Supporting Military Families Through
Research and Outreach

Prevention of Child Neglect

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Research

Outreach

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Military REACH, a project of the DoD-USDA Partnership for Military Families, utilizes a multi-disciplinary approach integrating both Research and Outreach to support those who work with and on behalf of military families. Through our three-fold approach, we provide empirical research that identifies and addresses key issues impacting military families and the programs that serve them, offer outreach and professional development through online resources, and host a Live Learning Lab for program staff seeking constructive professional development feedback for their programs.

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Executive Summary

Child neglect is the most common form of child maltreatment, the most frequently investigated allegation by child protective services, and the most common reason for placing children in foster care (Ryan et al., 2013). Military children are not immune from child maltreatment, and may be at higher risk for experiencing neglect than other kinds of maltreatment (Thomsen et al., 2014). Despite these high rates of neglect (McCarthy et al., 2015; Wildeman et al., 2014), researchers have described a "neglect of neglect" in the research domain (Stoltenborgh, Bakermans-Kranenburg, van IJzendoorn, & Alink, 2013), indicating that there is relatively little research conducted in this area. Consistent with the literature, this report uses child maltreatment as a broad umbrella term (subsuming all kinds of child abuse and neglect), child abuse (referring to all kinds of abuse other than neglect), and child neglect (referring specifically to neglectful behaviors).

A comprehensive literature review was conducted on child neglect, including the risk and protective factors for child neglect and abuse, as well as available prevention and intervention programs to support at-risk families. The review focused on publications since 2010. The report begins with an overview of child neglect, including the challenges in studying child neglect, including definitional issues and several classification systems. The prevalence of child maltreatment in both the civilian and military sectors is described, including recent changes in rates of abuse, and specifically neglect. Due to the dearth of research specifically focused on neglect, information pertaining to other kinds of child abuse is also included when appropriate.

The vast literature on child maltreatment has identified many risk and protective factors.

This report then offers an overview of the research on the effects of child maltreatment on victims' physical health, mental health, academic functioning, and relationship functioning. Broader economic consequences for both individuals and communities are also described. Negative consequences from child maltreatment can emerge in childhood, adolescence, adulthood, or across the lifespan.

Furthermore, the vast literature on child maltreatment has identified many risk and protective factors which are summarized herein across the following categories:

- Child characteristics
- Parent characteristics
- Parent-child relationship quality
- Family structure
- Family characteristics
- Father characteristics
- Community and societal characteristics
- Military characteristics

Finally, many child abuse and neglect prevention programs have been designed to address the issue of child maltreatment. Programs vary in modality, focus, setting, provider, curricula, and aims. Sixty-six programs and initiatives are described herein, including 52 selective programs, 6 universal programs, and 8 other initiatives that build protective factors. Many of the programs were developed based on sound research, and evaluations have been conducted for many of these programs. However, the quality and findings of these evaluations vary considerably, and relatively few civilian-based programs

have been evaluated with military families. Research has found that multifaceted prevention and intervention programs are most effective in preventing maltreatment and supporting at-risk families (Institute of Medicine, 2014). Recommendations for future directions for research, including prevention programs and longitudinal studies, are described.

Introduction

Child neglect is the most common form of child maltreatment, the most frequently investigated allegation by child protective services, and the most common reason for placing children in foster care (Ryan et al., 2013). For example, in fiscal year 2013, 80% of all cases nationally referred to child protective services involved neglect, 18% physical abuse, 9% sexual abuse, and 9% psychological abuse (United States Department of Health and Human Services, 2015). Similarly, approximately 78% of the allegations reported to child protection involved neglect, 18 % physical abuse, 10% sexual abuse and 8% psychological maltreatment (Ryan et al., 2013). Similar trends have emerged in studies of military families, with military children being at higher risk for experiencing neglect than other kinds of maltreatment (Thomsen et al., 2014). Despite these high rates of neglect, researchers have described a "neglect of neglect" in the research domain (Stoltenborgh, et al., 2013), indicating that there is relatively little research conducted in this important area.

Multiple terms are used in the literature pertaining to child maltreatment. Consistent with the literature, this report uses specific terms for different kinds of harm to children including:

- **Child maltreatment:** An umbrella term subsuming all kinds of child abuse and neglect.
- **Child abuse**: A broad label referring to all kinds of abuse other than neglect (e.g., physical abuse, sexual abuse, emotional abuse).
- **Child neglect**: A term specifically referring to neglectful behavior (e.g., failure to provide needed, developmentally-appropriate care)

A comprehensive literature review was conducted on child neglect, the risk and protective factors for child neglect, as well as available prevention and intervention programs to support these families. The review focused primarily on research published since 2010. The databases PsycINFO, Google Scholar, Pub Med, JSTOR, Academic Search Premier, and Sociological Abstracts were used in the search. A variety of search terms were used, such as child neglect, child abuse, and child welfare. Over 290 empirical articles, relevant literature reviews, reports, and policy briefs were examined.

This report is organized into four sections. The first section provides a brief overview of child neglect, including definitional issues, the prevalence of neglect both in civilian and military families, challenges in studying neglect, and classification systems for different types of neglect. The report then summarizes the consequences of child neglect across several domains of functioning, including physical health, mental health, academic functioning, and relationship well-being. The third section provides a comprehensive overview of risk and protective factors for child maltreatment, with a specific focus on neglect when possible. Finally, a description and tabular presentation of 66 programs targeted at both prevention and intervention for child neglect are described.

Definitions of Child Neglect

Definitions of neglect vary widely and are specific to each state. These differences make it difficult to classify what is and is not neglect. Moreover, it makes comparisons across sites challenging and hinders the development of a solid research base. However, three definitions are helpful in understanding the scope of child neglect, including the federal definition, the National Child Abuse and Neglect Data System (NCANDS) definition, and the Department of Defense's definitions.

First, the federal definition of child abuse and neglect is:

> *At a minimum, any recent act or set of acts or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act, which presents an imminent risk of serious harm.* (Section 3 of the Child Abuse Prevention and Treatment Act (CAPTA), Public Law 93–247; 42 U.S.C. § 5101 note)

This definition establishes the groundwork from which all states develop their laws regarding mandated reporting of child neglect and abuse to child protective services (Institute of Medicine, 2014). However, legal definitions about what constitutes abuse, mandated reporters, and the reporting process vary across states.

Definitions of neglect vary widely and are specific to each state.

Second, another important definition of child abuse and neglect comes from the National Child Abuse and Neglect Data System (NCANDS). This is the official United States government entity to which all states report annual rates of child abuse and neglect. This definition is:

> *An act or failure to act by a parent, caregiver, or other person as defined under State law that results in physical abuse, neglect, medical neglect, sexual abuse, emotional abuse, or an act or failure to act which presents an imminent risk of harm to a child*. (United States Department of Health and Human Services, 2015)

Third, the Department of Defense (DoD) has its own set of definitions. The DoD created the U.S. Army Family Advocacy Program in 1976 with a goal of preventing all kinds of child maltreatment and urging timely reporting of potentially abusive behavior. This organization investigates alleged cases of abuse and provides treatment to families (Fullerton et al., 2011). The Department of Defense uses the CAPTA definition listed above. However, the Manual for Child Maltreatment and Domestic Abuse Incident Reporting System (DoD 6400.1-M-1; http://dtic.mil/whs/directives/corres/pdf/640001m1.pdf) by the Under Secretary of Defense of Personnel and Readiness (2005, updated 2011) defines child maltreatment as:

> *The physical or sexual abuse, emotional maltreatment, or neglect of a child by a parent, guardian, foster parent, or by a caregiver, whether the caregiver is intrafamilial or extra familial, under circumstances indicating the child's welfare is harmed or threatened. Such acts by a sibling, other family member, or other person shall be deemed to be child maltreatment only when the individual is providing care under expressed or implied agreement with the parent, guardian, or foster parent* (AP1.6)

And child neglect as:

> *The negligent treatment of a child through acts or omissions by an individual responsible for the child's welfare under circumstances indicating the child's welfare is harmed or threatened. Includes "Abandonment," "Deprivation of Necessities," "Educational Neglect," "Lack of Supervision," "Medical Neglect," and/or "Non-Organic Failure to Thrive*." (AP1.27.1)

Although considerable overlap exists among the definitions, each is distinct. The differences among these definitions have complicated the study and understanding of child neglect.

Prevalence of Child Neglect

Determining the true prevalence of child neglect is difficult for many reasons. First, definitions of neglect and reporting requirements vary across states and agencies, making interpretation of data challenging. Second, researchers speculate that people tend to underreport abuse overall due to stigma and shame surrounding this family issue (Institute of Medicine, 2014). Third, many of the large-scale studies include neglect as one form of abuse, but do not specifically examine rates of neglect (Institute of Medicine, 2014). Fourth, studies use diverse modes of data collection, with considerable differences between information from large databases (such as from child protective service reports) versus retrospective self-reports (Institute of Medicine, 2014). Therefore, considerable variability exists across prevalence and incidence estimates, and it is likely that most figures are underestimates of the actual rates of neglect (Government Accountability Office, 2011; Institute of Medicine, 2014).

Considerable variability exists across prevalence and incidence estimates, and it is likely that most figures are underestimates of the actual rates of neglect.

Despite these measurement challenges, two recent studies (Stoltenborgh et al., 2013; Wildeman et al., 2014) provide insight into the scope of child abuse, the latter of which specifically examines neglect. Wildeman and colleagues (2014) examined states' reports of confirmed maltreatment to the National Child Abuse and Neglect Data System (NCANDS) from 2004 to 2011. They concluded that 12.5% (1 in 8) of American children experienced a confirmed case of maltreatment by 18 years of age; rates for Black children are even higher, as 20% of Black children experience such maltreatment by 18 years of age. Researchers note that these annual rates dramatically underestimate the cumulative prevalence of child maltreatment.

A second recent study was a meta-analysis of children from Australia/New Zealand, North America, Europe, Africa, South America, and Asia; it examined the prevalence of two forms of neglect, namely physical and emotional neglect (Stoltenborgh et al., 2013). A review of 13 independent samples totaling 59,406 children found an overall estimated prevalence of 163/1,000 for physical neglect. Similarly, their review of 16 independent samples of 59,655 children yielded an overall estimated prevalence of 184/1,000 for emotional neglect. Thus, it is clear that child maltreatment affects a large number of children and families across the world.

Although most of the studies have assessed prevalence via review of child abuse reports and large databases, other researchers have taken a different approach. Specifically, studies have asked respondents about specific experiences in their past, either in a recent specified period or at any time during their lives. Estimates from this retrospective approach tend to yield higher rates of abuse. For example, the National Survey of Children's Exposure to Violence was a national telephone survey of over 4,500 children up to age 17 (Finkelhor, Turner, Shattuck, & Hamby 2013). In this study, 26% of children reported having experienced any form of maltreatment during their lifetimes, and 15% had specifically experienced neglect. Prospective research can also shed light on rates of child abuse and neglect, and the National Longitudinal Study of Adolescent Health has followed a large sample of adolescents into adulthood. Interviews with young adults revealed high rates of some potentially neglectful abuse. For example, 42% of respondents reported that they had been left home alone as a child (Hussey, Chang, & Kotch, 2006). Participants also noted histories of other forms of abuse, including physical assault (28%) and physical neglect (12%). In light of the different prevalence estimates that emerged across studies,

attention to the mode of data collection, and the potential inherent biases with each approach, is important.

Prevalence of child abuse and neglect in the military. The research base pertaining to child neglect of military children is limited, with most of the research focusing on other forms of child maltreatment (e.g., physical abuse). Most of the recent research has focused on child maltreatment rates associated with parental deployment.

A few studies have specifically examined child neglect in military families. A review of U.S. Army child abuse data found that child neglect was highest during two time periods coinciding with increased numbers of combat deployments (McCarroll, Fan, Newby, & Ursano, 2008). Similarly, a review of Air Force Family Advocacy System of Records found that rates of neglect by the nondeployed caregiver increased by 124% during deployment relative to pre-deployment rates (McCarthy et al., 2015).

A review of U.S. Army child abuse data found that child neglect was highest during combat deployments.

Other research has examined child maltreatment in the military more broadly. For example, Rentz and colleagues (2007) reviewed child maltreatment records in Texas and found that substantiated child maltreatment rates doubled from before 9/11/2001 to October of 2002; they noted that the higher maltreatment rates coincided with periods of relatively higher numbers of military deployments. They further reported that the nonmilitary caretakers perpetrated the largest proportion of the maltreatment in these families. Similarly, analysis of U.S. Army data on substantiated incidents of parental child maltreatment from 2000 to 2004 found that the rates of child maltreatment during deployments was 42% higher than when the Soldiers were not deployed (Gibbs et al., 2007). Furthermore, the elevation in civilian female spouses' rates of moderate or severe child maltreatment was approximately four times greater during deployment periods.

Review of child maltreatment data in the United States Air Force has revealed similar trends, with rates of civilian-parent-perpetrated child abuse increasing by 52% during deployment; notably, these rates decreased after deployment, dropping to 85% of the pre-deployment rates (McCarthy et al., 2015). However, rates of emotional abuse by a civilian parent increased by 89% after deployment relative to during deployment. In another review of Air Force Family Advocacy Records (Thomsen et al., 2014), the overall frequency of child maltreatment was 13% lower after deployment in comparison to before; this finding was not affected by number of parental deployments. One exception to this overall finding was an increase in rates of severe child neglect (especially incidents involving alcohol) from before to after deployment.

In addition to understanding the prevalence of child maltreatment at a specific point in time, it is also useful to consider changes in rates across time.

Changes in Child Abuse and Neglect Rates

Numerous researchers and governmental agencies track changes in child maltreatment across time. Understanding these trends may offer insights into the factors that may pose additional stress on families, thereby increasing the risk for affected children. For example, from 2009 to 2013, the overall rates of child maltreatment in the United States declined, from 9.3 to 9.1 per 1,000 children in the

population (United States Department of Health and Human Services, 2015). Investigations of neglect specifically have found a similar decrease in victimization; a review of data from 1990-2001 found a 10% decline in neglect cases (Finkelhor et al., 2010). However, specific trends and rates vary considerably across states.

Changes in child abuse and neglect rates in the military. Rates of child abuse and neglect in the military have fluctuated over time. Rates of neglect in the U.S. Army decreased from 1975-1997 (McCarroll et al., 1999), and rates of maltreatment in the Army declined by 65% from 1990-2004, with most of the decreases being physical abuse (McCarroll, Fan, Newby, & Ursano 2008).

Considering neglect specifically, Army child neglect rates declined by 28% from 1991-2000. However, the neglect rate rebounded and surpassed 1991 levels in 2004; in fact, the increase from 2000-2004 was 40% (McCarroll et al., 2008). The time period of 2000-2004 corresponds to a time of high operational tempo of deployments to Iraq and Afghanistan. Notably, despite fluctuations in neglect rates in the military during this time period, U.S. national data showed little change in neglect nationally (U.S. Department of Health and Human Services, 2006).

Reports of suspected child abuse/neglect to the Family Advocacy Program increased by 2% from fiscal year 2012 to 2013 (Department of Defense's Family Advocacy Program, 2014). Of those incidents of child abuse and neglect that met criteria in fiscal year 2013, 58% specifically involved child neglect without concomitant emotional, physical, or sexual abuse. Most recently, fiscal year 2014 Department of Defense data revealed a 10% increase in confirmed child maltreatment (abuse or neglect) cases from the previous year, including a total of 7,676 cases. Notably, confirmed cases of neglect rose by 14% during 2014. Thirty military children died due to child abuse or neglect in 2014, with 18 of these children being under age one (Ryan, 2015).

Fiscal year 2014 Department of Defense data revealed a 10% increase in confirmed child maltreatment (abuse or neglect) cases from the previous year, including a total of 7,676 cases.

Challenges in Defining Neglect

As seen in these diverse definitions, defining neglect and intervening with families engaging in this form of child maltreatment are complicated. Neglect generally involves the omission of caretaking rather than perpetration of a specific, measurable, sometimes visible injury; therefore, levels of societal agreement about what constitutes neglect tend to be lower than what constitutes more overt aggression such as physical violence (Elliott & Urquiza, 2006). Furthermore, what is deemed appropriate versus neglectful may differ by culture (Elliott & Urquiza, 2006), thereby making such distinctions more difficult and complex.

Neglect generally involves the omission of caretaking rather than perpetration of a specific, measurable, sometimes visible injury.

Another challenge in defining child neglect is that such distinctions need to incorporate a developmental perspective (Fullerton et al., 2011). For example, leaving a 15-year old at home alone while a parent runs an errand may be entirely appropriate, while leaving a 2-year old in the same situation would be considered neglect. Therefore, categorical declarations of a particular behavior as neglectful may be inappropriate without consideration of the child's age and developmental stage.

Third, neglect rarely occurs in isolation from other forms of abuse. Child neglect commonly co-occurs with other forms of maltreatment, rendering the distinction of what is overt abuse versus neglect challenging. For example, in a National Institute of Child Health and Development (NICHD)-funded longitudinal study, neglect was accompanied by other types of maltreatment in 95% of the cases (Mennen, Kim, Sang, & Trickett, 2010). This considerable overlap underscores the importance of specificity regarding the kinds of neglect and abuse being examined, and the development of programs and services to meet each family's unique needs.

