between PAPÁS and the Beach Flats Community Center. In addition to providing a site for the program, LOFRC also provided case management, assessments and coordination of two groups of parents in the fiscal year just ending, one Spanish speaking group and one English, for a total of 14 families.

In addition to the direct service provision for families, PAPÁS also has a Father Friendly Initiative to increase positive father involvement more broadly in the community. The initiative focuses on two areas, agencies and the community. Services provided to agencies include assessments and consulting to increase the agencies' capacities to effectively involve fathers. PAPÁs works in the community to provide education and awareness about the importance of positive father involvement with children, for instance through a Father's Day event and community presentations.

Intended Outcomes: The program's ultimate intended outcome is a reduction in child abuse as evidenced by zero referrals of intervention families to child welfare services. Other intended outcomes include a reduction in domestic violence and a change in any of the five domains.

Results: Evaluations of the families indicate increased couple relationship satisfaction, increase of father involvement on a daily basis, reduced hyperactivity and aggression in the child, and reduced depression and anxiety in the parents. UC Berkeley, Yale, and Smith College of Social Work are conducting the research study.

RELATED LOCAL EFFORTS: None

Several survey respondents offered leads to other "father involvement" programs, but these activities were not discreet fatherhood programs. Rather, they were activities implemented for the purpose of encouraging fathers to participate in programs that traditionally targeted only mothers. While these efforts are noteworthy indicators of a changing climate in service delivery to families, none of these efforts to include fathers was comprehensive enough to note it here.

Differential Response
LOCAL BEST PRACTICE PROGRAMS: Two

Families Together: Santa Cruz Community Counseling Center is the lead agency for this secondary prevention program. Collaborators include several county agencies and family resource centers. As a differential response program, Families Together targets families who have been referred to child welfare based on an allegation of abuse or neglect, and who fit the program participant criteria. The program is voluntary. If families participating in Families Together "open to a case" with child welfare services, their involvement with Families Together ceases.

Families are invited into the program after receiving a disposition of either "assessed out" or "investigated and closed" following an allegation of child abuse or neglect by a concerned community member or mandated reporter. "Assessed out" means that the screener taking the child abuse call determined that there was insufficient evidence to investigate the allegations, or the activity described by the person making the report did not meet legal thresholds for child abuse and neglect. "Investigated and closed cases" are those in which the initial assessment indicated an investigation was in order, however the subsequent investigation failed to result in an open case. Again, it could be that allegations were not proved or that thresholds for abuse were not reached. Whether assessed out or investigated and closed, if a family has at least one child under six years AND at least two previous referrals (regardless of disposition) AND there is a concern about substance abuse, the family will be offered services by Families Together.

Once a family is identified for services, the first step is that the referral is sent by child welfare to the Families Together in-house child welfare worker, insuring that confidentiality is maintained. This worker then contacts the family via a mailed brochure and letter and a follow up phone call. Families are given information about the services available through the program, assured that it is voluntary, and invited to participate. If the family accepts services, the case is assigned to a Family Support Specialist. Families entering through the "investigated and closed" pathway will have had a risk

assessment by the child welfare investigator. Families "assessed out" will be given the same risk assessment by Families Together at entry into the program.

Based on the results of the risk assessment, a family is referred to either the community pathway or the intensive pathway. Families with low to medium risk for abuse are referred to one of the Family Resource Center partners for the community pathway, which consists of brief case management and information and referral services. If the family has a high or very high risk for abuse, they will go into the intensive pathway, which utilizes a multidisciplinary team approach. Families in this path receive approximately 12 months of services, whereas those in the community pathway generally receive services for 3-6 months. An alternate possible referral would be to another program, Primeros Pasos. This would be the appropriate referral for women who are abusing substances and are either pregnant or have young infants. Due to capacity limitations of Primeros Pasos, which is summarized in this report following Families Together, some qualifying families are remaining with Families Together.

Once assigned to either the community or intensive pathway, the next step for families is to go through a number of assessments to determine family strengths, needs, child health, home safety, parent/child relationship, child development, social supports, substance abuse and/or domestic violence issues, etc. In collaboration with the family, these assessments inform the development of a service plan, or "Family Partnership Agreement." In most cases the assessments are administered by the home visitor, however a Public Health Nurse also assesses families in the intensive pathway.

Services are home and center-based. Services include: skill building, parenting assistance, referrals to outside agencies, and strengthening families in alignment with the referral situation. For example if the referring issue was neglect, the program will encourage the parent to work toward self-identified goals which support her/him in becoming a more attentive parent. Home visitors also model basic parenting skills for parents, like reading to the children, accessing resources, eating nutritious foods, and maintaining a safe environment. Workers may also work with parents to help them understand how their histories may be impacting their parenting. In addition, the program staff encourage both parents and children to engage in enjoyable, meaningful activities in the community as a way to feel connected and increase self-esteem.

In the majority of cases the services are provided in the home, however if the primary caregiver is not comfortable with this, the services are provided in an alternate location such as a park or the Families Together office. The goal for frequency of visits is at least one visit per week for either pathway. The home visitor provides most of the services (all in the case of the community pathway), however other professionals, for example a substance abuse counselor or domestic violence specialist may interact with the family on occasion. In the intensive pathway, a range of professionals provide consultation to the home visitor on a needs-dependent basis.

Intended Outcomes: Following are some of the intended outcomes of the program:

- The child's living environment is safe.

- Every family that qualifies is linked to medical and dental homes.

- Child development is assessed; children are progressing in meeting developmental milestones or linked to appropriate services.

- Families are linked to appropriate services.

- Parent/child relationships are improved because parents increase their understanding of their child's needs and know how to create a growth-enhancing, nurturing environment.

- Families are able to continue being successful after they finish the program.

Results and Evaluation: The following changes have been observed by program staff and/or measured in program evaluations:

- Parents have developed basic nurturing skills.

- There is a decrease in maternal depression, and a corresponding activation in interactions with the child, e.g. improved connection, paying more attention to the child, and playing on the floor with the child.

- As a result, the children are more engaged and begin interacting with other children.

- Parents demonstrate their understanding of how to create a safe home.

The program is subjected to internal and external evaluations, in collaboration with ASR and the Children's Research Network.

Demographics: Of families referred to the program, approximately 75% accept services. The vast majority of primary caregivers are female. The majority of families are Latino, followed by Caucasian families. Clients live all over the county, however the majority reside in Santa Cruz or the surrounding areas and in the City of Watsonville. The vast majority of the clients have incomes below 200% of the poverty level.

Primeros Pasos: This collaborative program run by the Health Services Agency's Maternal Child and Adolescent Health program, Alcohol and Drug Division, the Human Services Department and Santa Cruz Community Counseling Center is for women who are pregnant or parenting a young child (0-7 years), are dealing with substance abuse issues, and have no open child welfare case. There are various means for entry into the program in addition to assessed out or investigated and closed child welfare referrals, so the program is not entirely a differential response model. It is placed in this section of the report, however, since it is a pathway for differential response locally. The program is a HRSA grant under the Abandoned Infant Act, and is a research project done in collaboration with UCSF, which provides the research questionnaire and compiles the data. The program focus is early intervention and prevention, and the primary target is pregnant Latina women who live in South County and are abusing substances. People living in other areas of the county or who have a different racial/ethnic profile are not turned away.

Program staff don't have to do a lot of outreach. Because the program has been in existence for a couple of years, they are getting lots of word-of-mouth referrals and community referrals, for example from Families Together, child welfare services, clinics, and OB/GYNs. Program staff include two case specialists: an alcohol and drug counselor and a public health nurse, in addition to a parent mentor, who is someone in recovery for substance abuse. Primeros Pasos staff prefer getting women early in the pregnancy to insure better outcomes. After the referral, staff ask clients their goals. In

most cases the moms have one overriding goal, to keep their baby. Additional common goals include staying clean and sober, appropriately parenting children, getting stable housing, dealing with domestic violence issues, accessing community resources, and meeting health needs. A family assessment is completed and the program staff enter into partnership with the family to work toward their goals.

For the first 4-6 weeks, case specialists see the family two times per week. That is followed by six weeks of weekly visits, then bi-weekly visits after the moms are in treatment and following through. Some visits are in the home and some in the office. The public health nurse works with the family on parenting issues, educates about child development through the Ages and Stages Questionnaire, and supports the family in meeting its health needs. The alcohol and drug specialist provides counseling. The parent mentor takes the mom to pro-social activities, for instance Together in the Park, parenting classes, or 12 step meetings, and also helps her apply for benefits, sign up on housing lists, and build social connections.

If there are older children they are supported in getting into constructive activities. The family is supported in enrolling young children into Head Start.

A lot of families in the program have extensive histories with child welfare services and have previously had one or more children removed by the system. Sometimes the problems seem very intractable, yet the program staff still work with the women to try to help them get clean and keep their baby. Sometimes child welfare services gets involved after a subsequent referral, and Primeros Pasos will stay involved if possible. Staff work to keep the clients motivated, to prevent isolation, and to build hope. Some clients have graduated from the program and have kept their kids.