Fourth, the label of child neglect subsumes a heterogeneous array of behaviors, ranging from mild to severe and possibly fatal. Abuse can vary not only in severity but also in chronicity, both of which can affect the level of risk for the child (Fullerton et al., 2011).

In an effort to improve our understanding of child neglect and overcome some of these challenges, researchers have created classification systems that will now be reviewed.

Classification Systems for Child Neglect

Multiple classification systems have emerged in an attempt to enhance the understanding of child neglect and to develop tailored supports for families. Some typologies distinguish among physical, medical, educational, and emotional neglect (Child Welfare Information Gateway, 2012; Sedlak et al., 2010). The National Institute of Child Health and Development (NICHD)-funded longitudinal study described several subtypes of neglect in its classification system, which was based on substantiated reports of maltreatment for youth ages 9-12; the researchers noted considerable overlap among categories (Mennen et al., 2010). Types of neglect in this classification system include:

- Supervisory neglect: lack of supervision
- Environmental neglect: failure to provide shelter
- Care neglect: failure to provide food, clothing, or hygiene
- Medical neglect: failure to provide medical care
- Educational neglect: educational maltreatment (e.g., parent fails to send child to school)

Multiple classification systems have emerged in an attempt to enhance the understanding of child neglect and to develop tailored supports for families.

In this study, the most frequently reported type of neglect was supervisory (73%), followed by environmental (62%), care (59%), educational (30%), and medical (23%).

Recently, Fullerton and colleagues (2011) considered child neglect specifically in Army families and outlined eleven domains of neglect (see Table 1 below). Within each domain of neglect, this classification system defines specific parental behaviors, the associated risks/dangers to the child, and potential child outcomes.

Table 1: Domains of Neglectful Behavior

Neglect Domain	Parental Behaviors	Risk/Danger to Child	Outcome to Child
Food	Meals not prepared, regular meals not provided	Poor nutrition, malnutrition, food insecurity	Obesity, stunting, starvation, behavioral problems
Clothing	Insufficient amount	Exposure	Illness
Shelter	Unsafe housing	Accidents, overcrowding	Injury, poor health
Medical/dental	Lack of medical care	No vaccinations, no physicals	Illness, developmental problems
Hygiene	Unsanitary housing	Poor child hygiene	Poor health, behavioral problems
Supervision	Does not know where child is after school	Inadequate monitoring of child	Injury, accidents, behavioral problems
Unsafe Household	Unsecured weapons in household	Accidental discharge of weapon	Injury, death
Emotional Neglect	Inattention to child's need for praise, comfort, or support	Child isolation, withdrawal, hostility	Behavioral problems, depression
Educational Neglect	Failure to enroll child in school, inattention to school progress, behavior at school, truancy	Poor school performance, lack of socialization	Poor cognitive, social development
Developmental Neglect	Failure to provide infant stimulation or other age appropriate activities	Withdrawal, apathy	Poor cognitive, social development, behavioral problems
Environmental Neglect	Parents let child play in unsafe areas	Accidents, abduction, vagrancy	Injury, criminal behavior

Table from Fullerton et al., 2011

In sum, similar to the challenges with overall definitions of neglect, the classification systems for specific types of child neglect are diverse. Further research is needed to better define the specific types of neglect, which can improve assessment and intervention efforts.

Demographics of Child Neglect and Abuse

Before considering the consequences of child maltreatment, it is useful to consider the demographics of abuse/neglect perpetrators and victims. Understanding the typology of potential perpetrators and victims can guide prevention and intervention efforts. In the civilian sector, the most recent available national research (U.S. Department of Health and Human Services, 2015) reveals that most (83%) perpetrators are between the ages of 18 and 44, and over half (54%) are women. Nationally, the majority of perpetrators are White (49%), followed by African-American (20%), and Hispanic (19.5%). About 91% of perpetrators are parents, 88% of whom are biological parents. Considering military families specifically, one study found that 90% of perpetrators are parents, 56% of whom are male and 44% female (McCaroll et al., 2008).

A vast number of children and families are affected by child maltreatment, and the military community is not immune to this public health problem.

Regarding child victims, some research finds an approximately equal gender breakdown (U.S. Department of Health and Human Services, 2015), while others find a higher cumulative presence of confirmed childhood maltreatment among girls (13%) than boys (12%) (Wildemann, 2014). Across studies, the youngest children are at highest risk for both abuse and neglect, as well as maltreatment-related fatalities (Wildemann, 2014; U.S. Department of Health and Human Services, 2015), including military samples (McCarroll et al., 2008). Racial differences have emerged in this research as well, with Black, Native American, and Hispanic children having higher rates of child maltreatment than White or Asian/Pacific Islander children (Sedlak et al., 2010; Wildemann, 2014).

In sum, a vast number of children and families are affected by child maltreatment, and the military community is not immune to this public health problem. Research in this field is beset with numerous definitional and measurement challenges, and several classification systems have emerged. As addressed in the following section, a large research base elucidates the consequences of child maltreatment across a variety of functional domains.

Consequences of Child Maltreatment

Child maltreatment, including neglect, can result in a range of negative consequences in a variety of functional domains. This section overviews the research on the effects of child maltreatment on physical health, mental health, academic functioning, and relationship functioning. Broader economic consequences are also described. The negative consequences can emerge in childhood, adolescence, adulthood, or across the lifespan. Much of the research collapses several categories of maltreatment (including, but not limited to, neglect); distinctions are noted when the research focuses specifically on neglect.

In considering these consequences, it is important to recognize that maltreated children are at increased risk for being re-victimized (Widom, 2014). People who have experienced childhood abuse are at increased risk for lifetime re-victimization across a variety of modes, including, but not limited to, physical assault, sexual assault/abuse, kidnapping, and stalking (Widom et al., 2008). Recognition of this elevated risk for re-victimization and appreciation of the potential for worsened outcomes for those who have endured multiple experiences of victimization (Currie & Tekin, 2012) underscore the importance of early intervention and treatment efforts.

Maltreated children are at increased risk for being re-victimized.

Considerable research shows that some children experience negative consequences; however, such problems are not universal. A recent meta-analysis of 21 studies concluded that 10-25% of maltreated children are resilient and achieve normal functioning after experiencing maltreatment (Walsh et al., 2010). However, minimal research has examined which children are resilient, the protective factors that may buffer children from problems, and how children become more resilient (Cicchetti, 2013). Another important caveat in considering this research is that much of it is cross-sectional or short-term longitudinal. Additional research is needed that follows children over a longer period of time to better understand and track the development of problems following maltreatment (Cicchetti, 2013).

Risk factors such as poverty or parental mental health problems may co-occur with child maltreatment, confounding attempts to decipher the contributions of the maltreatment versus other factors.

Finally, as discussed in more detail in the subsequent section on risk factors, drawing causal conclusions about specific consequences of child abuse is difficult. Risk factors such as poverty or parental mental health problems may co-occur with child maltreatment, confounding attempts to decipher the contributions of the maltreatment versus other factors. It will be important for future research to control for these factors, when possible, to improve our ability to differentiate between risk factors and consequences.

The following section describes research findings about the consequences of child maltreatment. Consequences are organized into five categories including: (1) physical health; (2) mental health; (3) academic functioning; (4) relationship functioning; and (5) economic issues.

Physical Health

One important domain of functioning that has been examined as a consequence of child maltreatment is physical health. Research on physical health consequences of child maltreatment spans several specific domains, including:

- General health
- Risk for diabetes
- Obesity
- Sexual behavior
- Mortality

General health. General health refers to individuals' overall physical well-being. Researchers have examined physical well-being in both adolescents and adults with histories of maltreatment. Teenagers with a history of childhood abuse or neglect report lower ratings of physical health compared to their peers (Bonomi et al., 2008; Hussey et al., 2006). Similarly, a longitudinal study of child abuse and neglect found that adults who had experienced childhood maltreatment had poorer physical functioning, more bodily pain, and poorer general health than comparison adults (Herrenkohl, Hong, Klika, Herrenkohl, & Russo, 2013). Further, 24% of adults who had been abused rated their current health as poor/fair, a statistically higher percentage than those in the non-abused comparison group (10%).

Risk for diabetes. Diabetes is a growing health concern in the American population. Research has examined diabetes as a correlate of child maltreatment. Several recent studies, including some prospective longitudinal projects, have examined associations between child maltreatment and risk for diabetes (Spatz et al., 2012). Physical abuse and neglect have predicted elevated hemoglobin A1C levels (a biomarker for diabetes) and albumin (a biomarker for liver and kidney function) (Widom et al., 2012). Emotional neglect specifically has increased the risk for poor glucose control (Thomas, Hyppönen, & Power, 2008).

Obesity. Obesity is a major public health problem in the United States (Ogden, Carroll, Kit, & Flegal, 2014), and several studies support a connection between childhood maltreatment and obesity. Studies controlling for family characteristics and individual risk factors have found links between child

abuse and neglect and increased body mass index and increased rates of obesity in childhood, adolescence, and adulthood (Gilbert, 2009; Institute of Medicine, 2014). Research focusing specifically on emotional neglect has yielded similar findings (e.g., Thomas, Hyppönen, & Power, 2008). One large birth cohort study of approximately 5,000 children from 20 large U.S. cities found the odds of obesity were 1.56 times higher among children who had experienced neglect after controlling for numerous parental and child factors, such as mother's race/ethnicity, education and body mass index and the child's gender and birth weight (Whitaker et al., 2007). There is a need for further examination of the relationship between neglect and child or adult obesity, as some studies have not found a relationship (e.g., Bennett, Sullivan, Thompson, & Lewis 2010; Bentley & Widom, 2009).

Sexual behavior. Research has also considered links between childhood maltreatment and potentially risky sexual behavior. For example, child abuse broadly has been associated with an increased risk for prostitution, early sexual activity, and contracting HIV (Jewkes et al., 2010; Wilson & Widom, 2008; Wilson & Widom, 2010). Concerning neglect specifically, a study of women who had experienced emotional neglect found higher rates of primary genital herpes over two years of follow up than comparison women (Jewkes et al., 2010). A meta-analysis of child neglect and adult well-being found that people who had experienced neglect were 1.57 times more likely to both participate in risky sexual behavior and have sexually transmitted infections (Norman et al., 2012).

Mortality. The most severe adverse consequence of child maltreatment is death. In 2013, approximately 1,520 children in the United States died as a result of abuse and neglect, corresponding to approximately 2.04 children per 100,000 children (United States Department of Health and Human Services, 2015). Fatality rates are higher for boys (2.36 per 100,000 boys) than girls (1.77 per 100,000 girls). Across gender, 74% of child fatalities include children under age three. Specific causes of fatalities are unique to each case and often involve a complex interaction of multiple factors; however, children tend to be at elevated risk for abuse-related fatalities in families that have experienced a major life stressor such as unemployment, moving, or the birth of a child (Welch & Bonner, 2013). Further, estimates suggest that approximately three-quarters of fatalities are associated with neglect (Institute of Medicine, 2014). A prior report of child abuse to child protective services tends to be a strong risk factor for child mortality before the age of five (Putnam-Hornstein, 2011). Within the Department of Defense, there were 31 child abuse-related fatalities reported to the Family Advocacy Program in fiscal year 2013 (Department of Defense, 2014).

Estimates suggest that approximately three-quarters of fatalities are associated with neglect (Institute of Medicine, 2014).

In summary, a strong research base supports the connections between childhood maltreatment and numerous physical health problems, including those that emerge in adolescence and adulthood. Problems may be evident in overall health, increased risk for diabetes and obesity, risky sexual behaviors, and mortality rates. In addition to these negative physical health correlates, many studies have found maltreated children are at increased risk for an array of mental health concerns.

Mental Health

Child maltreatment can have a variety of negative consequences on children's mental health. Research on mental health consequences of child maltreatment spans several specific domains, including:

- Depression, anxiety, and suicide
- PTSD
- Substance abuse
- Delinquency and criminal behavior

Depression, anxiety, and suicide. Multiple studies have documented an increased risk for depression among maltreated children during childhood (Kaplow & Widom, 2007), adolescence (Fergusson et al., 2008; Heneghan et al., 2013; Lansford et al., 2002) and adulthood (Widom, duMont, & Czaja, 2007). More specifically, neglect has been associated with elevated internalizing problems (e.g., depression, anxiety) among three- and five-year old children (Dubowitz et al., 2009). Young maltreated children also show heightened anxiety and emotional reactivity (Kaplow & Widom, 2007; Tottenham et al., 2009; Zeanah et al., 2009). By their late 20s, more than one-third of adults who were maltreated as children have signs of major depressive disorder (Gilbert et al., 2009), and as many as 25% of adults who were neglected meet the full criteria for major depression at some point in their lives (Widom, duMont & Czaja, 2007). Adults maltreated in childhood report not only more symptoms of both depression and anxiety, but also more impairment due to mental health problems than comparison adults (Herrenkohl et al., 2013). A recent meta-analysis of childhood neglect and mental health outcomes found that neglected people are 2.1 times more likely to experience subsequent depression than those who did not experience neglect (Norman et al., 2012).

Multiple studies have documented an increased risk for depression among maltreated children during childhood.

In light of the clearly increased risk for depression among neglected persons, the literature reflects a similar finding regarding suicide. Rates of suicide attempts in both adolescence and adulthood are elevated among individuals who experienced child maltreatment (Fergusson et al., 2008; Gilbert, Widom, Browne, Fergusson, Webb, & Janson, 2009). A meta-analysis of 124 studies of childhood neglect found that those who have experienced neglect are 1.95 times more likely to later attempt suicide (Norman et al., 2012).

PTSD. Both prospective and retrospective studies have consistently found associations between childhood neglect and PTSD, both in adolescence and adulthood, even after controlling for child and family characteristics (Gilbert, 2009; Nikulina, Widom, & Czaja 2011). One retrospective study that specifically examined neglect found that 31% of victims of childhood neglect met criteria for PTSD at some point in their lifetimes (Widom, 1999). A more recent study found that 33-50% of children who had experienced neglect and were exposed to intimate partner violence met criteria for PTSD (Kearney et al., 2010).

Substance abuse. Both teenagers and adults who have experienced child maltreatment are at increased risk for problems with alcohol, cigarette, and drug use (Gilbert et al., 2009; Hussey et al., 2006). Substance abuse is often a correlate of depression, anxiety, and PTSD, and may be a way of coping with these difficulties; however, alcohol and/or drug abuse typically creates additional problems. A meta-analysis found that individuals who were neglected in childhood were 1.36 times more likely to

use drugs than their peers who were not neglected (Norman et al., 2012). Furthermore, adults who were abused or neglected in childhood tend to report using more drugs and experiencing more substance use-related problems than their peers (Widom et al., 2006).

Delinquency and criminal behavior. Children who have experienced maltreatment are at elevated risk for numerous externalizing behavioral problems, such as conduct disorders, aggression, violence, and delinquency (Institute of Medicine, 2014; Lansford et al., 2009; Thornberry et al., 2010). Males who were abused or neglected in childhood are more likely to be involved in the juvenile justice system (Williams, Van Dorn, Bright, Jonson-Reid, & Nebbitt, 2010). Children who are maltreated are approximately twice as likely to engage in many different kinds of crimes, such as assault, theft, and armed robbery (Currie & Tekin, 2012); furthermore, the risk of perpetrating criminal behavior increases with the experience of multiple forms of maltreatment. One study that specifically examined neglect found that childhood neglect uniquely predicted the likelihood of being arrested for a crime in adulthood (Nikulina et al., 2011).

The ripple effects of childhood maltreatment on mental health, both in the short-term and across the course of one's life, can be great.

The ripple effects of childhood maltreatment on mental health, both in the short-term and across the course of one's life, can be great. Increased rates of depression, suicide attempts, PTSD, substance abuse, and delinquency among those who have been abused or maltreated attest to the potential harms to functioning.

Academic Functioning

Researchers concur that child maltreatment is also associated with poor school performance, both in the short- and long-term (Leiter, 2007; Manly, Lynch, Oshri, Herzog, & Wortel, 2013). A wide range of academic indices have been studied, including attendance, in-class behavior, and grade point average (GPA). In this domain of functioning, the kind of abuse appears to matter, with child neglect (versus other forms of abuse) being an especially strong predictor of academic underachievement (Jonson-Reid et al., 2004; Nikulina et al., 2011).

One two-year prospective study of urban low-income children focused specifically on neglect in the first four years of life and adaptation to school in kindergarten and first grade (Manly et al., 2013). Neglected children had significantly poorer classroom behavior (attending to tasks, behavior management) than their peers, and attendance rates were significantly lower (ranging from 24%-64% for some children). In addition, neglected children were more likely to have lower grades as they moved through first grade. Children who had experienced more severe neglect were more likely to have poorer receptive and expressive language skills and lower IQ.

Other studies have tracked older children and found elevated rates of enrollment in special education among victims of child maltreatment. For example, 24% of abused and neglected children (vs 14% of their peers) entered special education in a study of low-income children (Jonson-Reid et al., 2004). Longitudinal research has also found that the negative effects on school performance may linger over time, with especially detrimental impacts on school attendance (Leiter, 2007).