Intended Outcomes: The overall goals of the program are to keep kids with their parents and out of the child welfare system, and for moms to deliver healthy, drug-free babies. Following are some specific intended client outcomes:

- 65% more families will have 20% more clean and sober days.

- No more than 20% of families will have children removed.

- The program will assess 75 families/year and serve 45 families.

- 70% of participants will show a reduction in child abuse referrals and increase in family strengths.

- 90% of infants will have passing NCAST teaching and feeding scores.

- 70% of mothers will breastfeed.

- 90% of mothers will be connected to a primary care provider.

- Mothers have a source for and use of family planning.

- 90% of mothers have a positive screen for postpartum depression.

The program assesses outcomes utilizing a variety of tools, including: NCAST, Ages and Stages Questionnaire, UCSF questionnaire, Structured Decision Making, and the Addiction Survey Indicator.

Results and Evaluation: Following are a sample of observed and/or measured results:

- Parents establish more appropriate expectations for children.

- Parents and child demonstrate increased bonding.

- Areas of improved functioning include parent sobriety, child safety, and parent and child health.

- There are very few removals by child welfare.

- The program is meeting target population goals.

The UCSF program evaluator is Abram Rosenblatt.

Demographics: The program provides services to about 45 families per year. A single mom heads most families, however fathers are involved in almost a third of cases. About 59% of clients are Latino and about 41% are Caucasian. All of the clients have incomes at or less than 200% of the poverty level.

RELATED LOCAL EFFORTS: None

Therapeutic Intervention
LOCAL BEST PRACTICE PROGRAMS: None

There are many therapists in Santa Cruz County working with families and utilizing a number of techniques to prevent child abuse. Therapists in private practice, those working for the county, and those working for community-based agencies are undoubtedly having a positive impact on the lives of clients: providing tools for more effective parenting, supporting healing of childhood wounds in order to support people in breaking free from the abusive practices to which they were subjected, reducing stress and therefore reducing child abuse risk, etc. Agencies providing counseling services that were identified by our informants include Family Services Agency, County Mental Health, Youth Services, Mental Health Client Action Network, Community Connections, Volunteer Centers, Parent Center, Front Street, SPIN, and Survivors Healing Center. From conversations with informants, we did not get information that led us to believe that any organization was providing a specific best practice program designed to prevent abuse. The Parent Center does certainly gear programs to the issue of child abuse; the text below gives the rationale for our placement of this organization's programs in our "Related Local Efforts" section.

THERAPEUTIC INTERVENTION: RELATED LOCAL EFFORTS: Two

Trauma-Focused Cognitive Behavioral Therapy: The Parent Center is utilizing this evidence-based therapeutic model, a specific application of Cognitive Behavior Therapy (CBT) utilized to assist children, teens, and caregivers heal in the wake of child sexual abuse or other traumatic events. Given that it is use-specific for trauma survivors, it is a tertiary prevention strategy for purposes of this investigation. Even though most of the Parent Center clients do have open child welfare cases, the organization also provides therapy to people who are not child welfare involved on a sliding scale. In addition to the Trauma-Focused CBT, the Parent Center utilizes family systems work and parent education as part of its therapeutic tool kit.

MCR Therapy Program: Mountain Community Resources provides counseling for youth referred by Probation or who enter via the MCR Teen Program. An intern from New College provides the counseling services. Clients each get ten free sessions and transportation is provided. Intended outcomes are to insure teens have the tools they need to live successfully, that kids comply with the terms of their probation, and that recidivism is reduced. This is a high risk population, and there is a potential that some of these short term outcomes could result in getting on a better path that might lead to increased tools, skills, and healing, and ultimately better parenting. Evaluations are conducted via pre and post surveys. Demographic data was unavailable.

Section VI. CBC Findings & Next Steps

Community Blueprint for Children Findings

It is important to note that the data gathering phase of our efforts took much longer to complete than anticipated, therefore there was little time before the release of this report to thoroughly analyze the findings of the research. Therefore, the following key findings should be considered preliminary. Further collective review and analysis by a broad group of stakeholders would reveal more important information.

Key Finding 1:

A broad array of child abuse prevention programs are in practice in Santa Cruz County. These programs span the spectrum from programs with zero or little evidence to those that closely mirror extremely effective evidence-based practice from the field. Programs include primary and secondary prevention efforts and are offered through a number of different types of organizations: community-based agencies, governmental agencies, school districts, and collaboratives.

Key Finding 2:

Three child abuse prevention strategies are being practiced in the county through multiple applications by multiple organizations. These three strategies are parent education, home visitation, and early care and education with family support. Of these, parent education has the most applications in local practice. An interesting related finding of note is that a large number of service providers are utilizing the same best practice model for parent education. The greatest number of different best practice programs are in the home visiting category. Early care and education coupled with family support is probably reaching the largest number of people with an intervention that has a high level of evidence, due to the fact that one program, Migrant Head Start, is serving over 700 families. (Please note that all references to numbers served are gross estimates due to the limitations described in Section V: Assessment Results, under the subsection entitled General Comments on Assessment Results.)

Key Finding 3:

There are notable gaps in best practice offerings. Most of the remaining strategies in our matrix are not being offered locally in a manner that is reflective of best practices in the field, or are only being offered thus by one program. As a matter of full disclosure, we note that in some cases, for instance differential response, there is no need to have more than one program, however this program has are other capacity considerations that will be discussed in Key Finding 4. There are also some strategies that lack sufficient evidence base in the field (public education campaigns and community engagement), and this fact is reflected in local practice. There are a number of school-based prevention programs in the field that have some level of evidence; the lack of evidence of such programs locally may be partly due to the fact that this was not our most thoroughly researched strategy. In most of the strategies in our matrix, there are more practices locally that do not closely match best practices in the field than those that do.

Key Finding 4:

Programs do not meet the need or potential need for child abuse prevention services. Most programs are at capacity, serving more people than their stated capacity, or have waiting lists. Additionally, there is potential need that is not being realized due to several factors, including the fact that limited capacity issues discourage agencies from

more complete outreach. Another factor is that eligibility criteria may be set in such a way as to be able to serve those with the highest need, as opposed to everyone who has need. According to the US Census Bureau, there are over 29,000 families with children under 18 years old in Santa Cruz County. Although limitations in our research do not allow us to provide the number of families participating in child abuse prevention programs, we believe we can safely state that the full need for such programs is not being met by the current programs. Based on our research, we estimate that the number of families receiving services in a manner that is adequate to prevent abuse is a small percentage of all families in county.

Key Finding 5:
Programs in our county modeled after best practices in the field, where they exist, have broadly differing levels of evidence. For example Head Start is an evidence-based strategy, Positive Discipline is a promising practice, and Cara y Corazon is an emerging practice.

Key Finding 6:
One of the most effective evidence-based practices in the field, Nurse Family Partnership, is not being offered locally. One of the public health nurses at the Health Services Agency is trained in the model created by David Olds, however there is no funding to do the program.

Next Steps
The information in the Community Blueprint for Children report represents a strong foundation on which to build a broad community engagement process with the intent of creating a comprehensive, systematic, countywide approach to child abuse prevention. The current lead agency for CBC, the Santa Cruz County Child Abuse Prevention Council is in a transition phase in which the agency is planning to dissolve as a stand-alone nonprofit and merge with another organization. This change has been triggered by the loss of more than half of the revenues that have been supporting the agency's work. Due to the fact that there are still many unknowns, including what entity will take on the child abuse prevention council role in our county, whether or not that entity will have an interest in taking CBC to the next phase, and whether there are resources to carry the work forward, the following next steps are general ideas about what could potentially be done, dependent on the answers to the above questions.

- Distribute the report widely, and invite input from the community to further complete the assessment process.

- Utilize data from the report to build public will for a community engagement process to create a comprehensive, systematic approach to child abuse prevention.

- With input from interested stakeholders, design the community engagement process. A starting point is the CBC roadmap created by the Preplanning Team.

- Insure all stakeholders review and understand the data.

- Review and amend key findings.

- Review recent research findings for community-based initiatives for updated information.

- Discuss and agree on values and guiding principles for use in designing the plan. Suggestions to discuss from one of our Preplanning Team members are insuring integration of existing programs into a comprehensive continuum of services from primary prevention through intervention and treatment, develop strategies to increase both capacity and depth of services (e.g. to be able to serve all age groups), utilize a family-strengths model in program development, and insure that prevention activities are prioritized appropriately.

- Designate upstream indicators that can be tracked. Complete baseline assessment.

- In alignment with plan for community engagement process, create, modify, and adopt the Community Blueprint for Children plan. In creating the plan, utilize all the data, including the responses to the open-ended questions on the CBC survey. Consider existing local programs and also cultural appropriateness in creating the plan.

Appendices

Appendix A: Community Initiatives Research Process & Outcomes

Summary: The purpose of this document is to convey the parameters, scope, and methods used to identify and learn about successful community initiatives that have the potential to be models for our local project. While no claim is being made that the projects identified represent an exhaustive list of all possible similar initiatives, this document should support Children's Network Child Abuse Oversight Committee members in appreciating the state of the field.