Another domain of child functioning needing further research is maltreated children's risk for attentional difficulties. One study found that 19% of abused and neglected teens screened positive for ADHD, compared with 5% of children more broadly (Heneghan et al., 2013). If this finding is replicated in additional research, focused attention on supporting children with attention and concentration issues in school may be warranted.

Relationship Functioning

Young people who have been abused and/or neglected may experience challenges in their relationships with their peers and parents. The experience of being maltreated may shape children's perceptions about who they can trust, preclude children from having healthy role models for positive relationship skills, and result in numerous mental health challenges that may impede the development of successful relationships.

Young people who have been abused and/or neglected may experience challenges in their relationships with their peers and parents.

Maltreated children and adolescents may struggle in developing and maintaining healthy relationships with peers. Children who experience neglect in the first two years of life have been found to display more aggression toward their peers at ages four, six, and nine (Kotch et al., 2008). Maltreated children may also have difficulties regulating emotions, which can impair their skills in forming healthy relationships with peers (Kim & Cicchetti, 2010). Maltreated children may have difficulty managing frustrations and dealing with disappointments both in the classroom and on the playground. Sensing these children's atypical behaviors, peers may distance themselves, and avoid the maltreated children.

Young people who have been maltreated often experience difficulties in forming healthy relationships with their parents. Rates of difficulties with attachment among toddlers who have experienced substantiated neglect have been found as high as 40% (Zeanah et al., 2004). Toddlers who have experienced neglect appear to be at risk for socially indiscriminate attachment behavior as well, which can involve lack of selectivity in the choice of an attachment figure (Lyons-Ruth et al., 2009). A recent meta-analysis of 10 studies regarding attachment quality and child maltreatment found a large effect size for these children being at increased risk for both disorganized (i.e., unpredictable, erratic, confusing interaction patterns) and insecure (i.e., dismissing and avoidant of others or anxious and preoccupied with intimacy) attachment (Cyr et al., 2010). Given the growing research documenting the short- and long-term consequences of problematic parent-child attachment (Brumariu & Kerns, 2010; Raudino, Fergusson, & Horwood, 2013), including negative effects on adult intimate relationships (Mikulincer & Shaver, 2012), awareness of the impact of neglect on these foundational relationships is vital. As reviewed in the later section of this report on prevention and intervention programs, many services directly target the parent-child relationship as a means of building resiliency and minimizing negative impacts.

Economic Issues

According to the Centers for Disease Control, child maltreatment costs the United States $124 billion every year; the per-person lifetime cost of child maltreatment exceeds or matches other public health concerns such as stroke or type two diabetes (Fang et al., 2012). These costs encompass a wide range of

factors including but not limited to healthcare costs across the lifespan, lost productivity, child welfare costs, criminal justice system expenses, and special education costs.

At the individual level, adults who have experienced child maltreatment have lower levels of education, income, and employment than their peers (Currie & Widom, 2010). When controlling for background characteristics, there is a 14% gap between adults with histories of abuse/neglect and controls in the probability of employment in middle age. Thus, the economic impacts of abuse can be large and can span a lifetime.

In sum, child maltreatment can affect children and families across a wide array of domains. The impacts can be almost immediate as well as across the lifespan. Understanding the risk and protective factors for child maltreatment, as outlined in the following sections, can guide the development of effective prevention and intervention programs.

Risk Factors for Child Maltreatment

Predicting child abuse and neglect is difficult. Single risk factors are generally not good predictors of child maltreatment (MacKenzie, Kotch, & Lee, 2011), and combinations of risk factors may result in child maltreatment in some situations, but not in others. The complex interaction of multiple risk factors, protective factors, and resilience is not well understood (Institute of Medicine, 2014). The dearth of prospective studies of child neglect makes understanding predictors of difficult, but two longitudinal studies are useful, including the Fragile Families and Child Wellbeing Study (Waldfogel et al., 2010) and the Illinois Families Study – Child Wellbeing (Lewis, Shook, Stevens, Kleppner, Lewis, & Riger, 2000), both of which are referenced herein.

The vast literature on child maltreatment has identified many risk factors (Stith et al., 2009; Stoltenborgh et al., 2013; Institute of Medicine, 2014). These factors are summarized in Table 2 and can be considered across the following eight categories:

- **Child characteristics** include demographic characteristics (e.g., age, sex, ethnicity), disability status, social competencies, behavioral problems, pre- and neo-natal problems, and whether the pregnancy was desired or not.
- **Parent characteristics** include demographic factors (e.g., age, age at childbirth, race, religion), family history (e.g., abuse/maltreatment, relationship with own parents), substance use, and mental health/psychopathology including depression, anxiety, and antisocial behavior.
- **Parent-child relationship characteristics** include parent ideologies, skills, and knowledge, parents' attitudes towards their child(ren), and parental interaction styles with their child(ren).
- **Family characteristics** include both aspects of family structure (e.g., cohabitation, single parents, number of children) and other family characteristics including family stress, history of intimate partner violence (domestic abuse), family conflict/family cohesion, marital satisfaction, and socioeconomic status.
- **Father characteristics** include the father’s role in abuse and neglect. Many studies focused on the mothers’ role in abuse and neglect; however, approximately 85% of Active Duty and 82% of Reservists are men (DoD, 2012).
- **Community and societal characteristics** include environmental factors that influence the individual family. Community characteristics include poverty rates in a community, number of liquor outlets, crime, unemployment, population turnover, ratio of children to adults, and

number of single-parent families. Societal characteristics include societal attitudes regarding violence and cultural beliefs about corporal punishment.

- **Military characteristics** include features of military life that may be associated with child abuse and neglect, such as deployment and parental mental health problems.

While this organizational scheme treats risk factors separately, risk factors for abuse and neglect rarely occur in isolation (Gilbert et al., 2009). Many studies address multiple risk factors while controlling for demographic risk factors, and examine additional risk factors to determine the differential risk associated with each factor. The next section provides an overview of the research about the seven categories of risk and protective factors.

Risk factors for abuse and neglect rarely occur in isolation.

Child Characteristics

Numerous child characteristics have emerged in the literature that affect the level of risk for maltreatment. The characteristics can be grouped into three general categories: (1) demographic characteristics; (2) behavioral problems and disability status; and (3) pregnancy-related variables.

Demographic characteristics. The risk of neglect varies across numerous child demographic characteristics, including ethnicity, age, and sexual orientation. Younger children are at a higher risk of neglect than older children; 27% of maltreatment victims are under age three, and 20% are between the ages of three and five (Klevens & Leeb, 2010). Several studies have demonstrated a relationship between ethnicity and the risk of maltreatment; however, results have been mixed. For example, Palusci and colleagues (2008) examined 1.2 million confirmed cases of child maltreatment between 2003-2007, including 177,568 incidences of maltreatment in infants and children under age five. Results showed that rates of abuse and neglect were higher among White children than African American children. However, when comparing the risk of maltreatment among White and African-American children, Putnam-Hornstein (2012) found that the risk of maltreatment was twice as high for African American children than for White children. Lanier and colleagues (2014) provide some insights into this apparent contradiction. According to the results of their study, African-Americans were overrepresented in the 6 million children investigated for child abuse and neglect across the United States in 2012. However, the authors concluded that observed racial discrepancies may be attributable to other known correlates of child maltreatment, including higher rates of poverty, more extramarital childbearing, and higher rates of teen motherhood in both African-American and Hispanic communities.

Another risk factor that has recently been considered is the child's sexual orientation. Alvy and colleagues (2013) studied female sibling pairs, one of whom identified as heterosexual while the other identified as a sexual minority (e.g., identifying as an LGBTQ person). Children who identified as a sexual minority were significantly more likely to be abused or neglected than their heterosexual siblings.

Behavioral problems and disability status. Child behavior problems and developmental delay may influence the risk of child maltreatment. Studies of behavioral characteristics associated with maltreatment have focused on three types of behavior: *internalizing behaviors* which include low self-esteem, depression, anxiety, and withdrawal; *externalizing behaviors* which include aggression, violence, defiance, and criminal behavior; and *attention problems* which include impulsivity, inattention, and hyperactivity (Maguire et al., 2015). Current studies have examined behavioral problems as either

correlates or outcomes of abuse or maltreatment. However, children exhibiting internalizing and externalizing behavioral problems may be at higher risk of being victimized by both peers and caregivers than their non-maltreated peers. Turner and colleagues (2010) studied 1,467 children between the ages of 2-17 and found that children with co-occurring internalizing and externalizing behaviors were at an increased risk for several forms of victimization including: peer victimization, maltreatment by caregivers, and sexual abuse.

Children with disabilities are also at an increased risk of maltreatment by caregivers (Child Welfare Information Gateway, 2012; Murphy, 2011). According to Giardino and colleagues (2014):

> The very existence of a disability or limitation in a child that diminishes his or her ability to communicate, react, and/or meet parental or societal expectations can make some children more vulnerable. The unexpected realization of new parents that a child of theirs may never reach the full potential of their nondisabled peers may be particularly devastating to some (p. 169).

Children with disabilities are also at an increased risk of maltreatment by caregivers.

For example, a study of Finnish pre-teen and teenage school children found a clear relationship between risk of child maltreatment and visual impairment, mental health issues, learning and memory impairment, and other chronic conditions (including asthma) (Heinonen & Ellonen, 2013). Further, Dubowitz and colleagues (2009) found that poor performance on a standardized mental development assessment completed during a child's first 3.5 years of life was positively associated with neglect. Dubowitz's findings suggest that children perceived to be developmentally delayed early on were at an increased risk of later abuse. Nevertheless, some studies have suggested that the relationship between disability and maltreatment may be overstated, and find equivocal results based on variability in study populations, definitions, and methodologies (Leeb et al., 2012).

Pregnancy-related variables. Studies examining the relationship between child maltreatment and the conditions surrounding pregnancy are comparatively rare. However, a large cohort study of 14,256 children found that unintended pregnancy, poor child health, child developmental problems, and low birth weight were positively associated with maltreatment (Sidebotham et al., 2003). A more recent study examined pregnancy intention by asking asked parents at the time of birth whether they had considered abortion (Guterman, 2015). Fathers' reports of having considered abortion were positively associated with later perpetration of physical aggression, while mothers' reports were associated with later perpetration of psychological aggression and neglect. Thus, issues surrounding pregnancy intention may be an early risk factor for child maltreatment.

Parent Characteristics

While research on child characteristics has provided some insight into differential risk of maltreatment, parent characteristics have been one of the most widely explored topics in predicting risk of child maltreatment. Four categories of parent characteristics may impact the risk of maltreatment among children, including: (1) demographic and socioeconomic characteristics; (2) maternal history of abuse and neglect; (3) parental mental health; and (4) parent-child relationship characteristics.

Demographic and socioeconomic characteristics. Maternal demographic characteristics are a consistent predictor of child maltreatment, including maternal age at childbearing (de Paul & Domenech, 2000; Lee & Guterman, 2010). For example, Bartlett and Easterbrooks (2015) found that while 77% of mothers who had been abused in childhood were able to break the intergenerational transmission of abuse, younger mothers who had suffered abuse in childhood were more likely to abuse their children than older mothers who had been abused.

In addition to maternal age, mothers' education level has also been associated with child maltreatment. A prospective study of 332 low-income families found that mothers with less than a high school education were significantly more likely to engage in abusive or neglectful behaviors than mothers with at least a high school education (Dubowitz et al., 2009). Similarly, a longitudinal study following middle school students into adulthood found that mothers with less education were more likely to have a substantiated report to Child Protective Services (Thornberry et al., 2014).

Family financial hardship also consistently emerged as a risk factor for child maltreatment. Children living in situations characterized by economic hardship (e.g., low income, food pantry use, inability to receive medical care for a sick family member, difficulty paying rent, utility shut-offs) are at a higher risk of maltreatment than their peers in more economically stable environments (Berger & Waldfogel, 2011; Slack et al., 2011). Further, the risk of maltreatment by mothers may increase when fathers are unemployed (Lee & Guterman, 2010). Researchers have considered more global indices of family financial well-being by examining overall national economic conditions and consumer confidence; one study found a positive association between poorer national economic conditions and lower levels of consumer confidence and frequency of maternal spanking (Brooks-Gunn et al., 2013).

Maternal history of abuse and neglect. Mothers who were maltreated in childhood are at higher risk of perpetrating abuse to their own offspring (Fontaine & Nolan, 2012). The intergenerational transmission of abuse may elevate the risk of abuse in subsequent generations through both direct and indirect pathways. Support for the direct transmission comes from research with very young mothers; those who had been physically abused in childhood were four times more likely to neglect their own children (Bartlett & Easterbrooks, 2012). Research has also focused on the impact of the mother's relationships with her own parents as potentially predictive of the intergenerational transmission of child maltreatment. In a study of 73 at-risk mothers raising children with behavioral problems, Rodriguez and Tucker (2011) found that poor attachment between mothers and their own parents predicted both dysfunctional parenting practices and elevated child abuse potential even after controlling for a history of childhood abuse.

Mothers who were maltreated in childhood are at higher risk of perpetrating abuse to their own offspring.

On the other hand, the intergenerational transmission of abuse may occur indirectly, such as through an increase in maternal substance use. A study of 499 mother-child dyads found that mothers who were sexually or physically abused as children were more likely to engage in child abuse (Berlin et al., 2014). However, the authors found that the increased risk of physical abuse was attributable to an increased risk of substance abuse. Nevertheless, no relationship emerged between a childhood history of neglect and the likelihood of neglecting one's offspring. Taken together, these studies suggest that not only may parental history of abuse increase a parent's risk of engaging in maltreatment, but it may also increase other known risk factors for maltreatment, thereby compounding the risk of intergenerational transmission of abuse.

Parental mental health. Multiple studies have focused on parental mental health as a risk factor for perpetrating child maltreatment. Factors that have received particular attention in the literature are parental depression, trait anger, parenting stress, and substance use disorders.

A commonly cited parental risk factor for child abuse is parental depression. A four-year longitudinal study of 595 mothers found that mothers who were investigated for child maltreatment were significantly more likely to be depressed than mothers who were not investigated for child maltreatment (Campbell et al., 2010). Similarly, levels of paternal depression have been found to be higher in households where abuse and neglect were present (Lee et al., 2012). Parental depression may increase the risk of abuse in couples with substance abuse problems. In one study of parental substance abuse, parental depression was related to higher rates of child maltreatment and parental over-reactivity in disciplinary encounters with their children (Kelley et al., 2015).

A commonly cited parental risk factor for child abuse is parental depression.

Some studies have considered the role of trait anger among parents and its relationship to child maltreatment. In one study of 152 urban mothers, maternal anger arousal and reactivity were more salient predictors of child abuse than other diagnostic and demographic variables (Hein et al., 2010). A meta-analytic review of risk factors for child maltreatment found anger and hyper-reactivity to be associated with elevated risks for both abuse and neglect (Stith et al., 2009).

Parental substance abuse has also been consistently found to increase the risk for perpetrating child maltreatment (Staton-Tindall et al., 2013). For instance, maternal drug use has been found to increase the risk of both physical (Dubowitz et al., 2009) and sexual abuse (Walsh et al., 2003).

In addition to parental depression, anger, and substance abuse, parenting stressors and coping abilities have also been linked to the risk of perpetrating child maltreatment. Rodriguez and Green (1997) found that both anger expression and parenting stress were strongly associated with child abuse potential. Abusive parents may also be struggling with other non-parenting-related life stressors, which may impact their parenting behavior (Whipple & Webster-Stratton, 1991) and increase the risk that they may neglect their children (Lee et al., 2012). Researchers have suggested that building parents' ability to cope with stress and tolerate frustration may diminish the risk of child abuse or maltreatment (McElroy & Rodriguez, 2008)

Parent-child Relationship Characteristics

Parents' attitudes toward their children have received significant attention as a potential risk factor for child maltreatment. This area of study examines the relationship between parenting behaviors and (1) parents' perceptions and attributions of children's behavior; (2) parents' attachment to their children; and (3) parents' understanding of children's behaviors on their parenting behaviors.

Parents' perceptions and attributions of children's behaviors refers to underlying motivations that parents ascribe to their children's actions. Early research found that parents who ascribe negative motivations to their children's behaviors are more likely to mistreat their children (Larrance & Twentyman, 1983; Schellenbach et al., 1991). More recently, a study of 499 expectant mothers found that ascribing hostile motivations to infant behaviors (e.g., crying) increased the likelihood that the child would be mistreated by 26 months of age (Berlin et al., 2013). Similarly, Ateah and Durrant (2005) found

that maternal use of physical punishment was positively related to their perceptions of the gravity of the child's behavior as well as the child's intentions.

Additional research has focused on the emotional attachment between the parent and child in relation to maltreatment. In a study of preschool-aged children, Stronach and colleagues (2011) found maltreated preschoolers had lower rates of secure parental attachment, and higher rates of disorganized attachment (i.e., attachments simultaneously characterized by threat and security) than their non-maltreated peers. Like many correlates of maltreatment, poor and disorganized attachment may also be an outcome of rather than a risk factor for maltreatment. Some researchers have suggested that poor attachment is likely the result of living in high-risk environments (Cyr et al., 2010). However, at least some evidence suggests that it is poor attachment that increases the risk of maltreatment. In one study, mothers who had murdered their children were more likely to have insecure attachments with their children than both mothers living with serious mental illness and control group mothers (Barone et al., 2014). This suggests that poor parent-child attachment bonds increase the risk of maltreatment.