Parameters: The intent of the research was to find initiatives that fit within the following parameters:

- Intention: projects which had as their intent the reduction of child abuse

- Community Initiative: projects which comprehensively worked toward reduction of abuse community-wide and utilized community partners, as opposed to stand-alone programs or services

- Successful: projects which have a significant track record in reducing rates of child abuse within the community

Research Method: Leads were sought from multiple sources, then investigated via web research and telephone/email conversations with project administrators. In addition, web research was done using a search engine with multiple queries including some of the following:

- "child abuse" reduction initiative

- "child abuse" reduced rates

- "child abuse" reduction community goal

- child abuse prevention initiatives

- child abuse reduction community efforts

Initial organizations/individuals consulted for leads include:

- Anna Shetka, State of California Office of Child Abuse Prevention

- Angie Dillon-Shore, Child Abuse Training and Technical Assistance Center

- Scott Moak, Prevent Child Abuse California

- Barbara Rawn, Prevent Child Abuse America

- Kevin Kirkpatrick, Metropolitan Group

- members of Greater Bay Area Child Abuse Prevention Council Coalition

- Linda Johnson, Prevent Child Abuse Vermont

All of these contacts resulted in one or more leads. Those that appeared to fit the research parameters were investigated, and often more leads were uncovered in the process.

<u>Scope</u>: Ultimately, only a few identified projects fit research parameters. These are listed below, along with some projects that didn't make the cut. Information about some of these projects might also help our local effort. Initiatives identified as successful or promising will be detailed in other documents in this report. Initiatives that were not successful, are in the very early stages, or did not meet parameters for some other reason will be briefly described here.

Successful Community Child Abuse Reduction Initiatives

- Hampton Healthy Families, Hampton, Virginia

- Vermont Partnership for an Abuse Free State

Promising Community Child Abuse Reduction Initiative

- Strong Families for Children, southern Greenville County, South Carolina, and adjoining communities

Initiatives in Early Stages:

- Durham Family Initiative, Durham, North Carolina: an initiative to promote healthy parent-child relationships and the health and well-being of children in Durham, North Carolina. A core goal is to reduce child-abuse rates by 50% through a comprehensive community and family-based approach. Although the project was initiated in 2002, the Project Director indicated that they have not made much progress to date.

- Solano County, California: just now beginning to plan an initiative

- Ventura County, California just now beginning to plan an initiative

Initiatives Which Did Not Reduce Child Abuse Rates

- Creating Community Partnerships for Child Protection, four pilot sites in cities in Iowa, Florida, Kentucky, and Missouri: Eight year (1996-2004) foundation initiated pilot project intended to reduce abuse and reoccurrence of abuse by reforming child welfare practices, strengthening community collaboration, and creating neighborhood networks to increase both formal and informal support. The evaluation of the project concluded that the project did not consistently demonstrate reduced rates of subsequent abuse, nor did it consistently demonstrate reductions in reporting and substantiation rates, with the exception of one pilot site.

Wild Goose Chases Which Nevertheless May Prove Helpful

- Comprehensive Child Abuse Prevention Plan, Orange County: Two pieces of information discovered in the research indicated that Orange County might have an initiative that fit our parameters. One of these was "Comprehensive Child Abuse Prevention Plan for Orange County," a report and request for approval to the Orange County Board of Supervisors in 2000. A review of Orange County child welfare data revealed a distinct downward trend in substantiations starting in 2001. Orange County was also one of two counties that OCAP suggested

investigating. Ray Gallagher, the Deputy Director of Children and Family Services in Orange, stated that there may be a cause and effect relationship between the two, but there may not be. There are some innovative things being done in Orange County that we may choose to investigate further.

- Safe Kids/Safe Streets, five sites in different communities funded by the Office of Juvenile Justice and Delinquency Prevention. The funder has asked for a child abuse reduction outcome, however most of the sites have not specifically named this as an outcome for their projects. These are mostly secondary and tertiary prevention, although one site has a primary prevention component. The first evaluation will be available in a couple of months.

- Triple-P Positive Parenting Program: This program can be used as one strategy in or even the basis of a community-wide initiative aimed to reduce child abuse and neglect, in fact Mendocino County is using it as a core strategy of a children's mental health initiative. The intervention (or more accurately the Behavioral Family Intervention (BFI) method on which it is based) has ample empirical evidence to document its effectiveness in reducing problem behaviors in children and of increasing parental competence. As of this writing there do not appear to be any model initiatives that have demonstrated community-wide changes as a result of this intervention however, so it doesn't fit our research criteria.

Inconclusive Initiatives/Searches

- Massachusetts Citizens for Children: State Call to Action: a comprehensive plan intended to reduce abuse rates. Attempts to discover the outcome of the initiative have been unsuccessful.

- San Diego County, California: This is the second county referred by OCAP and also a county where a downward trend has occurred, however attempts to find out information were unsuccessful. There does not appear to be a comprehensive initiative in place, therefore the project does not meet the "intention" aspect of our parameters.

Appendix B: Successful Community Child Abuse Prevention Projects: Facts in Brief

Successful or Promising Child Abuse Reduction Projects
Facts in Brief

Project Name/ website	Location	Contact	Project Start Date	Brief Description	Selected Project Components	Demonstrated Outcomes
Strong Communities for Children http://www.clemson.edu/strongcommunities/about.html	southern Greenville County, South Carolina, and adjoining communities in Anderson and Laurens counties	Dr. Gary B. Melton, Director, Institute on Family and Neighborhood Life, Clemson University, Clemson, SC	Spring, 2002	Strong Communities is a comprehensive effort to prevent child maltreatment by building systems of support for families of young children. The underlying philosophy of the project is that child protection must become a part of everyday life in the neighborhoods where children live, study, and play if it is to be effective. The safety of children depends on the establishment of a norm of mutual assistance for all families so that the children most at risk are protected.	• community mobilization by outreach workers • engagement of broad spectrum of community partners • volunteer "Family Friends" • professional family advocates as needed • Family Activity Centers (like FRCs) • newsletter to all families with children 0-3 • parent engagement and leadership development	not yet available
Hampton Healthy Families Partnership http://www.hampton.gov/healthyfamilies/info.html	Hampton, Virginia	Debbie Russell, Resource Development & Communications Manager	1991	Hampton Healthy Families Partnership is a team effort in which city and community agencies have joined together with public and private organizations such as hospitals, restaurants, businesses, and banks to help the families in the community become healthy, happy, and self sufficient. The project's goal is to ensure that every child in Hampton is born healthy and enters schools ready to learn.	• 12 week prenatal parenting program • universal home visits for all families with newborns • welcome baby kit • extended home visitation for eligible families • free newsletter for all families • family centers in all public libraries • broad array of parenting classes • teen pregnancy prevention program	Community-wide: • 26.8% reduction in substantiated cases of child abuse between 1992 and 2000 • decreased infant mortality rate • changed community norms around parenting Healthy Start outcomes: • decreased pregnancy risk factors • increased immunizations • improved home environments • decreased child abuse rate • decreased repeat teen births • greater school readiness
Vermont Partnership for an Abuse Free State no website for project. Prevent Child Abuse Vermont: http://www.pcavt.org/	Vermont	Linda E. Johnson, Executive Director, Prevent Child Abuse Vermont	1990s	Vermont Partnership for an Abuse Free State came together in response to extremely high rates of child sexual abuse in Vermont. A group came together to address the problem and developed a 20 year action plan which was submitted to the Governor and approved. They consider it a "whole cloth" approach and cannot/will not attribute their successes to any one intervention or subset of interventions, but to the implementation of the plan as a whole.	• parent/child centers (home visiting/workshops/classes/etc.) • Nurturing Parents Program • trainings • healthy sexuality programs • Stop it Now - no longer in VT • juvenile perpetration prevention programs • model sex offender treatment programs • legislation	• 37% decrease in child sexual abuse between 1992-1997 • 49% decrease in sexual abuse of children 0-5 years of age • 38% decrease in physical abuse • 40% decrease in neglect • changed community norms around corporal punishment

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Appendix C: CBC Vision, Values, and Purpose

Community Goals	1. By 2010, children in Santa Cruz County will live in safer families and communities. (Champions = CAPC, CASA) 2. By 2010, families and children will have access to the information, resources and support they need to succeed. (Champion = FRN)
Purpose of Planning Process	To develop a community-wide action plan to improve the safety and well-being of children and families in Santa Cruz County.
Vision of Success	A broad base of stakeholders demonstrates support and ownership of a comprehensive plan for improving the safety and well-being of children and families in Santa Cruz County.
Values That Will Drive the Planning Process	We agree to: • Utilize evidence-based and promising practices in the areas of primary and secondary prevention. • Build on existing efforts in the community in order to leverage resources and avoid duplication. • Use a strengths-based approach with each other and when addressing needs of children and families. • Practice "out-of-the-box" thinking that focuses on possibilities versus limitations; • Allow room for controversy in a way that is respectful and productive. • Engage a broad representation of partners in the planning process, including both "traditional" service providers and "non-traditional" partners. • Address a continuum of supports that reflects the diversity of families' needs.

Decision-Making Procedure	Meta-Decision using Gradients of Agreement (with Majority Vote as a fall-back)
	
	1. Identify the *Poll Assessor* (rotate each meeting).
	2. The *Facilitator* leads the discussion. Everyone can participate in the discussion.
	3. Any group member can call to close the discussion.
	4. The group member that closes the discussion clarifies the proposal, and the *Facilitator* writes it down.
	5. The *Facilitator* polls the voting members using the Gradients of Agreement. (1 agency = 1 rating)
	
	7. The *Facilitator* records the poll results according to the Gradients of Agreement.
	8. The *Poll Assessor* decides:
	   a) We need more discussion **or** b) The poll is good enough to be the final decision
	               (As long as there are no "5's")
	
	9. If more discussion is needed, repeat steps 2-8.
	10. If after three rounds of discussion there is still no decision, a final vote will be taken with one vote per agency. A 2/3-majority vote is needed to ratify the decision.

Gradients of Agreement	1	2	3	4	5
	I strongly support this.	I basically like this (minor points of contention).	I can live with it.	I don't like this, but I won't block.	I strongly object. I'd block if I could.

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Appendix D: CBC Terms and Definitions

Term	Source	Clarification/Definition
At-risk	Adapted from ADVFN Financial Glossary	Exposed to risk factors of child abuse that may lead to the possibility of harm
Best Practice	Implementing Best Practices Initiative, May 2004 http://www.hopkinsmedicine.org/ccp/ibp/Bestpractices.htm	When the term "Best Practice" is used, it refers to an array of evidence-based tools, materials and practices, including guidelines, norms, standards, experiences and skills, among others, that have proven their worth.
Child Abuse and Neglect	California Penal Code, Section 11165.6	11165.6. As used in this article, the term "child abuse or neglect" includes physical injury inflicted by other than accidental means upon a child by another person, sexual abuse as defined in Section 11165.1, neglect as defined in Section 11165.2, the willful harming or injuring of a child or the endangering of the person or health of a child, as defined in Section 11165.3, and unlawful corporal punishment or injury as defined in Section 11165.4. "Child abuse or neglect" does not include a mutual affray between minors. "Child abuse or neglect" does not include an injury caused by reasonable and necessary force used by a peace officer acting within the course and scope of his or her employment as a peace officer.
Child Abuse	California DSS Manual of Policies and Procedures, Section 31-002(c) (9)	"Child Abuse" means the nonaccidental commission of injuries against a person. In the case of a child, the term refers specifically to the nonaccidental commission of injuries against the child by or allowed by a parent(s)/guardian(s) or other person(s). The term also includes emotional, physical, severe physical and sexual abuse as defined in Sections 31-002 (c) (9)(A) through (D). (A) "Emotional abuse" means nonphysical maltreatment, the results of which may be characterized by disturbed behavior on the part of the child such as severe withdrawal, regression, bizarre behavior, hyperactivity, or dangerous acting-out behavior. Such disturbed behavior is not deemed, in and of itself, to be evidence of emotional abuse. (B) "Physical abuse" means nonaccidental bodily injury that has been or is being inflicted on a child. It includes, but is not limited to, those forms of abuse defined by Penal Code Sections 11165.3 and .4 as "willful cruelty or unjustifiable punishment of a child" and "corporal punishment or injury." (C) "Severe physical abuse" means any single act of abuse which causes physical trauma of sufficient severity that, if left untreated, it would cause permanent physical disfigurement, permanent physical disability, or death; any single act of sexual abuse which causes significant bleeding, deep bruising, or significant external or internal swelling; or repeated acts of physical abuse, each of which causes bleeding, deep bruising, significant external or internal swelling, bone fracture, or unconsciousness. (D) "Sexual abuse" means the victimization of a child by sexual activities, including, but not limited to, those activities defined in Penal Code Section 11165.1.

Term	Source	Clarification/Definition

Child Neglect	California Penal Code, Section 11165.2	11165.2 As used in this article, "neglect" means the negligent treatment or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person.
		   (a) "Severe neglect" means the negligent failure of a person having the care or custody of a child to protect the child from severe malnutrition or medically diagnosed nonorganic failure to thrive. "Severe neglect" also means those situations of neglect where any person having the care or custody of a child willfully causes or permits the person or health of the child to be placed in a situation such that his or her person or health is endangered, as proscribed by Section 11165.3, including the intentional failure to provide adequate food, clothing, shelter, or medical care.
		   (b) "General neglect" means the negligent failure of a person having the care or custody of a child to provide adequate food, clothing, shelter, medical care, or supervision where no physical injury to the child has occurred.

	California DSS Manual of Policies and Procedures, Section 31-002(n)	Neglect means the failure to provide a person with necessary care and protection. In the case of a child, the term refers to the failure of a parent(s)/guardian(s) or caretaker(s) to provide the care and protection necessary for the child's healthy growth and development. Neglect occurs when children are physically or psychologically endangered. The term includes both severe and general neglect as defined by Penal Code Section 11165.2 and medically neglected infants as described in 45 Code of Federal Regulations (CFR) Part 1340.15(b).
Client Outcome Objective	What Works Common Definitions. 1999	A specific, measurable statement of the service's intended effect on a client's knowledge, attitude, condition and behavior. Example: Improvement in parent functioning.
Cross-system approach	King County, Washington. Department of Community and Human Services http://www.metrokc.gov/dchs/mhd/children.htm	A service approach that recognizes that unmet service needs of children, youth and their families are not and must not be the sole responsibility of any one formal system. For children and youth to lead fully functional lives, they must be able to succeed at school, in their homes, at work, and in their communities. Cross-system collaborations and partnerships foster cooperative approaches.
Differential Response Keep both definitions for clarity	US DHHS, Admin for Children & Families, National Clearinghouse on Child Abuse and Neglect Info, Glossary California Breakthrough Series Collaborative on Differential Response	Differential Response - an area of CPS reform that offers greater flexibility in responding to allegations of abuse and neglect. Also referred to as "dual track" or "multi-track" response, it permits CPS agencies to respond differentially to children's needs for safety, the degree of risk present, and the family's needs for services and support. A child welfare intake structure that allows for assessment of need and follow up services for all families reported to the county child abuse hotlines, from connecting families with public and community resources with no open child welfare case; to voluntary child welfare services with public and community partner involvement; to court-ordered child welfare services with public and community resources. The goal is to engage families and agency teams in the assessment of families' strengths and needs so that they may receive services and support to address problems early, preventing future referrals and promoting timely safe and permanent homes for children.

Term	Source	Clarification/Definition
Evidence-based Practice	CWS Redesign Final Report	A set of tools and resources for finding and applying the best current research evidence to service delivery, and integrating this information with clinical expertise and client values.
Family support	Family Support America. http://www.familysupportamerica.org/content/learning_dir/about_fs.htm	**A set of beliefs and an approach** to strengthening and empowering families and communities so that they can foster the optimal development of children, youth, and adult family members. **A type of grassroots, community-based program** designed to prevent family problems by strengthening parent-child relationships and providing whatever parents need in order to be good nurturers and providers. These programs have been proliferating across the country since the 1970s. **A shift in human services delivery** that encourages public and private agencies to work together and to become more preventive, responsive, flexible, family-focused, strengths-based, and holistic—and thus more effective. **A movement for social change** that urges all of us—policymakers, program providers, parents, employers—to take responsibility for improving the lives of children and families. The family support movement strives to transform our society into caring communities of citizens that put children and families first and that ensure that all children and families get what they need to succeed.
Indicator *Synonyms: benchmark, milestone, performance indicator*	Mark Friedman, Fiscal Policy Studies Institute. 1999 Family Support America website	A measure, for which data is available, which helps quantify the achievement of a result (outcome). Several indicators can pertain to each outcome. For example: indicators pertaining to healthy children could include immunization rates, rates of various diseases, and rates of exercise.
Intervention	Adapted from County of Santa Clara, Phase II Children & Family Services and Investment Profile. June 2002)	Intervention services for child abuse and neglect are services provided to children, youth and families who are already manifesting problems related to child maltreatment. Intervention services are designed to reduce the severity of the problems and / or reduce further complications

Leveraging	Adapted from http://regcol.edb.utexas.edu/Barufaldi/Publication/dynamic.pdf University of Texas	A method by which to enhance services through the maximization of funds by utilizing public or private resources to access other funds. Can be used as criteria when applying for funds. The leveraging of funds through cost sharing and in-kind contributions by human and financial resources
Outcome *Synonyms: Community goal (What Works), result, goal*	Mark Friedman, Fiscal Policy Studies Institute. 1999 Innovation Network www.innonet.org	A condition of well-being for children, adults, families or communities. Examples: healthy births; children succeeding in school. • Shorter-Term Outcome: outcome achieved during the program's timeframe, is within program's control • Intermediate Outcome: outcome achieved at the end of or beyond the program's timeframe • Longer-Term Outcome: outcome achieved after the program's timeframe, is outside the program's direct control
Performance Measure *Synonym: program measure*	Mark Friedman, Fiscal Policy Studies Institute. 1999	A measure of how well agency or program service delivery is working. Example: Percent of teen parents keeping clinic appointments; child abuse investigations initiated within 24 hours.
Prevention	CWS Redesign Final Report	Service delivery and family engagement processes designed to mitigate the circumstances leading to child maltreatment before it occurs.
Prevention - Primary	US DHHS, Admin for Children & Families, National Clearinghouse on Child Abuse and Neglect Info, Glossary	Activities geared to a sample of the general population to prevent child abuse and neglect from occurring. Also referred to as "universal prevention."
Prevention - Secondary	US DHHS, Admin for Children & Families, National Clearinghouse on Child Abuse and Neglect Info, Glossary	Activities targeted to prevent breakdowns and dysfunctions among families who have been identified as at risk for abuse and neglect.
Prevention - Tertiary	US DHHS, Admin for Children & Families, National Clearinghouse on Child Abuse and Neglect Info, Glossary	Activities or treatment efforts geared to address situations where child maltreatment has already occurred with the goals of preventing child maltreatment from occurring in the future and of avoiding the harmful effects of child maltreatment.
Promising Practice	Promising Practices Network www.promisingpractices.net/orientation2.asp	When the term "Promising Practice" is used, it refers to programs whose publicly available evaluation shows a positive effect. It may not have been replicated.