Research has demonstrated that increasing parenting knowledge may help reduce the risk of child maltreatment (Child Welfare Information Gateway, 2014; Stith et al., 2009). However, very few studies have examined knowledge differentials between abusive and non-abusive parents as potentially predictive of abuse or neglect. Rather, most studies either reviewed or conducted meta-analyses on intervention programs for at-risk families (Geeraert et al., 2004; Lundahl et al., 2006; MacLeod & Nelson, 2000). While many of programs have demonstrated improvements in a range of domains that will be covered later in this report (e.g., parenting attitudes towards abuse, children's emotional adjustment, childrearing skills, and enacted abuse) (Lundahl et al., 2006), intervention programs may have a host of benefits beyond parenting knowledge, including broadened support networks. As a result, it is impossible to determine how much positive change is due to improved knowledge of parenting, and how much is due to other benefits derived from participation in parenting education programs. Future research is needed to assess parents' knowledge of child development prior to involvement in intervention programs.

Increasing parenting knowledge may help reduce the risk of child maltreatment.

Family Characteristics

The family structure, including who resides in the home and who cares for the child, may impact the risk of child maltreatment. Research examining the impact of family structure on child maltreatment shows that parents' relationship status, blended family status, number of children in the home, and care setting can impact a child's likelihood for maltreatment.

Parents' relationship status. Relationship status, including whether parents are married, single, or in a cohabiting relationship, can impact the risk of child maltreatment (Sedlak et al., 2010). In a longitudinal study of family structure and risk of child maltreatment, single parent families tended to engage in neglect significantly more often than dual parent families; further, families with single, *working* mothers were even more likely to engage in neglectful behavior compared to single families where the mother did not work outside the home (Berger, 2004). Mothers who re-partnered had similarly negative outcomes. According to a congressionally mandated report on child abuse and neglect incidence in the United States (Sedlak et al., 2010), children residing with a single parent and a

cohabiting partner had 10 times the risk of physical abuse and eight times the risk of neglect when compared to children living with both biological parents.

Blended family status. While some studies have focused on the parents' relationship status, other studies have examined blended families specifically. Children in blended families are more likely to be maltreated than children residing with both biological parents (Alexandre et al., 2010; Berger et al., 2009; Malvaso et al., 2015). Berger and colleagues (2009) studied the relationship between blended families and Child Protective Service involvement. The study examined the mothers' relationship status specifically, and found that families in which the mother was living with a male partner who was not the biological father of all children in the household were significantly more likely to be contacted by child protective services than families in which the mother's partner was the biological father of all resident children. Nevertheless, the issues are complex. For example, while Malvaso and colleagues (2015) also found an elevated risk of abuse among children living with stepfathers, this effect disappears when the researchers accounted for child's sex (male), frequent changes of residence, and mother's problematic alcohol abuse. Thus, the presence of a stepfather in and of itself may not be the risk factor, but may be related to the presence of other risk factors. Similarly, in a study of Brazilian women with a current male partner and a child (age 1-12), 34% of children living with stepfathers had experienced physical abuse, compared to only 18% of those living with biological fathers (Alexandre et al., 2010). However, the abuse was predominantly perpetrated by the biological mothers in these situations, and not the stepfathers.

Children in blended families are more likely to be maltreated than children residing with both biological parents.

While research continues to show disadvantages for children living in single-parent and blended families, Waldfogel and colleagues (2010) suggest that these results may represent a holdover from a time when such families were more stigmatized. According to the authors of the Fragile Families and Child Wellbeing study, many of the studies that demonstrate a link between non-traditional family structures were conducted before the large upsurge in extramarital childbearing that now characterizes U.S. families. Future research may consider analyzing whether observed variance in child maltreatment in blended families can be attributed to other explanatory variables.

Number of children in the home. A greater number of children in the home may increase both the risk and gravity of child maltreatment. Research by Sedlak and colleagues (2010) found that the incidence of maltreatment was positively associated with the number of dependent children in the house. Specifically, the risk of abuse was twice as high in households with three or more children, compared to families with only two children. However, the relationship between number of children and the risk of maltreatment was not linear. Risk of maltreatment was highest in families with more than four children, intermediate in families with one or three children, and lowest for families with only two children. The number of children in the household may also impact the gravity of abuse and neglect. In a study of 685 child neglect cases in Oklahoma over a 21-year period, the number of children in the household was positively associated with an increased risk of death resulting from neglect (Damashek et al., 2013).

Care setting. Another risk factor for child maltreatment is residing in foster or other institutionalized care settings. Benedict and colleagues (1994) analyzed abuse and neglect reports in

foster care and compared them to the general population. Foster care families were three times more likely to be reported for instances of child maltreatment than families from the general population. Further, foster family maltreatment reports were significantly more likely to involve physical abuse, while general public reports were more likely to focus on neglect. Research has also found evidence of increased risk of maltreatment in institutional care systems. Euser and colleagues (2013) analyzed rates of child sexual abuse in foster and residential care as compared to the general population in the Netherlands. While findings indicated that there was no increased risk of child sexual abuse in foster settings, rates of sexual abuse were higher in institutional care settings. Taken together, these findings suggest that care settings may not only predict heightened risk of maltreatment, but that the particular type of abuse may differ based on the specific care setting.

While some research has focused on the compositional characteristics of family environments in which abuse and neglect occur, other research has examined characteristics of the family environment that may contribute to elevated stress levels, a risk factor for child maltreatment. Research on family characteristics has examined factors such as: (1) low socioeconomic status; (2) presence of intimate partner violence; and (3) low stability as potential risk factors for child maltreatment.

Low socioeconomic status. Families with limited economic resources are at an increased risk of child maltreatment (Maguire-Jack & Klein, 2015; Slack et al., 2011; Warren & Font, 2015). Across various definitions of economic hardship (e.g., receipt of public benefits, borrowing money from family members, using food banks, and inability to pay for medical care), many studies have found a positive relationship between family economic hardship and risk of child maltreatment. Family-level economic hardship may serve to increase the level of stress in a household, thereby increasing the risk of child maltreatment. For example, a study of 1,597 young parents found that *paternal* unemployment was a risk factor for increased *maternal* aggression (Lee & Guterman, 2010).

Presence of intimate partner violence. Intimate partner violence in the home can be stressful for all family members. States vary in their definition of whether observing inter-parental intimate partner violence or living in a household in which intimate partner violence occurs constitutes child maltreatment (Postmus & Merritt, 2010). Nevertheless, intimate partner violence commonly co-occurs with child maltreatment. In a study of 4,595 children, one-third of those who reported witnessing intimate partner violence in the home also reported experiencing at least one form of maltreatment during the past year (Hamby et al., 2010). The increased risk of maltreatment associated with intimate partner violence may not be completely attributable to the presence of a violent adult in the home. According to Nicklas and Mackenzie (2013), experiencing violence at the hands of a partner may not only negatively impact maternal well-being, but also interfere with mothers' ability to provide basic care and nurturance to children. In support of this notion, Taylor and colleagues (2009) found that mothers who were victims of intimate partner violence were more likely than non-victims to engage in all four types of child maltreatment: psychological abuse, physical abuse, neglect, and spanking.

Intimate partner violence commonly co-occurs with child maltreatment.

Low stability. Other family characteristics that have received attention in the literature relate to the stability, cohesion, and social connectedness of family environments. For example, one study classified 113 mothers as high, moderate, or low-risk for perpetrating child maltreatment; high-risk mothers were more likely to report more stressful life events and more family problems than low-risk

mothers (Kolko et al., 1993). In addition, families in which child maltreatment occurs tend to experience more life stressors. Eckenrode and colleagues (1995) found that maltreated children moved twice as often as their non-maltreated peers. Families in which maltreatment occurs may also have significantly fewer social connections with extended family, neighbors, and the community (Coulton et al., 2007), creating the potential for low social support and increased isolation. Future research may consider economic and other circumstances that predispose parents to limited family stability and social isolation as key points for intervention.

Father Characteristics

Research on parent characteristics and parent-child relationships have tended to focus largely on mothers, with relatively less literature available about fathers. The limited research on fathers has focused on the differential risk associated with fathers versus stepfathers. However, statistics from the U.S. Department of Health and Human Services (2006) show that fathers, acting alone or in conjunction with mothers, are responsible for perpetrating 36% of all reported abuse cases. However, this overrepresentation of mothers in reported cases of abuse or neglect may reflect a greater number of children in divorced or separated families who reside with their mother, given that research has shown that fathers are more likely to be abusers than mothers. In a study of fatalities among children under five, Klevens and Leeb (2010) found that fathers, including stepfathers and mothers' resident male partners, were *more* likely than mothers to perpetrate abusive head trauma and physical abuse. By contrast, mothers were more likely to neglect their children.

One important area of research on fathers pertains to their mental health. In interviews with 121 fathers who had maltreated their child(ren), Stewart and Scott (2014) found that half of the fathers showed problems with emotional unavailability, unresponsiveness, and negative attitudes toward their children. Paternal depression may also be a risk factor for child maltreatment. In a study of 1,089 families, rates of paternal depression were double in families in which evidence of child neglect was present compared to families in which evidence of child neglect was not present (Lee et al., 2012). Similarly, paternal depression has been associated with greater than double the odds of child neglect and Child Protective Services involvement (Lee, 2013). Given the demonstrated link between parental psychopathology and difficulties in forming interpersonal attachments (Mikulincer & Shaver, 2012), this research has implications for the likelihood of perpetrating child maltreatment. For instance, Howard (2010) studied 72 fathers to examine the relationship between risk of maltreatment and fathers' attachment style. Fathers who rated their attachment to their children as "secure" reported lower levels of abuse potential, lower parenting stress, higher levels of parenting efficacy, and better knowledge of child development. As a result, parenting programs may consider including information on how fathers may form secure attachments with all resident children.

Additional paternal characteristics that have received attention in the research literature include the fathers' country of origin and history of incarceration. Lee and colleagues (2011) studied 372 foreign and native-born Hispanic biological fathers of young children. Foreign-born fathers tended to use less aggressive behaviors than native-born Hispanic, White, or Black fathers. The findings of this study point to the potential impact of country of origin and culture in considering the risk of child maltreatment. Fathers' incarceration status has also been examined as a risk factor. Turney (2014) found that the incarceration of a residential father was associated with an increase in maternal neglect and physical aggression. Paternal incarceration may result in changes to the other relationships in the home, to economic security, and to household stress, all of which may impact the risk of child maltreatment.

Community and Societal Characteristics

Some research has pointed to community or societal characteristics that can impact children's risk of abuse or neglect. Neighborhood risk factors include poverty within the local community, number of liquor outlets, crime, unemployment, population turnover, ratio of children to adults, and number of single-parent families (Institute of Medicine, 2014; Stith, 2009). Societal characteristics include societal attitudes regarding violence and societal beliefs about corporal punishment (Kracke & Hahn, 2008). Research has demonstrated a consistent link between these broad influences and parenting behaviors related to child maltreatment.

One area that has received considerable attention in recent literature is neighborhood characteristics, including distance to social services. Maguire-Jack and Klein (2015) examined the relationship between child neglect and proximity to four types of social services, including child care, domestic violence shelters, mental health/substance abuse clinics, and poverty services. Longer driving distance between a parent's home and mental health/substance use clinics was associated with an increased risk of child neglect. Another neighborhood characteristic that has been studied in relation to risk of child abuse or neglect is housing insecurity. Housing insecurity may indirectly contribute to the risk of maltreatment by decreasing family well-being and increasing maternal stress (Warren & Font, 2015). Further, Freisthler and Maguire-Jack (2015) examined relationships between neighborhood variables and risk of child maltreatment. Social disorder, defined as heavy traffic, neighborhood violence, gang activity, and the presence of illicit drugs, was associated with higher rates of child physical abuse.

Longer driving distance between a parent's home and mental health/substance use clinics was associated with an increased risk of child neglect.

Societal characteristics, such as cultural definitions of abuse and neglect, coupled with children's roles and importance within a culture, may impact the nature and quality of both discipline and supervision. Research by Elliott and Urquiza (2006) showed that characteristics associated with culture and ethnicity have consistently emerged as predictors of maltreatment risk. Similarly, Freisthler and Maguire-Jack (2015) showed that rates of neglect within a community varied based on the ethnic composition within that community. Specifically, according to the results of the study, a low number of Latino males in a community was associated with an increased risk of physical abuse; the presence of more naturalized Hispanic and Asian/Pacific Islander families was associated with more child physical abuse in a community. Elliott and Urquiza (2006) make several recommendations for the further study of ethnicity and culture in child maltreatment studies including culturally appropriate definitions of discipline and supervision.

Military Characteristics

Limited research has examined aspects of military service that may be risk factors for child maltreatment. Some documented risk factors in the civilian sector (e.g., poverty, poor health care, housing insecurity, and unemployment) represent minimal risk within the confines of the military (Maguire-Jack & Klein, 2015). Similarly, while substance use disorders are associated with an increased risk for child maltreatment (Lee, 2013; Malvaso et al., 2015), Service members face penalties or

discharge for drug and alcohol abuse problems, such that the prevalence of severe substance abuse in the military is relatively low (Phipps, 2009).

However, some structural elements of military life correspond with risk factors known to exacerbate the risk of maltreatment. Early research suggests that an authoritarian work environment and high exposure to violence may increase the risk that Service members will engage in child maltreatment (Dubanoski & McIntosh, 1984). Phipps (2009) cites other features of military life known to correlate with increased rates of child maltreatment in the civilian sector including frequent geographic moves (Eckenrode et al., 1995) and isolation from social support networks (Coulton et al., 2007).

Vast numbers of families have experienced deployment to a combat zone in the past 15 years in support of the wars in Iraq and Afghanistan. Saltzman and colleagues (2011) proposed a theoretical framework whereby military families facing deployment may experience increased stress. The authors propose five family-level mechanisms of risk including: (1) a family's a failure to understand deployment, its impact, and its stressors; (2) impaired family communication due to physical separation; (3) impaired parenting due to an increase in stress and decrease in parenting support; (4) impaired family organization due to changes in roles and responsibilities; and (5) lack of a guiding belief in the importance of a Service member's overseas assignment. Although purely theoretical, these five risk mechanisms may be useful in guiding research and conceptualizing prevention and intervention efforts focused on child maltreatment.

Several studies have specifically examined parental deployment and child maltreatment. Across military branch and across type of maltreatment (abuse and neglect), higher rates of civilian-parent-perpetrated child abuse correspond to periods of high operational tempo of deployments (Gibbs et al., 2007; McCarthy et al., 205; Rentz et al., 2007; Thomsen et al., 2014). Although the precise cause of this relationship between deployment and increased child abuse is unknown, research has found that deployment is related to increased stress among Service members, civilian spouses, and their children.

Service members may experience difficulties prior to, during, and following deployment. For example, Farmer and colleagues (2014) surveyed 2,620 Marines as they prepared for deployment to Iraq or Afghanistan, and found elevated rates of major depressive disorder and problematic drinking compared to the general population. Some Service members also experience mental health issues in after deployment, including adjustment disorders, depression, anxiety, and problematic substance use (Institute of Medicine, 2014; McAndrew et al., 2013). Taken together, depression, anxiety, and other mental health issues encountered in preparation for and in the aftermath of deployment may increase household stress, and thereby increase children's risk for maltreatment (Campbell et al., 2010; Staton-Tindall et al., 2013).

Depression, anxiety, and other mental health issues encountered in preparation for and in the aftermath of deployment may increase household stress, and thereby increase children's risk for maltreatment

Deployment-related stress may also impact the mental health of civilian spouses who are left to attend to responsibilities at home and often worry about the well-being of a loved one (Werber et al., 2013). Research with wives of deployed Service members found increased rates of depression, sleep disorders, anxiety, acute stress reactions, and adjustment disorders during their husbands' deployment (Mansfield et al., 2010). Civilian parents temporarily serve as the single parent during deployment, a family

constellation that is associated with an increased risk of maltreatment (Sadlak et al., 2010). Although homecoming of the deployed parent can be joyful and exciting, reintegration of the Service member may cause an increase in household stress; couples renegotiate household roles and responsibilities, and sometimes the family must adapt to combat-related mental and physical health challenges (Bowling & Sherman, 2008). These stressors may result in increased difficulty meeting parenting responsibilities, thereby increasing the risk of child maltreatment (Gewirtz et al., 2014; Lauterbach et al., 2007).

Deployment may also cause challenges for children as they cope with the absence of their deployed parents and worry for their well-being. School staff serving children of deployed parents have observed increased child anxiety, increased responsibilities for children at home, and increased stress among non-deployed parents (Chandra et al., 2010). Deployment may also correspond to an increase in behavioral difficulties among children (Chartrand, Frank, White, & Shope, 2008), which may increase parenting stress and risk of maltreatment. Further, some children struggle in adjusting to a returned parent who has mental health problems, including but not limited to PTSD (Lester et al., 2010). Clear associations have been found between parental PTSD and a range of behavioral and emotional adjustment difficulties in children (Lambert et al., 2014). These child behavior problems may exacerbate parental mental health problems, affect parental perceptions of children's behavior, and increase the risk of child maltreatment (Duranceau, Fetzner & Carleton, 2015). Taken together, these studies suggest that deployment can have a ripple effect across the entire family and may increase risk of maltreatment via several mechanisms of action.

Table 2: Risk Factors for Child Neglect

CHILD CHARACTERISTICS		
	Risk Factor	**Research Support**
Demographic characteristics	*Being younger* *Being White* *Being African American* *Identifying as a LGBTQ person*	Klevens & Leeb, 2010 Palusci et al., 2008 Putnam-Hornstein, 2012 Alvy et al., 2013
Behavioral problems and disability status	*More internalizing and externalizing behaviors* *Visual impairment* *Mental health issues* *Learning and memory impairment* *Other chronic conditions (e.g., asthma)* *Poor performance on standardized mental development assessment*	Turner et al., 2010 Heinonen & Ellonen, 2013 Heinonen & Ellonen, 2013 Heinonen & Ellonen, 2013 Heinonen & Ellonen, 2013 Dubowitz et al., 2009
Pregnancy-related variables	*Unintended pregnancy* *Poor child health* *Child developmental problems* *Low birth weight* *Fathers' consideration of abortion*	Sidebotham et al., 2003 Sidebotham et al., 2003 Sidebotham et al., 2003 Sidebotham et al., 2003 Guterman, 2015

PARENT CHARACTERISTICS		
	Risk Factor	**Research Support**
Demographic and socioeconomic characteristics	*Younger maternal age at childbirth* *Less education* *Family financial hardship (e.g., low income, food pantry use, inability to access medical care, difficulty paying rent, utility shut-offs)* *Paternal unemployment* *Poor national economic conditions* *Low levels of consumer confidence*	Bartlett & Easterbrooks, 2015 De Paul & Domenech, 2000 Lee & Guterman, 2010 Dubowitz et al., 2009 Thornberry et al., 2014 Berger & Waldfogel, 2011 Slack et al., 2011 Lee & Guterman, 2010 Brooks-Gunn et al., 2013 Brooks-Gunn et al., 2013
Maternal history of abuse and neglect	*Maternal maltreatment in childhood* *Poor maternal attachment to mother's own parents*	Fontaine & Nolan, 2012 Bartlett & Easterbrooks, 2012 Rodriguez & Tucker, 2011
Mental health	*Maternal depression* *Paternal depression* *Anger arousal and reactivity* *Substance use* *Parenting stress* *Other non-parenting stressors* *Low coping and low tolerance for frustration*	Campbell et al., 2010 Lee et al., 2012 Hein et al., 2010 Stith et al., 2009 Staton-Tindall et al., 2013 Dubowitz et al., 2009 Walsh et al., 2003 Green, 1997 Whipple & Webster-Stratton, 1991 Lee et al., 2012 McElroy & Rodriguez, 2008
PARENT-CHILD RELATIONSHIP CHARACTERISTICS		
	Risk Factor	**Research Support**
Attributions for child's behavior	*Ascribing negative motivations to children's behavior*	Larrance & Twentyman, 1983 Schellenbach et al., 1991 Berlin et al., 2013 Ateah & Durrant, 2005
Attachment	*Insecure or disorganized parental attachment*	Stronach et al., 2011 Barone et al., 2014
Parenting knowledge	*Low parenting knowledge*	Child Welfare Information Gateway, 2014 Stith et al., 2009

FAMILY CHARACTERISTICS		
	Risk Factor	**Research Support**
Parents' relationship status	*Single-parent family* *Single-parent, working family* *Re-partnered families*	Sedlak et al., 2010 Berger, 2004 Sedlak et al., 2010
Blended family status	*Being a blended family; presence of male partner who is not biological father*	Alexandre et al., 2010 Berger et al., 2009 Malvaso et al., 2015
Number of children in home	*Having three or more children* *Having more children*	Sedlak et al., 2010 Damashek et al., 2013
Care setting	*Residing in foster or residential care*	Benedict et al., 1994 Euser et al., 2013
Socioeconomic status	*Economic hardship (e.g., receipt of public benefits, borrowing money from family, using food banks, inability to pay for medical care)*	Maguire-Jack & Klein, 2015 Slack et al., 2011 Warren & Font, 2015
Intimate partner violence	*Presence of intimate partner violence*	Hamby et al., 2010 Nicklas & Mackenzie, 2013 Taylor et al., 2009
Stability	*More stressful life events* *More life stressors*	Kolko et al., 1993 Eckenrode et al., 1995
FATHER CHARACTERISTICS		
	Risk Factor	**Research Support**
Mental health	*More emotional unavailability, unresponsiveness, and negative attitudes towards children* *Depression*	Lee et al., 2012 Lee, 2013
Father-child relationship quality	*Insecure father-child attachment*	Howard, 2010
Country of origin	*Being native-born*	Lee et al., 2011
Incarceration	*Incarceration of residential father*	Turney, 2014
COMMUNITY / SOCIETAL CHARACTERISTICS		
	Risk Factor	**Research Support**
Neighborhood factors	*More poverty in local community, higher number of liquor outlets, more crime, high unemployment, high population turnover, higher number of single-parent families* *Longer driving distance to mental health/substance use clinics* *More housing insecurity* *More social disorder (e.g., heavy traffic, neighborhood violence, gang activity, presence of illicit drugs)*	Institute of Medicine, 2014 Stith, 2009 Maguire-Jack & Klein, 2015 Warren & Font, 2015 Freisthler & Maguire-Jack, 2015

	Risk Factor	Research Support
Culture	*Low number of Latino males in community* *More naturalized Hispanic and Asian/Pacific Islander families*	Freisthler & Maguire-Jack, 2015 Freisthler & Maguire-Jack, 2015
MILITARY CHARACTERISTICS		
	Risk Factor	**Research Support**
Deployment	*Experiencing deployment*	Gibbs et al., 2007 McCarthy et al., 2015 Thomsen et al., 2014

Protective Factors for Child Maltreatment

Protective factors for child maltreatment are qualities of individuals, families, and communities that promote healthy child and family functioning.

Protective factors for child maltreatment are qualities of individuals, families, and communities that promote healthy child and family functioning (Walsh et al., 2015). Protective factors can be either internal to the family, such as strong parenting skills, or external, such as access to community resources. For example, some research has focused on cognitive aspects of functioning as protective factors, including self-efficacy in coping with challenges, self-confidence (Hauser, Allen & Golden, 2006), and the ability to learn from past successes and challenges (Quinton & Rutter, 1988). Interestingly, recent research has suggested that repeated brief exposure to negative experiences in which a person copes successfully may promote resilience (Rutter, 2013). While experiencing adversity may sensitize children to vulnerabilities, challenging situations may also "steel" or strengthen children, helping them to cope effectively with future stressors (Rutter, 2013). The factors that result in increased vulnerability versus strengthening, as well as the mediators of those effects, are yet unknown.

Although there is a large literature on general child protective factors as moderators of the negative effects of exposure to risk (Masten, 2011; Rutter, 2012), including research on military children (Easterbrooks, Ginsburg, & Lerner, 2013; Werner, 2012), there is a dearth of research specific to protective factors for child maltreatment (Institute of Medicine, 2014). Factors that protect against maltreatment can function in several manners; they can buffer children from being maltreated, bolster them after experiencing abuse or neglect, and promote overall resilience.

An important distinction in this area of inquiry is the population being studied. Although relatively little is known about factors that protect at-risk children from being abused or neglected, more is known about promoting resilience and minimizing re-victimization among children who have already been maltreated (Institute of Medicine, 2014). This section will address individual-level protective factors in both parents and children, family-level protective factors, and broader societal-level protective factors. It is noteworthy that some, but not all, of these protective factors are the inverse of risk factors noted above. For example, parents who report higher levels of social support are at lower risk for perpetrating child maltreatment (Counts et al., 2010), whereas social isolation is a commonly cited risk factor for maltreating children (Berlin et al., 2011). Although minimal empirical research exists regarding protective factors of the military culture, consideration of these issues will conclude this section.

The protective factors described in this section are listed in Table 3 and can be considered across the following five categories.

- **Child characteristics** include personality traits and mental health indices, skills, intelligence, and social support.
- **Parent characteristics** include demographic factors, psychological well-being, parent-child relationship characteristics, knowledge of parenting and child development, and social support.
- **Family characteristics** include socioeconomic status, family structure, social support, family functioning, and life events.
- **Community and societal characteristics** include geographic proximity to mental health and substance abuse services, neighborhood collective efficacy, positive school environment, social support, and sense of community.
- **Military characteristics** include features of military life that may bolster child and family functioning, including numerous supports and resources and the Family Advocacy Program.

Child Characteristics

The literature on child-level protective factors for maltreatment focuses on skills, traits, or qualities that are associated with child resilience following abuse and neglect. Factors described in the literature include: (1) personality traits and mental health indices; (2) skills; (3) intelligence; and (4) social support.

Personality traits and mental health indices. Numerous personality traits have been identified as protective factors for child maltreatment among children, including ego resilience (i.e., mastery over impulses), ego control (i.e., ability to modify behavior in response to stressors) (Cicchetti & Rogosch, 1997; Kim et al., 2009), adaptability, and flexibility (Cicchetti et al., 1993; Cicchetti & Rogosch, 2007; Flores, Cicchetti, & Rogosch, 2005). Several other protective factors related to emotional health include an easy child temperament (Brown, Cohen, Johnson & Salzinger, 1998; Martinez-Torteya et al., 2009), high self-esteem, (Cicchetti et al., 1993; Cicchetti & Rogosch, 1997), external attributions for blame, and an internal locus of control (i.e., sense of ability to exert influence in one's life) (Institute of Medicine, 2014).

Numerous personality traits have been identified as protective factors for child maltreatment among children, including ego resilience (i.e., mastery over impulses), ego control (i.e., ability to modify behavior in response to stressors), adaptability, and flexibility.

Skills. Possession of specific skill sets may be protective against child maltreatment, including strong interpersonal and relationship skills (Afifi & Macmillan, 2011; Collishaw et al., 2007; Jaffee & Gallop, 2007), healthy daily living skills (Schultz et al., 2009), effective social skills (Rajendran & Videka, 2006), strong communication skills, and the ability to effectively regulate strong emotions (ACYP, 2013; Shonkoff, & Philips, 2000). Children with better skills across these domains tend to have better functioning after experiencing maltreatment.

Intelligence. Research on the role of intelligence or cognitive abilities as protective factors has yielded mixed results, with some showing benefits for child functioning (Masten & Tellegen, 2012) and others not finding a protective influence (Jaffee et al., 2007). Issues related to the child's broader environment may explain or moderate the role of intelligence as a protective factor.

Social support. Finally, as with parents, social support is a known protective factor for children who have experienced maltreatment (Institute of Medicine, 2014). Children who are more satisfied with the emotional support received from caregivers after maltreatment (Rosenthal, Feiring & Taska, 2003), who are more trusting of others, and who feel more empowered by support figures (Daigneault, Hebert, & Tourigy, 2007) tend to have better functioning after maltreatment.

Parent Characteristics

Very few studies have examined parental protective factors that buffer against the risk of child maltreatment. Rather, most of the research assumes that protective factors represent either the absence or opposite of known risk factors. Nevertheless, there is a growing interest in parental characteristics that may reduce a child's risk of maltreatment, or buffer against the deleterious effects of maltreatment. Parent-level protective factors may be considered across the following four domains: (1) demographic characteristics; (2) psychological well-being; (3) parent-child relationship characteristics; and (4) parental knowledge of child development.

Demographic characteristics. A few studies have considered parental demographic variables including marital status, education, age, and income. In a longitudinal study of 405 young children, Li and colleagues (2011) found that married mothers and those with a high school education were significantly less likely to have engaged in child maltreatment. Similarly, Lee and Guterman (2010) studied 1,597 at-risk families and determined that adult mothers were significantly less likely to engage in harsh parenting behaviors than adolescent mothers. Studies of protective factors have also demonstrated that stable financial situations (Currie & Widom, 2010) can also buffer against risk of maltreatment in children.

Psychological well-being. Parents with good mental health may be at lower risk for perpetrating child maltreatment. For example, Slack and colleagues (2011) found a significant inverse relationship between parental well-being and risk of child maltreatment. Similarly, programs and research have begun to focus on increasing resilience in parents. In a review of research supporting maltreatment prevention programs, Walsh and colleagues (2015) emphasize the importance of promoting parental well-being (e.g., self-esteem, self-efficacy) and resilience as vehicles for decreasing the risk of child maltreatment.

Parent-child relationship characteristics. Safe, stable, nurturing parent-child attachments have been linked to both a decreased risk of child maltreatment (Centers for Disease Control and Prevention, 2007; Howard, 2010; Schofield et al., 2013) and to reduced negative later-life outcomes in maltreated children (MacMillan, 2011). For example, in a study of 72 fathers of young children, Howard (2010) found that fathers who rated their attachment to their children as "secure" were more likely to report low abuse potential, greater parenting efficacy, lower parenting stress, and better knowledge of child development.

Safe, stable, nurturing parent-child attachments have been linked to both a decreased risk of child maltreatment and to reduced negative later-life outcomes in maltreated children.

Knowledge of parenting and child development. Research has suggested that increasing parenting knowledge may help reduce the risk of child maltreatment (Child Welfare Information Gateway, 2012; Stith et al., 2009). Such programs often involve group-based discussions and opportunities for modeling and practice of skills (Centers for Disease Control and Prevention, 2009). However, very few studies have examined knowledge differentials between abusive and non-abusive parents as potentially predictive of abuse or neglect.

Social support. The protective effects of social support in both preventing and reducing the ill effects of child maltreatment are well-established in the research literature; parental social support is consistently negatively associated with both child physical abuse and child neglect (see Stith et al., 2009) and positively correlated with increased resilience (Afifi & MacMillan, 2011). For example, one study found that compared to demographically matched mothers, maltreating mothers listed fewer friends in their social support networks, reported less contact with friends, and gave lower ratings of quality of support received from friends (Bishop & Leadbetter, 1999). Similarly, in a study of mothers drawn from the Fragile Families project, Lim (2010) found that while poor mothers were more likely to mistreat their children, social support had a protective effect that diminished the risk that poor mothers would engage in child maltreatment. The pathways by which social support serves as a protective mechanism are unclear. The presence of social support may reflect a parent's ability to form healthy relationships, may provide healthy models of behavior, and/or may be opportunities to garner advice, information, and support.

Family Characteristics

Recent research has examined characteristics within the family system that may protect against child maltreatment, including (1) family socioeconomic status; (2) family structure; (3) social support/social capital; (4) family functioning; and (5) number of life events.

Family socioeconomic status. Higher levels of family income and income security are clear protective factors against child abuse and neglect (Affifi et al., 2015; Berger, 2004; Cancian et al., 2010). For example, one study found that children in higher socioeconomic status families were five times less likely than children from lower socioeconomic backgrounds to experience maltreatment (Sedlak et al., 2010). Family financial stability may also relate to the intergenerational transmission of child maltreatment. For example, Dixon and colleagues (2009) found that families who were able to break the cycle of child maltreatment were more likely to be financially stable than maltreating families.

Family structure. Research has examined several factors related to family structure, including parents' marital status, number of parents in the home, involvement of grandparents as caregivers, number of children in the family, and birth spacing between children.

Children living with married, biological parents are less likely to experience maltreatment than children in other family structures (Affifi et al., 2015; Berger, 2004; VanIJzendoorn et al., 2009). In one study, children living with married, biological parents were eight times less likely to experience maltreatment than children living with single parents and their live-in partners (Sedlak et al., 2010). Similarly, parents who were maltreated in childhood but did not maltreat their offspring were more likely to be currently two-parent families than single parent families (Dixon et al., 2009).

Grandparents are increasingly active in childrearing, either as a primary caregiver or as a support to the parent(s). The presence of a supportive grandparent in both caregiving and support roles has been found to be a protective factor against child maltreatment (Lee, Kotch, & Cox, 2004; Sedlak et al., 2010).

Child maltreatment risk has generally been shown to be lower among families with fewer children (Berger, 2004; Dubowitz et al., 2011). Specifically, in one study child maltreatment rates were the lowest among families with two dependent children, while families with one child and families with four or more children had higher rates of maltreatment (Sedlak et al., 2010). A longer period of time between births in a family is another protective factor against child neglect, specifically. For instance, families who had at least two years between the births of children were less likely to be reported for neglectful parenting (Crowne, Gonsalves, Burrell, McFarlane, & Duggan, 2012).

Families with high levels of social support are at lower risk for child maltreatment.

Social support and social capital. Families with high levels of social support are at lower risk for child maltreatment. In one study, families who reported having strong social support were 1.29 times less likely to have a child maltreatment report than families with low support (Li, Godinet, & Arnsberger, 2011). Increased social capital (e.g., attendance at church, psychological connection to community) has also been associated with reduced risk of neglectful and psychologically harsh parenting (Zolotor & Runyan, 2006).

Family functioning. Some research has broadly examined positive family functioning in relation to child maltreatment. One study found a composite scale of family functioning (e.g., having adaptive skills to persevere in times of crisis, the family's ability to openly share positive and negative experiences with each other, and the family's ability to mobilize to accept, solve, and management problems) was negatively associated with child abuse potential (Counts, Buffington, Chang-Rios, Rasmussen, & Preacher, 2010).