Strategy *Synonym: Service Strategy*	What Works CommonDefinition. 1999	A general approach to achieve the outcome or goal. Examples: school-linked center- based, home-based.
Sustainability	Non-profit Good Practice Guide www.nonprofitbasics.org	The ability of an organization to develop a strategy of growth and development that continues to function indefinitely.
System	Merriam-Webster Dictionary, Merriam-Webster OnLine, m-w.com/dictionary	A regularly interacting or interdependent group of items forming a unified whole (a number *system*); a group of interacting bodies under the influence of related forces (a gravitational *system*); a group of devices or artificial objects or an organization forming a network especially for distributing something or serving a common purpose; an organized set of doctrines, ideas, or principles usually intended to explain the arrangement or working of a systemic whole; an organized or established procedure; a manner of classifying, symbolizing, or schematizing.
System of Care	US DHHS, Admin for Children & Families, National Clearinghouse on Child Abuse and Neglect Information	System of Care is a process of partnering an array of service agencies and families, working together to provide individualized care and supports designed to help children and families achieve safety, stability and permanency in their home and community. This approach facilitates these partnerships to create a broader, more seamless array of services and supports. This approach is based on the development of a strong infrastructure of interagency collaboration, individualized care practices, culturally competent services and supports, and child and family involvement in all aspects of the system. The end result is better outcomes for children and families.
Target population	Adapted from Monihan. Creating Target Population Estimates using National Survey Data. University of Illinois http://www.uic.edu/sph/dataskills/publications/wrkbkpdfs/chap6.pdf	Target populations may be defined by a number of variables including but not limited to: age and sex, program eligibility, income level, risk factors, service needs or demographics.
Treatment	US DHHS, Admin for Children & Families, National Clearinghouse on Child Abuse and Neglect Info, Glossary	The stage of the child protection case process when specific services are provided by CPS and other providers to reduce the risk of maltreatment, support families in meeting case goals, and address the effects of maltreatment.

Appendix E: Ecological Model of Child Abuse

An Ecological Model of Child Maltreatment

Adapted from: New Directions for North Carolina

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

http://www.preventchildabusenc.org/taskforce/report

	Cultural/Societal	Community	Family	Individual Parent
Risk Factors	▪ Societal norm of violence ▪ Sanctioned violence against children ▪ Secondary status of children ▪ Prioritization of families' "privacy" over protection of children	▪ Unemployment ▪ Poverty ▪ Housing ▪ Lack of informal/formal family supports ▪ Isolation	▪ Child/Parent interaction ▪ Parental stress ▪ Parental discord ▪ Isolation from extended family ▪ Domestic violence	▪ Parenting skills and capacities ▪ Child development knowledge ▪ Past history of abuse ▪ Substance abuse ▪ Mental illness ▪ Special needs child
Protective Factors	▪ Society discourages violence ▪ Support of families' basic needs ▪ Collective responsibility for children's health, safety and well-being	▪ Neighborhoods that are stable and cohesive ▪ Access to adequate healthcare, quality education and employment services	▪ Availability of caring and emotionally supportive family, friends, siblings, teachers and neighbors ▪ Presence of adult role models ▪ Marital harmony	▪ A supportive, helpful person available at birth of child ▪ Social network of relatives or friends ▪ Emotionally satisfying relationships with others

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Appendix F: Risk and Protective Factors

Common Risk Factors for Child Abuse and Neglect

Child risk factors
- Premature birth, birth anomalies, low birth weight, exposure to toxins *in utero*
- Temperament: difficult or slow to warm up
- Physical/cognitive/emotional disability, chronic or serious illness
- Childhood trauma
- Anti-social peer group
- Age
- Child aggression, behavior problems, attention deficits

Parental/family risk factors
- Personality factors
- External locus of control
- Poor impulse control
- Depression/anxiety
- Low tolerance for frustration
- Feelings of insecurity
- Lack of trust
- Insecure attachment with own parents
- Childhood history of abuse
- High parental conflict, domestic violence
- Family structure—single parent with lack of support, high number of children in household
- Social isolation, lack of support
- Parental psychopathology
- Substance abuse
- Separation/divorce, especially high conflict divorce
- Age
- High general stress level
- Poor parent-child interaction, negative attitudes and attributions about child's behavior
- Inaccurate knowledge and expectations about child development

Social/environmental risk factors
- Low socioeconomic status
- Stressful life events
- Lack of access to medical care, health insurance, adequate child care, and social services
- Parental unemployment; homelessness
- Social isolation/lack of social support
- Exposure to racism/discrimination
- Poor schools
- Exposure to environmental toxins
- Dangerous/violent neighborhood
- Community violence

*Please note that this is not an all-inclusive or exhaustive list. These factors do not imply causality and should not be interpreted as such.

Common Protective Factors for Child Abuse and Neglect

Child protective factors
- Good health, history of adequate development
- Above-average intelligence
- Hobbies and interests
- Good peer relationships
- Personality factors
- Easy temperament
- Positive disposition
- Active coping style
- Positive self-esteem
- Good social skills
- Internal locus of control
- Balance between help seeking and autonomy

Parental/family protective factors
- Secure attachment; positive and warm parent-child relationship
- Supportive family environment
- Household rules/structure; parental monitoring of child
- Extended family support and involvement, including caregiving help
- Stable relationship with parents
- Parents have a model of competence and good coping skills
- Family expectations of pro-social behavior
- High parental education

Social/environmental protective factors
- Mid to high socioeconomic status
- Access to health care and social services
- Consistent parental employment
- Adequate housing
- Family religious faith participation
- Good schools
- Supportive adults outside of family who serve as role models/mentors to child

Excerpted from *Emerging Practices in the Prevention of Child Abuse and Neglect*, (2003) U.S. Department of Health and Human Services, Administration for Children and Families, Administration for Children, Youth, and Families, Children's Bureau, Office on Child Abuse and Neglect
Updated on May 30, 2006

Source: http://www.childwelfare.gov/preventing/overview/commonfactors.cfm

Appendix G: Continuum of Child Abuse Prevention Practices

Continuum of Child Abuse Prevention Practices

Also referred to as	EVIDENCE-BASED PRACTICE *Demonstrated Effective, Proven*	PROMISING PRACTICE *Reported Effective*	EMERGING PRACTICE *Innovative*
Study design used to determine effectiveness	Experimental (e.g. randomized control group)	Quasi- or non-experimental (e.g. single subject, non-randomized control group)	No comparison group *or* research not completed yet
Documentation	There is a book, manual and/or other written information that <u>specifies the components</u> of the practice protocol and <u>describes how to implement it</u>.	There is a book, manual and/or other written information that <u>specifies the components</u> of the practice protocol and <u>describes how to implement it</u>.	There is a book, manual and/or other written information that <u>specifies the components</u> of the practice protocol and <u>describes how to implement it</u>.
Level of Evidence	There is <u>empirical evidence</u> that the child abuse prevention practice is effective in reducing known risk factors and/or enhances known protective factors.	There is a <u>sound theoretical basis</u> for believing that the child abuse prevention practice is effective in reducing known risk factors and/or enhances known protective factors.	The child abuse prevention practice represents a new or innovative approach that <u>needs further research</u> to demonstrate its effectiveness.
Conclusiveness of Outcomes	Outcomes are considered <u>conclusive</u> based on strength of study design.	Outcomes are <u>not considered conclusive</u> because of study design considerations.	There is <u>not enough research</u> to determine the conclusiveness of outcomes.
Availability of Results	Publicly Available	Publicly Available	Limited Distribution

Adapted from:

- The California Evidence-Based Clearinghouse for Child Welfare, Scientific Rating Scale (http://www.cachildwelfareclearinghouse.org/scientific-rating/scale#rating1)
- Child Welfare Information Gateway, Emerging Practices in the Prevention of Child Abuse and Neglect (http://www.childwelfare.gov/preventing/programs/whatworks/report/report.pdf)
- Promising Practices Network, Evidence Criteria (http://www.promisingpractices.net/criteria.asp)

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Appendix H: Best Practices Matrix

	Child Abuse Prevention Practice	Examples	Evidence-Based (EB), Promising (Pr) or Emerging (Em)	To What Extent (Target Population, #'s Served, Geographic Area, etc)	Outcome(s)	Indicators	Critical Program Elements
PRIMARY PREVENTION	Public education campaign	Don't Shake a Baby http://www.dontshakeababy.com/	Pr, Em				• Specific target audience identified • Message content based on opinions of experts or focus groups • Emotional aspect (fear, anxiety) paired with action steps • Control over message placement • High production quality • Pre-test campaign theme and message
		Triple-P Positive Parenting Program – Level 1 http://www.triplep-america.com/whatis/triplepwhatis.htm	EB (complete program)	Target Population: All parents interested in information about promoting their child's development	• Positive parenting practices • Positive community attitudes towards parenting • Receptivity to program/seeking help	• Child behaviors • Parenting confidence • Parenting practices • Satisfaction with program	• Video-taped television series on Triple P • Parents watched all episodes • Handouts complemented each episode
	Prenatal Screening for Risk Factors	Perinatal SART/4 P's Plus	EB	Target Population: All pregnant women	• Pregnant women at risk for substance abuse, depression or domestic violence receive in-depth assessment and monitoring		• Screen all pregnant women for substance abuse, depression or domestic violence • Assess women with a positive screen • Refer for full assessment and appropriate treatment • Provide gender-specific treatment
	Universal home visiting	Minnesota Healthy Beginnings		Target Population: All families before and			

	Child Abuse Prevention Practice	Examples	Evidence-Based (EB), Promising (Pr) or Emerging (Em)	To What Extent (Target Population, #'s Served, Geographic Area, etc)	Outcome(s)	Indicators	Critical Program Elements
PRIMARY PREVENTION				following the birth of a baby to age one			
	School-based violence prevention programs	Roots of Empathy http://www.rootsofempathy.org/	EB/Pr	Target Population: School-age children K-8th	• Children are socially and emotionally competent • Children are knowledgeable about human development and effective parenting practices	• Pro-social behaviors • Aggressive behaviors	• Monthly classroom visits by infant and parent • Intensive training, certification and mentoring for program instructors
	Parent Education	Positive Discipline http://www.positivediscipline.com/	Pr	Target Population: Children/youth Adults (parents, teachers, childcare providers, etc)	• Improved parenting skills		
		Nurturing Parenting Programs http://www.nurturingparenting.com/index.htm	Pr (FRIENDS National Resource Center for Community-Based Child Abuse Prevention)	Target Population: Parents and children prenatal – adolescence	• Knowledge of child development • Nurturing parenting skills	• Parenting attitudes • Use of nurturing parenting concepts, practices and strategies	• Group activities for parents and children (according to age) • Focus on parenting skills and self-improvement/nurturing • Family Nurturing Time part of curriculum • Formal training for program facilitators
		Parents Under Construction http://www.childbuil	Pr	Target Population: School-age children	• Children's knowledge of parenting skills • Children's positive	•	• Parent involvement

	Child Abuse Prevention Practice	Examples	Evidence-Based (EB), Promising (Pr) or Emerging (Em)	To What Extent (Target Population, #'s Served, Geographic Area, etc)	Outcome(s)	Indicators	Critical Program Elements
		ders.org/programP UC.htm			attitudes about mentally healthy discipline techniques		
	Community Engagement	Strong Communities http://www.clemson.edu/strongcommunities/about.html	Em		• Community concern for child well-being • Neighborhood involvement • Institutional and organizational support Parenting efficacy	• Rates of child injuries due to maltreatment •	
SECONDARY PREVENTION	**Targeted home visiting**	Nurse Family Partnership http://www.nursefamilypartnership.org/index.cfm?fuseaction=home	EB (Promising Practices Network)	Target Population: First-time mothers, pregnancy – 2 yrs; new mothers w/ additional risk factors	• Improved pregnancy outcomes • Decreased substance abuse • Improved child health, development and safety • Enhanced parent life-course development	• Health-related behaviors in pregnancy • Qualities of parent care-giving (including child abuse rates) • Rates of subsequent pregnancy • Educational achievement • Participation in workforce • Use of welfare	• Services provided by registered nurses • Home visiting schedule follows developmental stages of pregnancy and early childhood • Uses mother's existing support system to help family access health and human services • .5 FTE nursing supervisor for every 4 nurses
		Healthy Families New York http://www.healthyfamiliesnewyork.org/	EB (Promising Practices Network)	Target Population: Expectant parents and parents w/infant >3 months considered at risk for child abuse and neglect Geographic Area: New York	• Healthy and Safe Children	• Parents self-report fewer acts of abuse/ neglect • Substantiated child abuse/ neglect reports • Babies born weighing 5.5 pounds or more	• Based on Healthy Families America home visiting model

	Child Abuse Prevention Practice	Examples	Evidence-Based (EB), Promising (Pr) or Emerging (Em)	To What Extent (Target Population, #'s Served, Geographic Area, etc)	Outcome(s)	Indicators	Critical Program Elements
SECONDARY PREVENTION		Healthy Families America http://www.healthyfamiliesnewyork.org/	Pr (FRIENDS National Resource Center for Community-Based Child Abuse Prevention)	Target population: may vary by community/ state Geographic Area: Programs are located in 450 communities in 38 states, D.C. and Canada	• Reduced child maltreatment rates • Enhanced maternal and child health outcomes • Improved children's cognitive and emotional development • Improved maternal life course outcomes	• Child abuse reports • Parent-child interactions • Health care utilization • Utilization of formal and informal social supports • Child cognitive and social development	• Universal screening prenatally or at birth w/standardized risk assessment tool • Services are voluntary and long-term • Services support the parent, parent-child interaction and child development. • Families are linked to a medical provider and other services. • Staff have limited caseloads. • Service providers are selected based on their ability to establish a trusting relationship. • Service providers receive comprehensive training.
	Early care and education w/ comprehensive family support	Child-Parent Centers	EB (Promising Practices Network)	Target Population: Low-income children in preschool – 3rd grade Geographic Area: Chicago, IL	• Healthy and safe children • Children ready for school • Children succeeding in school	• Students performing at grade level or meeting state curriculum standards • Students graduating from high school	• Center is directed by head teacher • Teacher-to-child ratio is 1:8 in preschool class • Teacher-to-child ratio is 1:12 in K-3 classes • Parents required to volunteer • Staff provide outreach (includes recruitment), home visits (upon enrollment and ongoing as needed), referrals, transportation • Children undergo health screening from registered nurse • All children receive free breakfast and lunch

	Child Abuse Prevention Practice	Examples	Evidence-Based (EB), Promising (Pr) or Emerging (Em)	To What Extent (Target Population, #'s Served, Geographic Area, etc)	Outcome(s)	Indicators	Critical Program Elements
		High/Scope Perry Preschool http://www.highscope.org/index.asp	EB	Target Population: Low-income children in preschool	• Children succeeding in school • Economic stability • Healthy family functioning	•	• Program run by teachers with bachelor's degrees and certification in education • Teacher-to-child ratio is 1:8 • Program runs for 2 school years for children who are 3 and 4 years of age with daily classes of 2 ½+ hours • Uses the High/Scope model or a similar participatory education approach • Teachers visit families at least every two weeks or schedule regular parent events
		Head Start/Early Head Start	EB	Target Population: Low-income pregnant women and families with children birth-5	• Healthy prenatal outcomes • Healthy child development • Healthy family functioning • Children ready for school	•	• Follow Head Start Performance Standards
	Parent Education/ Training	Strengthening Families http://www.strengtheningfamiliesprogram.org/	EB (FRIENDS National Resource Center for Community-Based Child Abuse Prevention)	Target Population: At-risk parents/ caregivers and children 3-17 y.o.	• Decrease behaviors related to risk factors • Increase behaviors related to protective factors	• Family conflict and stress • Child depression and aggression • Parent and child substance use • Parenting skills • Children's social skills	• Full implementation of 12-14 parent, child, and family skills training sessions using the SFP manuals. • Implemented in groups of 4 to14 families. • Trained and experienced staff consisting of a part-time site coordinator and four group leaders • Three-hour booster sessions every 6 months. • Family meals, transportation, and child care provided to reduce barriers to attendance.