Life events. Families who experienced fewer past-year stressful life events (e.g., economic stress, chronic stress) were less likely to be reported for child maltreatment than families who experienced more life events (Li et al., 2011). Another study found that families who had not moved or given birth to a new child were less likely to be investigated for child maltreatment than families who had not experienced these life events (McDaniel & Slack, 2005). Family life events may increase family and parental stress, leading to harsh or neglectful parenting (Li et al., 2011; McDaniel & Slack, 2005).

Community and Societal Characteristics

While individual- and family-level protective factors have received more attention in the literature than community-level factors (Walsh et al., 2015), there is some evidence that broader community characteristics may help prevent child maltreatment and promote resilience among victims of abuse and neglect. Preliminary evidence suggests that close geographic proximity to mental health and substance abuse services and neighborhood collective efficacy may be protective factors for child maltreatment. In addition, a small but important research base suggests that neighborhood collective efficacy, positive school environment, social support, and a sense of community may be predictors of resilience among children, youth, and/or adults who have experienced maltreatment.

Geographic proximity to mental health and substance abuse services. Access to mental health and social services has been posited as a protective factor in the prevention of child maltreatment. In one study conducted in Los Angeles County, a shorter driving distance to mental health and substance abuse services was associated with lower levels of parent-reported neglectful behavior (Maguire-Jack & Klein, 2015). Proximity to other services (e.g., childcare or poverty relief) was not associated with decreases in neglectful behavior.

Neighborhood collective efficacy. Collective efficacy refers to the combination of informal social control (e.g., neighbors' willingness to intervene if they witness children skipping school or spray-painting graffiti) and social cohesion (e.g., neighbors getting along and helping one another). Higher levels of neighborhood collective efficacy have been associated with lower rates of physical abuse among residents (Freisthler & Maguire-Jack, 2015).

Higher neighborhood collective efficacy may also predict resilience in children who have been maltreated (Jaffee, Caspi, Moffitt, Polo-Tomas, & Taylor, 2007). For example, youth who have experienced neglect (but not other forms of child maltreatment) demonstrated fewer externalizing symptoms (e.g., aggression) in neighborhoods with higher levels of collective efficacy (Yonas et al., 2010). In particular, high social cohesion has been associated with fewer internalizing symptoms (e.g., depression and anxiety) among maltreated children (Riina, Martin, & Brooks-Gunn, 2014).

Recently, researchers in South Korea have attempted to disentangle informal social control and social cohesion (Emery, Trung, & Wu, 2015; Emery et al., 2014). Instead of measuring informal social control as neighbors' willingness to intervene in neighborhood delinquent activities, researchers asked participants whether and how their neighbors would respond to family violence. These anticipated neighbor responses were then categorized as either protective (e.g., trying to calm the parent down) or punitive (e.g., threatening to call the police). Researchers found that protective informal social control of child maltreatment was associated with lower odds of severe physical abuse and child injuries in the community (Emery et al., 2015).

Positive school environment. Limited research suggests that a positive school environment may be a predictor of resilience among maltreated children (Administration on Children, Youth, and Families, 2013; Herrenkohl, Tajima, Whitney, & Huang, 2005; Williams & Nelson-Gardell, 2012). More research is needed in this area.

Social support. Social support is related to resilience in maltreated children. For example, the ability to form a positive relationship with an adult who is not an immediate family member has been shown to be a predictor of resilience among maltreated Latino children (Flores, Cicchetti, & Rogosch, 2005). Support from family and friends has been associated with reductions in depression, anxiety, anger, and hostility, especially among those who experienced low levels of childhood maltreatment (Folger & Wright, 2013). Support from peers, in particular, has been associated with better academic performance and lower levels of substance use, antisocial behavior, and suicide among maltreated children (Bolger, Patterson & Kupersmidt 1998; Collishaw et al., 2007; Herrenkohl et al., 2005; Perkins & Jones, 2004; Schultz, Tharp-Taylor, Haviland, & Jaycox, 2009).

More research is needed to understand the role neighborhoods and communities play in the preventing child maltreatment and promoting resilience among those who have experienced abuse or neglect.

Sense of community. Adult survivors of child maltreatment who describe having a sense of community have reported lower levels of psychological distress in adulthood than those who do not feel a sense of community (Greenfield & Marks, 2010). Further research is necessary to understand how people build and maintain this sense of community over time.

Prior to considering military protective factors, it is important to note that the research on community-level protective factors is small, and the literature has been critiqued for problems with study design and methodology. Regarding research on neighborhoods, for instance, some have argued that the processes that link neighborhood conditions to maltreatment are not clear and that selection bias and neighborhood definitions have not been adequately controlled for in many studies (Coulton et al., 2007). More research is needed to understand the role neighborhoods and communities play in the preventing child maltreatment and promoting resilience among those who have experienced abuse or neglect.

Military Characteristics

Empirical research has not explicitly examined protective factors against child maltreatment for military families; however, several theorists have described aspects of military family life that likely function to protect children from being abused or neglected. At the broad environmental level, military children live in ecological systems that differ from civilian children (Fullerton et al., 2011). All military families have at least one parent with consistent employment and income; the parent can pass military performance standards and function in a disciplined environment (Chamberlain, Stander & Merrill, 2003). As service members with serious problems (e.g., criminal behavior, serious mental illness or substance abuse, severe personality disorders) are often discharged from the military, most military parents do not have these difficulties (which are often risk factors for family violence). Military families, particularly Active Duty families, also have a social network of others with similar interests and experiences (Gibbs et al., 2008) who can offer social support during times of elevated stress.

Although both the civilian and military sectors have established procedures for investigating and responding to child maltreatment, the military's Family Assistance Program has some leverage that is unequaled in the private sector.

The military offers a wide range of services and supports to Service members and their families, including, but not limited to, quality healthcare, housing or stipends for housing, access to day care centers, legal assistance, and financial planning services (Chamberlain et al., 2003). Furthermore, military families have access to a range of family social services (e.g., parent training, social work, and mental health services) that may be challenging or expensive for civilians to utilize (Chamberlain et al., 2003; Rentz et al., 2006). Specific resilience-building programs have been developed in the past 15 years (e.g., the FOCUS Project discussed below; Beardslee et al., 2011) to help military families anticipate and cope with stressors associated with deployment. Thus, the numerous supports offered to military families may protect children from being neglected or abused.

Although both the civilian and military sectors have established procedures for investigating and responding to child maltreatment, the military's Family Assistance Program (FAP; Chamberlain et al., 2003) has some leverage that is unequaled in the private sector. In working to identify abuse and reduce recidivism, FAP staff can the garner support of commanders to ensure Service members comply with

treatment plans (Chamberlain et al., 2003). It is also easier to coordinate law enforcement, healthcare, and social work teams to support at-risk families in the military sector than the civilian one. Thus, the FAP can be seen as a strong protective factor for military children and their families.

Finally, although most of the research has examined deployment as a risk factor for child maltreatment, researchers have considered potential benefits of deployment for families. Specifically, Palmer (2008) and Porter (2013) have theorized that deployment may help families develop coping mechanisms; further, extended family members may offer additional support during this stressful time, strengthening family connections. Although the balance of risk versus protective mechanisms of deployment is unknown, recognition of possible positive correlates of deployment for families may be useful.
In sum, little research exists specifically targeting protective factors for child maltreatment, with much of the work having focused on children who have already been abused or neglect. A recent critique of protective factor research highlights definitional challenges in the research base, with inconsistency in measurement across studies hindering integration and generalization of findings; furthermore, effect sizes are not consistently reported, and the strength of the evidence varies (Walsh, McCourt, Rostad, Byers, & Ocasio, 2015). Future research is needed to expand our understanding of what protects children from being maltreated, as well as protective factors for re-victimization. Examining what factors are most potent, malleable, and protective for children in their natural environments will be important (Saltzman et al., 2011). Additional research can also inform the emerging conceptual models. Continued development and refinement of the instruments to measure protective factors can examine the individual, family, and community levels, as well as the interactions among these domains.

Table 3: Protective Factors for Child Neglect

CHILD CHARACTERISTICS		
	Protective Factor	**Research Support**
Personality traits and mental health indices	*Ego resilience (mastery over impulses)*	Cicchetti & Rogosch, 1997 Kim et al., 2009
	Adaptability and flexibility	Cicchetti et al., 1993 Cicchetti & Rogosch, 1997 Flores, Cicchetti, & Rogosch, 2005
	Easy child temperament	Brown, Cohen, Johnson, & Salzinger, 1998 Martinez-Torteya et al., 2009
	High self-esteem	Cicchetti et al., 1993 Cicchetti & Rogosch, 1997
	External attributions for blame	Institute of Medicine, 2014
	Internal locus of control	Institute of Medicine, 2014
Skills	*Strong interpersonal and relationship skills*	Afifi & Macmillan, 2011 Collishaw et al., 2007 Jaffee & Gallop, 2007
	Healthy daily living skills	Schultz et al., 2009
	Effective social skills	Rajendran & Videka, 2006
	Strong communication skills	ACYP, 2013 Shonkoff & Philips, 2000
	Effectively regulate strong emotions	ACYP, 2013 Shonkoff & Philips, 2000

Intelligence	*Higher intelligence and cognitive skills*	Masten & Tellegen, 2012
Social support	*Satisfaction with emotional support from caregivers* *More trusting of others* *Feel more empowered by support figures*	Rosenthal, Feiring, & Taska, 2003 Daigneault, Hebert, & Tourigy, 2007 Daigneault, Hebert, & Tourigy, 2007
PARENT CHARACTERISTICS		
	Protective Factor	**Research Support**
Demographics	*Being married* *At least high school education* *Being older* *Stable financial situation*	Li et al., 2011 Li et al., 2011 Lee & Guterman, 2010 Currie & Widom, 2010
Psychological well-being	*Higher levels of well-being* *High self-esteem and self-efficacy*	Slack et al., 2011 Walsh et al., 2015
Parent-child relationship Characteristics	*Safe, stable, nurturing, secure attachment*	Centers for Disease Control and Prevention, 2007 Howard, 2010 Schofield et al., 2013 MacMillan, 2011
Knowledge of parenting and child development	*Increased parenting and child development knowledge*	Child Welfare Information Gateway, 2012 Stith et al., 2009
Social support	*More friends in social support network* *More contact with friends* *Higher quality support from friends* *More parental social support*	Bishop & Leadbetter, 1999 Bishop & Leadbetter, 1999 Bishop & Leadbetter, 1999 See Stith et al., 2009 for review
FAMILY CHARACTERISTICS		
	Protective Factor	**Research Support**
Socioeconomic status	*Higher income, income security* *Higher socioeconomic status* *Family financial stability*	Affifi et al., 2015 Berger, 2004 Cancian et al., 2010 Sedlak et al., 2010 Dixon et al., 2009
Family structure	*Children live with married, biological parents* *Two-parent family*	Affifi et al., 2015 Berger, 2004 Sedlack et al., 2010 VanIJzendoorn et al., 2009 Dixon et al., 2009
Grandparent involvement	*Grandparent as caregiver/support role*	Lee, Kotch, & Cox, 2004 Sedlak et al., 2010

	Protective Factors	Research Support
Number of children	*Fewer children* *Two-child family* *More time between births*	Berger, 2004 Dubowitz et al., 2011 Sedlack et al., 2010 Crowne et al., 2012
Social support and social capital	*Strong social support* *Attending church* *Psychological connection to community*	Li et al., 2011 Zolotor & Runyan, 2006 Zolotor & Runyan, 2006
Family functioning	***Having adaptive skills to persevere during crisis*** *Openly sharing positive and negative experiences among family members* *More ability to accept, solve, and manage problems*	**Counts et al., 2010** Counts et al., 2010 Counts et al., 2010
Life events	*Fewer past-year stressful life events* *No recent geographic moves* *No recent births*	Li et al., 2011 McDaniel & Slack, 2005 McDaniel & Slack, 2005
COMMUNITY / SOCIETAL CHARACTERISTICS		
	Protective Factor	**Research Support**
Proximity to services	*Shorter driving distance to mental health and substance use services*	Maguire-Jack & Klein, 2015
Neighborhood efficacy	*Higher levels of neighborhood collective efficacy* *High social cohesion* *Informal social control*	Freisthler & Maguire-Jack, 2015 Riina, Martin, & Brooks-Gunn, 2014 Emery, Trung, & Wu, 2013
School environment	*Positive school environment*	ACYF, 2013 Herrenkohl et al., 2005 Williams & Nelson-Gardell, 2012
Social support	*Positive relationships with non-family adults* *Support from family and friends* *Support from peers*	Flores, Cicchetti, & Rogosch, 2005 Folger & Wright, 2013 Bolger et al., 1998 Collishaw et al., 2007 Herrenkohl et al., 2005 Perkins & Jones, 2004 Schultz et al., 2009
Sense of community	*More sense of community*	Greenfield & Marks, 2010

Interventions for Preventing Child Abuse and Neglect

A wide array of child abuse and neglect prevention programs are discussed in the literature, and many are listed in clearinghouses and databases. While most programs target civilian families, a few are specific to military families. For this report, registries searched included: (a) California Evidence-Based Clearinghouse for Child Welfare, (b) Clearinghouse for Military Family Readiness, (c) Office of Juvenile Justice and Delinquency Prevention Model Programs Guide, (d) Promising Practices Network on Children, Families, and Communities, and (e) Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (SAMHSA's NREPP). In addition, the Child Welfare Information Gateway, programs provided by the FRIENDS National Center for Community-Based Child Abuse Prevention, and maternal, infant, and early childhood home visiting programs summarized by the Health Resources and Services Administration (HRSA) were reviewed. Model programs described in *New Directions in Child Abuse and Neglect Research* (Institute of Medicine, 2014) and *Advances in Child Abuse Prevention Knowledge* (Daro, Donnelly, Huang, & Powell, 2015) were also reviewed.

A total of 66 prevention programs and initiatives are included in this report. All programs address multiple risk and protective factors and are organized into three broad categories (see Table 4): (1) selective programs for at-risk families; (2) universal prevention programs; and (3) initiatives that focus on building protective factors.

Table 4: Categories and Subtypes of Programs and Initiatives

Selective Programs (*n* = 52)	
Home visiting programs (*n* = 14)	Child First Early Head Start – Home Visiting Exchange Parent Aide Family Connections Family Spirit Health Access Nurturing Development Services Healthy Families America Healthy Start – Home Visiting Maternal Infant Health Outreach Worker Minding the Baby Nurse Family Partnership Parents as Teachers Play and Learning Strategies SafeCare and SafeCare Augmented

Selective Programs (*n* = 52) (continued)	
Parenting education and family programs (*n* = 13)	Adults and Children Together Raising Safe Kids Celebrating Families! Chicago Parent Program Circle of Security Parenting Training Families and Schools Together Incredible Years Nurturing Parenting Programs Parenting our Children to Excellence and and Criando a Nuestros Niños hacia el Exito Parenting Wisely Second Time Around Strengthening Families Program Teaching Important Parenting Skills for Great Kids Triple P
Military-specific programs (*n* = 9)	ADAPT – After Deployment: Adaptive Parenting Tools Child Parent Relationship Therapy with Military Families FOCUS – Families OverComing Under Stress New Parent Support Programs Nurturing Parenting Programs Parenting for Service Members and Veterans STRoNG Military Families Web-based Tutorial for Mandated Reporters Zero to Three - Babies on the Homefront (mobile app)
Parent mutual support programs (*n* = 2)	Circle of Parents Parent Anonymous
Therapy-oriented programs (*n* = 5)	Alternatives for Families: A Cognitive-Behavioral Therapy Attachment and Biobehavioral Catch-up Combined Parent-Child Cognitive Behavioral Therapy Multisystemic Therapy – Child Abuse and Neglect Parent Child Interaction Therapy
Programs in collaboration with pediatric clinics (*n* = 3)	Healthy Steps Safe Environment for Every Kid Building Healthy Children
Other prevention initiatives for at-risk families (*n* = 6)	Public Awareness Campaigns Family Resource and Support Centers Child-Parent Centers Planned Respite Care Crisis Child Care/Crisis Nurseries Infant Massage

Universal Programs (*n* = 6)	
Bystander mobilization programs (*n* = 3)	Communities NOW Darkness to Light Stop it Now! Circles of Safety
School-based curricula for students (*n* = 3)	Body Safety Training Program Childhelp Speak Up Be Safe The Safe Child Program
Initiatives that Build Protective Factors (*n* = 8)	
Cafés (*n* = 2)	Be Strong Families' Parenting Cafés The Community Café
Protective factors trainings (*n* = 2)	Living the Protective Factors National Alliance of Children's Trust and Prevention Funds
Protective factors assessments (*n* = 3)	Strengthening Families Self-Assessment (for programs) Strengthening Families Parents' Assessment of Protective Factors Instrument (for parents/caregivers) FRIENDS Protective Factors Survey (for parents/caregivers)
Resource guide (*n* = 1)	Making Meaningful Connections

Descriptions of Programs Organized by Modality of Services

This section overviews 66 programs, organized by the specific modes of service delivery. The selective program approaches are described first, followed by universal program models. The final programs are other initiatives that focus on building protective factors. Detailed corresponding charts in the appendices provide information about program structure, target audience, provider/facilitator, curriculum, and key research findings. A final appendix (Appendix K) also lists each program, its website, and the effectiveness rating as assessed by the Clearinghouse for Military Family Readiness.