	Child Abuse Prevention Practice	Examples	Evidence-Based (EB), Promising (Pr) or Emerging (Em)	To What Extent (Target Population, #'s Served, Geographic Area, etc)	Outcome(s)	Indicators	Critical Program Elements
		Project SafeCare http://www.cachildwelfareclearinghouse.org/program/6	Pr (CA Evidence-Based Clearinghouse)	Target Population: Parents at risk for child abuse and neglect	• Household safety • Problem-solving skills	• Home safety measures • Child health care skills • Child behavior management	• Training provided in-home • Direct, skills-based training • Homework
SECONDARY PREVENTION	**Differential Response**	Missouri Family Assessment and Response System	Pr	Target Population: Families reported to the state's child abuse hotline and referred for family assessment (low-med risk)	• Increase safety of the child • Preserve the family relationships • Decrease the abuse/neglect or the defining family problem • Prevent future abuse or neglect	• Hotline reports • Children's safety • Utilization of community resources • Recidivism rates • Family satisfaction	• Screening for assessment or investigation conducted during hotline call • Families with no immediate risk to child and low risk of future harm are placed on the family assessment track • Services provided by community-based organization or FARS worker • Flexibility to move case from one track to another if needed
	Therapeutic Intervention	Parent–Child Interaction Therapy	EB	Target Population: Children ages 2-7 with behavioral problems; Physically abusive parents with children 4-12	• Reduced risk of child abuse • Improved parenting skills and attitudes • Improved child behavior	• Self-reports of physical abuse • Parenting skills • Child behavior	• 14-20 one-hour sessions • Therapist discusses concepts with parents, observes parent-child interaction and provides live coaching • Assessments conducted before, during and after treatment Phase I • Focus on building a nurturing

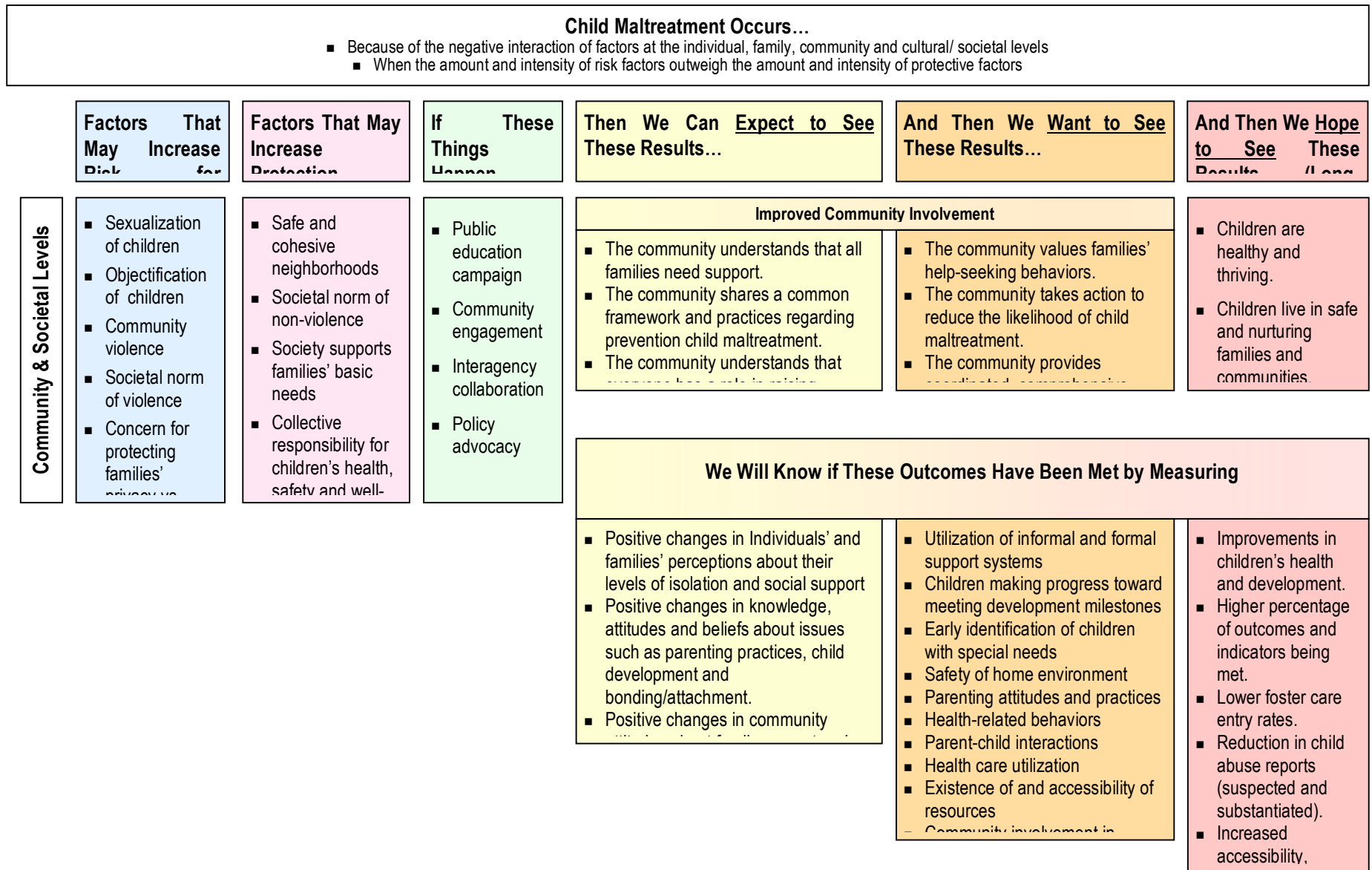|	Child Abuse Prevention Practice	Examples	Evidence-Based (EB), Promising (Pr) or Emerging (Em)	To What Extent (Target Population, #'s Served, Geographic Area, etc)	Outcome(s)	Indicators	Critical Program Elements
							relationship and secure bond between parent and child • Parent taught to follow child's lead (Child-Directed Interaction) • Parent taught to use positive reinforcement **Phase II** • Focus on establishing a structured and consistent approach to discipline Parents taught to take lead in discipline (Parent-Directed Interaction)
	Case Management				•	•	•

Appendix I: CBC Theory of Change/Logic Model

Child Maltreatment Occurs…
- Because of the negative interaction of factors at the individual, family, community and cultural/ societal levels
  - When the amount and intensity of risk factors outweigh the amount and intensity of protective factors

Factors That May Increase Risk for Maltreatment	Factors That May Increase Protection Against Maltreatment	If These Things Happen…	Then We Can Expect to See These Results…	And Then We Want to See These Results…	And Then We Hope to See These Results (Long-Term Outcomes)
- Harmful parental attitudes - Lack of appropriate parenting practices - Lack of bonding/ attachment between parent-child - Conflict in parent-child relationship - Lack of understanding of child development - Family violence - Poor physical and/or mental health - Substance use - History of abuse - Child's temperament	- Positive parenting attitudes - Nurturing parenting practices - Bonding/attachment between parent-child - Positive parent-child relationship - Healthy family dynamics - Good physical and mental health - Positive parenting role models - Child's temperament - Socio-economic stability - Family support and involvement - Access to informal and formal support networks	- Parent education/ training - Home visiting (universal and/or targeted) - Early care & education with comprehensive family support - Case management - Prenatal screening for risk factors - School-based violence prevention - Differential response - Therapeutic interventions	**Improved Parent-Child Relationships** - Parents know about effective parenting practices. - Parents understand the nature and importance of parent-child bonding and attachment. **Improved Child Health and Development** - Parents/caregivers understand child health and development, including the importance of the early years. - Parents understand the importance of having a medical home. **Improved Family Support** - Families understand the importance of having informal and formal support networks. - Families know about available resources that promote health, safety, **Improved Family Functioning** - Families know skills and behaviors that support healthy family dynamics. **Improved Child Safety** - Parents and allies know how to ensure children's safety in their homes and	**Improved Parent-Child Relationships** - Parents use effective parenting practices. - Parents and children have positive, nurturing relationships. **Improved Child Health and Development** - Parents/caregivers provide care that fosters optimal development in children. - Children develop optimally. - Children receive appropriate health **Improved Family Support** - Families feel comfortable seeking support. - Families have informal and formal support networks. - Families access the resources they **Improved Family Functioning** - Families communicate effectively. - Families have healthy interactions. **Improved Child Safety** - Parents and allies ensure children's safety in their homes and	- All children are healthy and thriving. - All children live in safe and nurturing families and communities.

Individual & Family Levels

Child Abuse Prevention Theory of Change and Logic Model (continued)

Child Maltreatment Occurs…

- Because of the negative interaction of factors at the individual, family, community and cultural/ societal levels
  - When the amount and intensity of risk factors outweigh the amount and intensity of protective factors

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	Factors That May Increase Risk for	Factors That May Increase Protection	If These Things Happen	Then We Can <u>Expect to See</u> These Results…	And Then We <u>Want to See</u> These Results…	And Then We <u>Hope to See</u> These Results (Long

Community & Societal Levels

Factors That May Increase Risk for	Factors That May Increase Protection	If These Things Happen			And Then We Hope to See
■ Sexualization of children ■ Objectification of children ■ Community violence ■ Societal norm of violence ■ Concern for protecting families' privacy vs	■ Safe and cohesive neighborhoods ■ Societal norm of non-violence ■ Society supports families' basic needs ■ Collective responsibility for children's health, safety and well-	■ Public education campaign ■ Community engagement ■ Interagency collaboration ■ Policy advocacy	**Improved Community Involvement**		■ Children are healthy and thriving. ■ Children live in safe and nurturing families and communities.