Selective programs are designed for families that are at elevated risk of maltreatment due to the presence of risk factors such as poverty, substance abuse, or history of domestic violence.

Selective Programs

Selective programs are designed for families that are at elevated risk of maltreatment due to the presence of risk factors such as poverty, substance abuse, or history of domestic violence. Prevention approaches include home visiting, parenting education, parent mutual support, and behavioral therapy as well as programs delivered in collaboration with pediatric clinics and other prevention initiatives such as family resource and support centers, planned respite care, and crisis nurseries. Programs (*n* = 52) are listed by approach.

Home visiting programs. Home visiting programs (*n* = 14) are well established and some, such as Nurse-Family Partnership, have been in existence for decades (see Appendix A). Programs vary in terms of frequency and number of visits, age of the child served, type of provider, and curriculum. In general, however, programs consist of one-hour weekly visits from a social worker, nurse, or trained community member. Services start during pregnancy or shortly after birth and continue until the child is about three years old. Visitors typically provide health information, parenting education, and referrals.

Parenting education and family programs. Parenting education programs (*n* = 13) are diverse (see Appendix B). They vary across a number of domains including length of program, target audience, facilitator, setting, and curriculum. In general, these programs consist of multi-family, weekly sessions delivered over a period of approximately three months in a community setting such as a school or childcare center. Programs often include parent-child interaction time and parent group time with a trained educator. Topics addressed typically include child behavior, sleep, and parental self-care.

Military-specific parenting education, family, and home visiting programs. Several parenting education and family programs and one home visiting program have been designed specifically for military families (*n* = 9) (see Appendix C). In addition to addressing child development, nutrition, discipline, and other typical parenting education topics, these programs also address issues specific to life in the military such as preparing for deployment, coping with separation, PTSD, and reunification.

Parent mutual support programs. These support programs for parents and other caregivers (*n* = 2) are usually ongoing, and include weekly group meetings with a trained facilitator (see Appendix D). Childcare is typically available. Adults provide peer support to one another and discuss topics such as positive discipline, communication, and age-appropriate expectations.

Therapy-oriented programs. Based on behavioral health techniques, these therapy-oriented programs (*n* = 5) are delivered by a trained psychotherapist (see Appendix E). Programs involve both individual therapy and joint parent-child sessions, and are designed for caregivers and children ages 6 months to 17 years. Sessions range in frequency and duration. Some programs last only 10 weeks, while others are 6-12 months long. Programs often provide parent coaching and aim to improve parent-child interaction.

Programs in collaboration with pediatric clinics. As shown in Appendix F, some programs work with medical staff in preventing and intervening with child maltreatment (*n* = 3). Pediatric clinics are good places to screen, identify, and intervene with families. These programs employ a variety of techniques, from embedding a child welfare specialist in the clinic to offering home visits and treatment for maternal depression. These programs are sometimes referred to as professional practice reforms.

Other prevention initiatives for at-risk families. In addition to offering home visiting, parenting education, parent mutual support groups, and therapy-oriented programs and making reforms to medical practice, there are a number of other steps communities can take to try to reduce child maltreatment, six of which are described herein (see Appendix G). These initiatives include programs such as public awareness campaigns, family resource and support centers, and respite and crisis care services.

Universal Programs

Universal programs (*n* = 6) are designed for members of the general population, regardless of risk profile. Approaches described below include bystander mobilization training and school-based curricula.

Bystander mobilization programs. People often feel helpless when they see a family struggling or a child who might be at risk for maltreatment; bystanders may not know what to say or how to help (see Appendix H). Bystander mobilization programs (*n* = 3) teach community members about the warning signs of abuse or neglect and offer strategies for intervening. One goal of such programs is to create a culture in which people help one another and take action to keep children safe and healthy.

School-based curricula for students. Another strategy to prevent child maltreatment involves teaching children safety skills (see Appendix I). These curricula (*n* = 3) help reduce children's vulnerability, and educate them on the responsibilities of adults for keeping them safe. Curricula have been developed for teachers to use in schools with students of various ages.

Initiatives that Focus on Building Protective Factors

The programs listed in Appendix J are not specifically selective nor universal programs, but target protective factors more broadly (*n* = 8). These programs address parent resilience, knowledge of parenting and child development, social and emotional competence of children, social connections, and concrete support in times of need are important for keeping families healthy, overcoming risk factors, and preventing child maltreatment. In this section, four general approaches to building protective factors are described, including parent and community cafés, trainings for service providers and parents, assessments for organizations and caregivers, and a resource guide.

Conclusion

Child maltreatment is a serious public health problem. In the United States, about three million reports of abuse and neglect involving more than six million children are made every year (National Kids Count, 2015). Such adverse childhood experiences are associated with a range of short- and long-term physical and mental health impacts including depression, substance abuse, obesity, diabetes, and death. Maltreatment also has consequences for children's academic functioning and relationship functioning (both in the parent-child relationship and in later adult relationships). Maltreatment is associated with significant economic costs as well, both at the individual and societal levels.

Child maltreatment is a broad construct, encompassing a range of forms of child abuse and neglect, and with varying levels of impact and severity. Child neglect is the most common form of child maltreatment, but it has been relatively neglected in the research literature (Stoltenborgh et al., 2013). The study of child neglect is complicated by definitional differences across states and studies, the necessity of taking a developmental perspective in considering target behaviors, and cultural issues that shape perceptions of neglect. Further, much of the research subsumes neglect as one component of overall child maltreatment, hindering the ability to specifically focus on the correlates, predictors, and outcomes of neglect.

Both civilian and military children experience maltreatment. Department of Defense data revealed a 10% increase in confirmed child abuse and neglect cases between 2013 and 2014, and a 14% increase in cases of neglect (Ryan, 2015). In total, 7,676 cases of maltreatment were confirmed in 2014 and 30 military children died as a result of abuse or neglect.

Risk factors for child maltreatment exist across a variety of domains and include child factors such as age, sex, and ability/disability; parent characteristics such as age, mental health status, and personal history of abuse; family characteristics such as family structure and family functioning; and community characteristics such as poverty, unemployment, and crime. Risk factors for abuse and neglect are complex; they interact with one another and with other social systems, and change over time.

Comparatively less research has examined factors that may protect children from being maltreated. Protective factors are often constructed as either the absence of or the opposite of risk factors. As most families with known risk factors (e.g., low education or poverty) do not engage in abusive behavior, further examination of these families and the strengths that support them would be useful. More research has examined factors that are associated with child resilience and a decreased risk of re-victimization following abuse and neglect, such as child personality traits, social support, positive school environments, and family access to mental health services.

More research is needed to understand risk and protective factors for abuse among military families. Studies examining the relationship between military-specific experiences (e.g., deployment and service-related mental health problems) and maltreatment are limited and have produced mixed results. Some documented risk factors for child maltreatment in the civilian sector (e.g., poverty, limited health care, housing insecurity, and unemployment) represent minimal risk within the confines of the military. However, some structural elements of military life (e.g., frequent geographic moves) correspond with risk factors known to exacerbate the risk of maltreatment (e.g., stress and instability). Further, considerable numbers of Service members who served in Iraq and Afghanistan are experiencing difficulties with reintegrating and mental health problems upon homecoming, both of which may

increase household stress, parenting challenges, and potentially the risk for child maltreatment. In light of the recent increases in confirmed child abuse and neglect cases in the military (Ryan, 2015), continuing to detect and mitigate risk factors, identify and bolster protective factors, and support military families where child maltreatment has occurred will be important.

In this report, 66 prevention programs and initiatives were reviewed. Evaluation is a high priority for those who create and implement such programs. Many programs are based on research and/or have curricula that are evidence-based. Few, however, have been evaluated using longitudinal methods or randomized control trials. Although some program evaluation findings are published in peer-reviewed journals, many are in technical reports based on internal evaluations or efforts of consulting groups.

> There is no simple solution for preventing child maltreatment. It is important to incorporate multiple types of programs that address individual-, family-, and community-level risk factors, while simultaneously building protective factors.

The vast majority of prevention programs address multiple risk factors, build on a variety of protective factors, and focus on both abuse and neglect (as opposed to neglect only). These are generally based on a home visitation or parenting education model, and are designed to intervene at the level of the individual parent or family. Relatively fewer programs intervene at the level of the child (e.g., by reducing children's vulnerability or developing their self-esteem and self-reliance) or at the level of the community (e.g., by changing cultural norms around child maltreatment and social responsibility for children's safety). Because most programs have been developed and evaluated for civilian families, it is important to learn more about the feasibility, acceptability, and effectiveness of these programs with military populations.

There is no simple solution for preventing child maltreatment. Therefore, it is important to incorporate multiple types of programs, both selective and universal, that address individual-, family-, and community-level risk factors, while simultaneously building protective factors. In addition, professional practice reforms, collaboration among service providers and community-based agencies, and efforts to change social norms and create a cultural commitment to child welfare may be beneficial (Daro, Budde, Baker, Nesmith, & Harden, 2005).

Further, selecting programs and practices that are evidence-based is not enough. Implementation and sustainability are also essential (Daro, Donnelly, Huang, & Powell, 2015; Institute of Medicine, 2014). Successful program implementation depends upon striking a balance between fidelity (i.e., adherence to an original program model) and flexibility or adaptation to local circumstances. Recognizing this, many programs now build flexibility into their models as they prepare them for replication. Success also requires attention to organizational capacity, staff skills, supervision, and caseloads. Long-term sustainability requires plans for evaluation and funding as well as supportive policies. Beyond choosing programs that are evidence-based and a good fit for a particular community, issues of implementation and sustainability are vital to consider.

> Selecting programs and practices that are evidence-based is not enough. Implementation and sustainability are also essential.

Recommendations

Stemming from empirical research findings, the following recommendations may support initiatives designed to prevent child neglect. These recommendations may also support initiatives designed to intervene in situations where children and families have experienced child neglect.

- **Focus on malleable risk and protective factors for child neglect.** Some risk and protective factors are more amenable to influence than others. For example, initiatives cannot change a child's disability status or a parent's age. However, efforts may be able to address a parent's stress management practices. Initiatives and programs that support children and families could:
    - **Address children's behavioral problems.** Additional supports could be provided to both children and parents to address this particular risk factor for child neglect and abuse. Educating parents about behavioral problems and effective strategies for addressing children's difficult behavior may alleviate the impact of children's behavior on parents' stress levels and subsequent parenting practices.
    - **Assist parents in managing stress levels.** Several studies found that parenting stress can contribute to likelihood of neglectful or abusive behavior. Parenting education programming could incorporate modules or units about effective stress relief or mindfulness techniques for parents.
    - **Acknowledge parents' own experiences of neglect and abuse.** Research shows child maltreatment can be an intergenerational, cyclical problem. As parents who were neglected or abused as children are at increased risk of perpetuating neglectful or abusive behavior, programs and resources for parents may consider addressing parents' own history and provide suggestions for coping with past maltreatment.
    - **Refer parents and caregivers to substance abuse treatment as necessary.** Parents who abuse substances are at risk for abusive and neglectful parenting behavior. Providing referrals to appropriate programs and professionals that treat substance abuse in adults may contribute to preventing child neglect.
    - **Strengthen social support networks for children, parents, and families.** Social support was a consistent correlate of child neglect for children, parents, and families, and was particularly associated with resilience after child maltreatment. Supports for children could encourage positive friendships, and supports for parents and families could focus on encouraging parents and families to reach out to other friends and family members for help during times of need.
    - **Provide unique supports and program content for fathers.** Research shows that paternal mental health is particularly important regarding risk for abuse and neglect. Programs and resources could provide recommendations for strengthening father-child relationships in an effort to prevent harsh or neglectful parenting behavior among fathers.
    - **Consider families' proximity to mental health and social services.** Given that longer driving distance to mental health and substance use clinics is a risk factor for child neglect, it is important to consider parents' driving distance to programs and resources. If possible, delivering programs and resources closer to where families live may be helpful for parents and families.

- **Timing of delivering programs and resources.** Research shows timing of providing programs and resources could be important for making a positive difference. For example, moving to a new location, the birth of a child, and deployment and reintegration can be particularly vulnerable times for children, parents, and families. Programming and resources, such as parenting education, family activities, and support groups can be provided during these particularly stressful times to help meet the needs of families and perhaps prevent child neglect from occurring. It is important to consider when the delivery of programs and supports could have the most impact of at-risk families.

- **Consider a multi-faceted, multi-level approach.** Child neglect is a complex issue, and multiple efforts are needed to prevent and intervene in cases of neglect. Multiple types of programs that address multiple levels of risk and protective factors may be more effective than implementing one type of program. In addition, collaborations between service providers and community-based agencies may strengthen community commitment to child welfare.

- **Balance program fidelity and flexibility in meeting the local community's needs.** While choosing evidence-based programs and practices is important, implementation and sustainability of programs and services are also important. Programs and resources could consider building flexibility into their delivery systems to support sustainability, meet consumers' needs, and encourage attendance at programs.

- **Invest in strengthening research examining child neglect.** Few studies examined child neglect specifically, and many researchers use the terms "abuse," "neglect," and "maltreatment" interchangeably. This complicates the interpretation of the results of these studies. Future research needs to clearly define and measure these constructs to improve the usefulness and generalizability of findings from studies examining child neglect and abuse. Many studies use cross-sectional designs; however, longitudinal designs are needed to examine mediators and moderators of child neglect and resilience, as well as factors that contribute to breaking the cycle of child abuse and neglect.

Considering these recommendations may strengthen child neglect prevention and intervention initiatives aimed at supporting children, parents, families, and communities.

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Appendices

Appendix A. Home Visiting Programs

Child First	
Structure	Two home visits per week during the first month. Usually one visit per week for the next 6-12 months. Duration of services and number of visits per week dependent on needs of family. Visits last 1-1.5 hours.
Age of Child	Prenatal through five years at the onset of services.
Target audience	Families with multiple risk factors such as poverty, depression, violence, substance use, homelessness, child maltreatment, or incarceration. Children with emotional, behavioral, developmental, or learning problems.
Provider/Facilitator	A licensed master's level mental health clinician and a bachelor's level care coordinator.
Curriculum	Seven components to the program: engagement of family; comprehensive assessment; development of child and family plan of care; parent-child psychotherapeutic intervention; enhancement of executive functioning; mental health consultation; and care coordination. Examples of topics covered during sessions include, normal developmental challenges and expectations, processing abilities of children, impacts of trauma, child behavior, appropriate responses to behavioral challenges, and emotion regulation.
Research on Effectiveness	Lowell, D.I., Carter, A.S., Godoy, L., Paulicin, B., Briggs-Gowan, M.J. (2011). A randomized controlled trial of Child First: A comprehensive, home-based intervention translating research into early childhood practice. *Child Development, 82*(1), 193-208. doi:10.1111/j.1467 8624.2010.01550.x
Research Findings	Intervention group less likely than usual care group to be involved with protective services (39% less likely during 12 month follow-up period, 33% less likely at 3 year follow-up).
URL	http://www.childfirst.com

Early Head Start - Home Visiting	
Structure	90 minute weekly home visit. Twice per month meetings with other children and parents.
Age of Child	Birth through age three.
Target audience	Low-income families.
Provider/Facilitator	Most programs require that staff have a least an associate's degree.
Curriculum	Topics covered include: home safety; calming a fussy baby; child development; nutrition, and discipline.
Research on Effectiveness	Roggman, L. A., & Cook, G. A. (2010). Attachment, aggression, and family risk in a low-income sample. *Family Science, 1*(3), 191-204. doi:10.1080/19424620.2010.567829
Research Findings	Intervention group less likely than control group to report having spanked their children in the last week.
URL	http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc/about-ehs#welcome

Exchange Parent Aide	
Structure	Weekly home visits (1-2 hrs. each) for an average of 13 months.
Age of Child	Prenatal through 12 years.
Target audience	Families at-risk for abuse or neglect.
Provider/Facilitator	Trained volunteer, professional, or paraprofessional workers. College-level or paraprofessional workers in human services; may be paid or volunteer, training is required.
Curriculum	Family treatment plan includes: child safety, problem solving skills, parenting skills, social support.
Research on Effectiveness	Guterman, J., Tabone, J. K., Bryan, G. M., Taylor, C. A., Napoleon-Hanger, C., & Banman, A. (2013). Examining the effectiveness of home-based parent aide services to reduce risk for physical child abuse and neglect: Six-month findings from a randomized clinical trial. *Child Abuse & Neglect, 37*(8), 566-577. doi: 10.1016/j.chiabu.2013.03.006
Research Findings	Parents enrolled in case management plus the parent aide program reported greater reductions in psychological aggression and physical assault toward child than parents enrolled in case management only.
URL	https://www.preventchildabuse.com/content/exchange-parent-aide-model