Improved Community Involvement

Then We Can Expect to See	And Then We Want to See
■ The community understands that all families need support. ■ The community shares a common framework and practices regarding prevention child maltreatment. ■ The community understands that everyone has a role in raising	■ The community values families' help-seeking behaviors. ■ The community takes action to reduce the likelihood of child maltreatment. ■ The community provides coordinated, comprehensive

We Will Know if These Outcomes Have Been Met by Measuring

■ Positive changes in Individuals' and families' perceptions about their levels of isolation and social support ■ Positive changes in knowledge, attitudes and beliefs about issues such as parenting practices, child development and bonding/attachment. ■ Positive changes in community attitudes about families, parents and	■ Utilization of informal and formal support systems ■ Children making progress toward meeting development milestones ■ Early identification of children with special needs ■ Safety of home environment ■ Parenting attitudes and practices ■ Health-related behaviors ■ Parent-child interactions ■ Health care utilization ■ Existence of and accessibility of resources ■ Community involvement in	■ Improvements in children's health and development. ■ Higher percentage of outcomes and indicators being met. ■ Lower foster care entry rates. ■ Reduction in child abuse reports (suspected and substantiated). ■ Increased accessibility,

Appendix J: CBC Roadmap

Planning Activity	Purpose or Outcome	Step	Targeted End Date
A. Complete Local Assessment	Understand current status of child abuse prevention activities in Santa Cruz County	1. Complete informant interviews 2. Review and analyze data 3. Create report of current state including activities, extent of implementation (target populations, capacity, etc.), alignment with best practices, gaps, etc.	2/15/08
B. Identify Stakeholders	Ensure broad representation in CBC planning process.	1. Identify Stakeholder categories and appropriate individuals/agencies 2. Develop/compile contact list	1/25/08 1/25/08
D. Plan first Stakeholder meeting	Initiate engagement of Stakeholders	1. Select date and location 2. Send save-the-date notice 3. Send invitation to attend 4. Plan agenda; coordinate logistics	1/11/07 6 weeks prior 3 weeks prior Up to meeting
E. Secure resources for planning			Ongoing
F. Conduct Stakeholder meetings	Generate buy-in and consensus on direction of planning process	1. Identify factors contributing to child abuse/barriers to preventing child abuse from various Stakeholder perspectives 2. Develop vision for children, families and community 3. Review/prioritize evidence-based and promising practices in child abuse prevention; review countywide practices research 4. Identify role in planning process (in-kind resources, work group, data, etc)	2/22/08 3/28/08 4/25/08 4/25/08
G. Develop "chain of outcomes"	Identify desired changes in knowledge, behavior and conditions	1. Review, amend, and approve short-term, intermediate and long-term outcomes 2. Identify indicators and methods of measurement 3. Establish baseline measurement	5/23/08 5/23/08 7/25/08
H. Identify strategies, activities and resources necessary to achieve outcomes	Prepare plan that can be implemented	1. Brainstorm strategies and activities 2. Compare brainstormed strategies/activities to evidence-based and promising practices 3. Prioritize strategies/activities 4. Identify resources needed to begin implementation of strategies/activities	6/27/08 7/25/08 9/26/08
I. Develop and approve plan			10/24/08

Appendix K; Type 1 Survey Questionnaire

Interview Script – Type 1

Interviewer name _____ Date_____

Interviewee
name_____phone#_____

Interviewee organization or affiliation_____

As part of our assessment in the Community Blueprint for Children project, we are looking for programs in Santa Cruz County that follow the matrix of best practices. Because we would like to be as thorough as possible, we would like to know if you are aware of any programs or campaigns that follow best practices models in the effort to prevent child abuse.

Request for Leads Survey:

1. Are you aware of any public education campaigns with the intended purpose of preventing child abuse?   **Yes**   **No**

    a. If yes, what is the name of the program(s)?_____

    _____

    b. Do you have contact information?   **Yes   No**

        1. If yes, what is the contact's name? _____

        2. Phone number? _____

        3. Email? _____

2. Are you aware of any prenatal screening for risk factors programs with the intended purpose of preventing child abuse?   **Yes**   **No**

    a. If yes, what is the name of the program(s)?_____

    _____

    b. Do you have contact information?   **Yes   No**

        1. If yes, what is the contact's name? _____

        2. Phone number? _____

        3. Email? _____

3.   Are you aware of any home visiting programs with the intended purpose of preventing child abuse?   **Yes**   **No**

a. If yes, what is the name of the program(s)?_____

_____

b. Do you have contact information?   **Yes   No**

1. If yes, what is the contact's name? _____

2. Phone number? _____

3. Email? _____

4. Are you aware of any school based child abuse prevention programs? **Yes   No**

a. If yes, what is the name of the program(s)?_____

_____

b. Do you have contact information?   **Yes   No**

1. If yes, what is the contact's name? _____

2. Phone number? _____

3. Email? _____

5.   Are you aware of any parent education programs with the intended purpose of preventing child abuse?   **Yes   No**

a. If yes, what is the name of the program(s)? _____

_____

b. Do you have contact information?   **Yes   No**

1. If yes, what is the contact's name? _____

2. Phone number? _____

3. Email? _____

6.   Are you aware of any community engagement programs with the intended purpose of preventing child abuse?

a. If yes, what is the name of the program(s)?_____

_____

b. Do you have contact information?   **Yes   No**

1. If yes, what is the contact's name? _____

2. Phone number? _____

3. Email? _____

7. Are you aware of any early care and education programs with comprehensive family support intended to prevent child abuse?   **Yes   No**

a. If yes, what is the name of the program(s)?_____

_____

b. Do you have contact information?   **Yes   No**

1. If yes, what is the contact's name? _____

2. Phone number? _____

3. Email? _____

8. Are you aware of any therapeutic intervention programs intended to prevent child abuse?   **Yes   No**

a. If yes, what is the name of the program(s)?_____

_____

b. Do you have contact information?   **Yes   No**

1. If yes, what is the contact's name? _____

2. Phone number? _____

3. Email? _____

8. Are you aware of any father involvement programs intended to prevent child abuse?
        Yes   No

a. If yes, what is the name of the program(s)?

_____

b. Do you have contact information?   **Yes   No**

1. If yes, what is the contact's name? _____

2. Phone number? _____

3. Email? _____

Open-ended Questions:

9. If you were designing a systematic, comprehensive approach to preventing child abuse in Santa Cruz County, what strategies would you employ? _____

_____

_____

_____

10. Are you aware of any unmet needs in terms of child abuse prevention programs in Santa Cruz County? _____

_____

_____

_____

_____

Appendix L. Type 2 Survey Questionnaire: Parent Education

Interview Script Type 2

Parent Education

Date _____

Interviewer name_____

Interviewee name_____

Interviewee organizational affiliation_____

Interviewee position_____

Request for Leads Survey (Administer this first.)

Parent Education Questionnaire:

1. Do you have a parent education program with the intended outcome of preventing child abuse? **Yes   No**

      a. If yes, answer questions **56-68**

      b. If no, skip to question **69**

2. What is the name of your program?_____

3. Is your program based on best practices?   **Yes   No**

      a. If yes, is there a model program?   **Yes   No**

      b. If yes, what is the name of the model program?_____

      c. How closely does your implementation match the model?_____

      _____

      d.   If no model program, please explain research base of best practices_____

4. Are there collaborators or partners involved in this program?   **Yes   No**

      a. If yes, name partners

      _____

5. What is the target population for your program? (All parents, parents of a certain age group, Spanish speakers, new parents, income level)

_____

a. **Just for us:** What type of prevention?   **Primary**   **Secondary**

6. What geographic area is targeted?

_____

7. What are the eligibility criteria? _____

8. How many unduplicated clients can you serve annually?_____

9. How many unduplicated clients did you serve in the last fiscal year? _____

    a. Demographic characteristics:

        i. Do you know the racial demographic of the people you serve?
            1. African American_____
            2. Latino American_____
            3. Caucasian American_____
            4. Native American _____
            5. Asian American_____
            6. Other _____
            7. Don't know _____

       ii. Do you know the income levels of the people you serve?

            1. Less than 100% poverty_____

            2. 100-200% poverty_____

            3. 200% poverty and above _____

            4. Unknown _____

      iii. Do you know the geographic areas of the people you serve?

            1. City of Capitola _____

            2. City of Santa Cruz _____

            3. City of Scotts Valley _____

            4. City of Watsonville _____

            5. Uninc. Mid Santa Cruz County _____

            6. Uninc. North Santa Cruz County _____

            7. Uninc. San Lorenzo Valley _____

            8. Uninc. South Santa Cruz County _____

            9. Other-Non-Santa Cruz County_____

            10. Unknown _____

      ii. Gender **Male**   **Female**   **Both**

      iv. Age _____

10. Do you have a waiting list? **Yes No**

    a. If yes, how many people are on your waiting list? _____

11.   What   strategies   do   you   employ   in   your program?_____

_____

_____

12. What are your intended outcomes

_____

_____

_____

13. Do you track indicators to assess your outcomes? **Yes**   **No**

    a.   If   yes,   what   are   the indicators?_____

        i. Have indicators shown a change in outcome? **Yes**   **No**

        ii. If yes, what is the change?_____

           _____

14. Do you evaluate the effectiveness of the program?   **Yes No**

    a. If yes, by what means?

_____

<u>Open-ended Questions</u>: Finally, administer the last two questions.

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