Family Connections	
Structure	Weekly home visits for at least 3 months. Program also includes emergency assistance, service coordination and referrals (e.g., to substance abuse treatment), and multifamily recreational activities (e.g., dinner gatherings and fieldtrips).
Age of Child	Ages 5 to 11.
Target audience	Families at risk for child maltreatment, especially child neglect.
Provider/Facilitator	Master's level social worker or bachelor's level worker supervised by a staff member with a master's degree or higher.
Curriculum	Topics addressed include: understanding children's needs, child development, child safety, and child behavior.
Research on Effectiveness	DePanfilis, D., & Dubowitz, H. (2005). Family Connections: A program for preventing child neglect. *Child Maltreatment, 10*(2), 108-123. doi: 10.1177/1077559505275252 DePanfilis, D., Filene, J. H., & Lim Brodowski, M. (2009). Introduction to Family Connections and the national replication effort. *Protecting Children, 24*(3), 4-14.
Research Findings	Program participants experienced positive changes in protective factors such as parenting competence and social support; decreases in risk facors such as parenting stress and depression, and improved child safety and behavior.
URL	http://www.family.umaryland.edu/

Family Spirit	
Structure	43 culturally congruent, structured lessons delivered at home during one hour visits. Visits occur weekly through the third trimester of pregnancy, biweekly until 4 months postpartum, monthly between 4 and 12 months postpartum, and bimonthly between 12 and 36 months postpartum.
Age of Child	Prenatal through 3 years.
Target audience	Young American Indian families.
Provider/Facilitator	Paraprofessional with a minimum of a high school diploma or GED plus two years of additional job-related education or work experience.
Curriculum	Lessons focus on reducing poor monitoring, coercive interaction, and harsh parenting. Content also includes maternal behavior and mental health problems such as substance use and depressive symptoms.
Research on Effectiveness	Barlow, A., Mullany, B., Neault, N., Compton, S., Carter, A., Hastings, R., ... & Walkup, J. T. (2013). Effect of a paraprofessional home-visiting intervention on American Indian teen mothers' and infants' behavioral risks: A randomized controlled trial. *American Journal of Psychiatry, 170*(1), 83–93. doi: 10.1080/19424620.2010.567829 Barlow, A., Mullany, B., Neault, N., Goklish, N., Billy, T., Hastings, R., ... & Walkup, J. T. (2015). Paraprofessional delivered, home-visiting intervention for American Indian teen mothers and children: Three-year outcomes from a randomized controlled trial. *American Journal of Psychiatry, 172*(2), 145-162. doi: 10.1176/appi.ajp.2014.14030332
Research Findings	Compared to standard care group, intervention group had greater parenting knowledge, parenting self-efficacy, and home safety attitudes at 12 months postpartum. Findings were similar at 36 months postpartum, with intervention group showing increased effective parenting, reduced maternal risks, and improved child development outcomes.
URL	http://www.jhsph.edu/research/affiliated-programs/family-spirit/

Health Access Nurturing Development Services (HANDS)	
Structure	Frequency and duration of home visits determined by family's needs.
Age of Child	Prenatal to age 2.
Target audience	Kentucky parents expecting a first baby (all 120 counties) and families with more than one child (in 78 counties), especially parents with challenges such as single parenthood, low income, substance abuse, or domestic violence.
Provider/Facilitator	Trained paraprofessional or professional (e.g., social worker).
Curriculum	Healthy pregnancy, caring for and bonding with the baby, how to provide the child with learning experiences, home safety, community resources, child development, stress management.
Research on Effectiveness	No peer-reviewed articles available.
Research Findings	According to program website: Participation in the HANDS program is associated with lower rates of child neglect, as compared to the general population.
URL	http://www.kyhands.com

Healthy Families America (HFA)	
Structure	At least one, one hour home visit per week for the first six months after the child's birth. Visit frequency after 6 months determied by local programs and family's needs.
Age of Child	Prenatal through 3-5 years.
Target audience	Parents at-risk of child maltreatment and facing multiple challenges such as single parenthood, low income, history of trauma, intimate partner violence, substance abuse, or mental health issues.
Provider/Facilitator	Certified clinician/parent educator and/or nurse practicioner.
Curriculum	Program services cover: child development and caring for infants, toddlers, and young children, ensuring families have a medical provider, connecting families to community resources for job training and day care, and following up with of childhood immunizations.
Research on Effectiveness	Harding, K., Galano, J., Martin, J., Huntington, L., & Schellenbach, C. J. (2007). Healthy Families America® Effectiveness: A comprehensive review of outcomes. *Journal of Prevention & Intervention in the Community, 34*(2), 149-179. doi:10.1300/J005v34n01_08 Rodriguez, M. L., Dumont, K., Mitchell-Herzfeld, S. D., Walden, N. J., & Greene, R. (2010). Effects of Healthy Families New York on the promotion of maternal parenting competencies and the prevention of harsh parenting. *Child Abuse & Neglect, 34*(10), 711-723. doi:10.1016/j.chiabu.2010.03.004
Research Findings	A review of 33 evaluations of HFA sites shows mixed results with respect to parenting and child maltreatment outcomes (Harding et al., 2007). This may be due to differences in site implementation or family characteristics. A study of a local implementation in New York found that program participation improved positive parenting outcomes such as maternal responsivity and cognitive engagement (Rodriguez et al., 2010). Program participants were also less likely than control group counterparts to engage in harsh parenting.
URL	http://www.healthyfamiliesamerica.org

Healthy Start - Home Visiting	
Structure	Biweekly, monthly, and then quarterly home visits over the course of 2 years.
Age of Child	Prenatal through age 2.
Target audience	Pregnant women and families at risk of low birth weight, preterm birth, and maternal mortality.
Provider/Facilitator	Registered nurse, social worker, with work experience in relevant fields; additional training is required.
Curriculum	Services include: referrals and ongoing health care coordination for well-woman, prenatal, postpartum, and well-child care; smoking cessation; perinatal depression screening; reproductive life planning; child development education; parenting support.
Research on Effectiveness	Duggan, A., McFarlane, E., Fuddy, L., Burrell, L., Higman, S. M., Windham, A., & Sia, C. (2004). Randomized trial of a statewide home visiting program: Impact in preventing child abuse and neglect. *Child Abuse & Neglect, 28*(6), 597-622. doi:10.1016/j.chiabu.2003.08.007
Research Findings	Randomized trial of Hawaii Health Start Program found that the program had a modest impact in preventing child neglect. It did not prevent other forms of child abuse.
URL	http://healthystartepic.org/

Maternal Infant Health Outreach Worker (MIHOW)	
Structure	Monthly home visits and group services.
Age of Child	Birth to age 3.
Target audience	Economically disadvantaged and geographically and/or socially isolated families.
Provider/Facilitator	Trained parents from the local community.
Curriculum	Outreach workers educate families about nutrition, child health, child development, positive parenting practices. Links to medical and social services are also provided.
Research on Effectiveness	Per the website, a three year, multi-site, mixed-methods, randomized control trial is currently underway in rural West Virginia.
Research Findings	According to program statistics available at www.mihow.org/about/impact.php: Compared to those children not enrolled in the program, MIHOW children are more likely to be put to sleep on their backs, ride in car seats at two years of age, and live in homes with fire escape plans and safe gun storage.
URL	http://www.mihow.org/

Minding the Baby	
Structure	8-10 weekly visits during pregnancy. Weekly visits during the baby's first year and every other week during the second year. Visits average 45-90 minutes.
Age of Child	Prenatal through 2 years.
Target audience	First-time, low income mothers.
Provider/Facilitator	Pediatric nurse practitioner and a licensed clinical social worker.
Curriculum	The program aims to promote secure attachment, parental reflection, physical and mental health, and self efficacy.
Research on Effectiveness	In the final phase of a randomized control trial. Sadler, L. S., Slade, A., & Mayes, L. (2006). *Minding the baby: A mentalization-based parenting program*. Chichester, UK: Wiley.
Research Findings	Preliminary findings suggest: Children in the intervention group show higher rates of secure attachment and lower rates of disorganized attachment than those in the control group. Mothers in the intervention group are less likely to describe their children as having behaviroal problems than those in the control group.
URL	http://mtb.yale.edu/

Nurse Family Partnership	
Structure	60-90 minute visits with pregnant mothers early in their pregnancy, weekly for the first month and then every other week until the baby is born. Weekly visits for the first six weeks after the baby is born, followed by over other week visits until baby is 20 months. Last four visits are monthly until the child is two years old.
Age of Child	Prenatal until age 2.
Target audience	First-time, low-income mothers.
Provider/Facilitator	Registered public health nurse.
Curriculum	The program strives to improve pregnancy outcomes by empowering women to engage in good preventive health practices (e.g., healthy diet, reduce substance use). Nurses improve child health and dvelopment by helping parents provide competent care. Also encourage parents to continue their education and find employment.
Research on Effectiveness	Olds, D.L., Kitzman, H., Hanks, C., Cole, R., Anson, E., Sidora-Arcoleo, K.,...& Bondy, J. (2007). Effects of nurse home visiting on maternal and child functioning: Age-9 follow-up of a randomized trial. *Pediatrics, 120*(4), e832-845. Eckenrode, J., Campa, M., & Luckey, D.W. (2010). Long-term effects of prenatal and infancy nurse home visitation on the life vourse of youths: 19-year follow-up of a randomized trial. *Archives of Pediatric Adolescent Medicine, 164*(1), 9-15. doi:10.1001/archpediatrics.2009.240.
Research Findings	Randomized clinical trials find improved prenatal health, fewer childhood injuries, reduced child abuse and neglect, and reduction in health-care encounters for injuries.
URL	http://www.nursefamilypartnership.org/

Parents as Teachers	
Structure	60-minute personal home visits are delivered weekly, every 2-4 weeks depending on family needs. At least twelve 1-2 hour group connections should also be provided across the program year.
Age of Child	Conception to kindergarten.
Target audience	Families with an expectant mother or parents of children up to kindergarten entry (usually 5 years).
Provider/Facilitator	Anyone who has successfully completed the Parents as Teachers Foundational and Model Implementation trainings.
Curriculum	Personal home visits (emphasizing parent-child interaction, development-centered parenting, and family well-being), annual child health screenings, and optional group connections.
Research on Effectiveness	Pfannenstiel, J., Lambson, T., Yarnell, V., Research and Training Associates Inc. (1991). Second wave study of the Parents as Teachers program: Executive summary. St. Louis, MO: Parents as Teachers National Center.
Research Findings	Participants were less likely to be investigated by child protective services and their children were less likely to be treated for an injury. Participants also had fewer documented cases of child maltreatment in comparison to national average.
URL	www.parentsasteachers.org

Play and Learning Strategies (PALS)	
Structure	Weekly visits for 3 months
Age of Child	PALS Infant (5-18 months); PALS Toddler (18 months-3 years).
Target audience	Parents of infants and toddlers subjected to risk factors during prgenancy or birth.
Provider/Facilitator	Trained family educators.
Curriculum	Using videotaped parent-child interactions and guided practice, teach responsive parenting skills to support children's social-emotional, cognitive, and language development. Parents learn behaviors that help her tune into her child, respond in a sensitive and contingent manner, provide appropriate cognitive and language stimulation, and manage behavior and discipline in a positive, developmentally appropriate manner.
Research on Effectiveness	Guttentag, C.L., Pedrosa-Josic, C., Landry, S.H., Smith, K.E., & Swank, P.R. (2006). Individual variability in parenting profiles and predictors of change: Effects of an intervention with disadvantaged mothers. *Journal of Applied Developmental Psychology, 27*(2), 349-369. doi:10.1016/j.appdev.2006.04.005 Landry, S. H., Smith, K. E., Swank, P. R., & Guttentag, C. (2008). A responsive parenting intervention: The optimal timing across early childhood for impacting maternal behaviors and child outcomes. *Developmental Psychology, 44*(5), 1335-1353. doi.org/10.1037/a0013030
Research Findings	Participants demonstrated greater competence in responsive parenting behaviors, and improved child development and school readiness.
URL	https://www.childrenslearninginstitute.org/programs/play-and-learning-strategies-pals/

SafeCare and SafeCare Augmented	
Structure	18-20 weekly home visit sessions, 60-75 minutes each. Home visitors begin with an assessment and then focus on areas of concern. SafeCare Augmented supplements the original model with staff training in motivational interviewing and domestic violence.
Age of Child	Age 0-5.
Target audience	Parents with a history of perpetrating child maltreatment or those at risk.
Provider/Facilitator	Recommended coaches have a college education, but 5-day onsite training is required.
Curriculum	Via in-home parent-child interaction training, help parents reduce the risk of child maltreatment by improving child behavior management skills and improving attachment. Includes home safety assessment and training, modeling, and role plays.
Research on Effectiveness	Gershater-Molko, R. M., Lutzker, J. R., & Wesch, D. (2002). Using recidivism data to evaluate Project Safecare: Teaching bonding, safety and healthcare skills to parents. *Child Maltreatment, 7*(3), 277-285. doi:10.1177/1077559502007003009 Chaffin, M., Hecht, D., Bard, D., Silovsky, J. F., & Beasley, W. H. (2012). A statewide trial of the SafeCare home-based services model with parents in child protective services. *Pediatrics, 129*(3), 509-515. doi:10.1542/peds.2011-1840
Research Findings	Participants showed reduced recidivism of child maltreatment.
URL	http://safecare.publichealth.gsu.edu/ http://safecare.publichealth.gsu.edu/training/safecare-augmented/

Appendix B. Parenting Education and Family Programs

Adults and Children Together (ACT) Raising Safe Kids Program	
Structure	8, 2-hour sessions.
Target audience	Parents and caregivers of children from birth to age 8.
Provider/Facilitator	Trained and certified ACT facilitators, may include social workers, counselors, psychologists, nurses, teachers, and clergy.
Setting	Variety of settings including schools, prisons, churches, community centers, childcare centers, mental health clinics.
Curriculum	8 modules: 1. understanding children's behaviors, 2. impact of exposure to violence on children, 3. understanding and controlling parents' anger, 4. understanding and helping angry children, 5. children and electronic media, 6. discipline and parenting styles, 7. discipline for positive behaviors, and 8. parents as teachers, advocates, and protectors of their children.
Research on Effectiveness	Portwood, S. G., Lambert, R. G., Abrams, L. P., & Nelson, E. B. (2011). An evaluation of the adults and children together (ACT) against violence parents raising safe kids program. *Journal of Primary Prevention, 32*(3-4), 147-160.
Research Findings	Reduction in harsh verbal and physical discipline, increase in nurturing behavior at conclusion of program and at 3-month follow-up.
URL	www.actagainstviolence.apa.org

Celebrating Families!	
Structure	16, 2-hour sessions (plus family dinner before each session).
Target audience	Families with children ages 6-11 in which one or both parents have a problem with alcohol or other drugs and are at high-risk for domestic violence, child abuse, or neglect.
Provider/Facilitator	Not specified; likely mental and behavioral health professionals serve as facilitators.
Setting	Variety of settings including residential, outpatient, and other community settings.
Curriculum	16 sessions addressing healthy living and nutrition, communication,anger management, chemical dependency, goal setting, boundaries, and friendships and relationships.
Research on Effectiveness	No peer-reviewed articles available. LutraGroup (2006). *Year one evaluation report for the Celebrating Families! Grant*. Unpublished report. Salt Lake City, UT: Karol Kumpfer.
Research Findings	According to non-peer-reviewed reports: Reduction in family conflict and parent depression in pre-post test; Increases in positive parenting, parenting skills, parenting efficacy, family cohesion, family strengths/resilience, and family communication.
URL	http://www.celebratingfamilies.net/

Chicago Parent Program	
Structure	12-session in-person weekly parenting program.
Target audience	Parents of children ages 2-5.
Provider/Facilitator	Trained group leader guided by The Chicago Parent Program Group Leader Manual (2nd edition).
Setting	Variety of settings including childcare centers.
Curriculum	Uses 160 video scenes to teach concepts and generate discussion, problem solving, and an exchange of ideas among parents. Weekly sessions include group discussion, role play, interactive activities, handouts, and assignments.
Research on Effectiveness	Gross, D., Breitenstein, S., Eisbach, S., Hoppe, E., & Harrison, J. (2014). *Promoting mental health in early childhood programs: Serving low-income ethnic minority families*. In M. Weist, N. Lever, C. Bradshaw, & J. Owens (Eds.), *Handbook of School Mental Health*, 2nd ed, pp.(109-130). New York: Springer.
Research Findings	Decreases in parents' use of corporal punishment. Increases in parents' consistency with discipline. Improvements in children's behavior.
URL	http://www.chicagoparentprogram.org/

Circle of Security Parenting Training	
Structure	8-session DVD parent education program.
Target audience	Families at risk for neglect or child maltreatment.
Provider/Facilitator	Social workers, therapists, mental health counselors, home visitors, family support workers, and parent educators.
Setting	Can be used in group settings or incorporated into home visitation or individual counseling.
Curriculum	Based in attachment theory, teaches parenting skills, children's needs and parents' responses to those needs, exploration and attachment in children, and teflective dialogue about parenting strengths and difficulties.
Research on Effectiveness	Hoffman, K., Marvin, R., Cooper, G. & Powell, B. (2006). Changing toddlers' and preschoolers' attachment classifications: The circle of security intervention. *Journal of Consulting and Clinical Psychology, 74*(2), 1017-1026. doi:10.1037/0022-006X.74.6.1017 Cassidy, J., Ziv, Y., Stupica, B., Sherman, L. J., Butler, H., Karfgin,...& Powell, B. (2010). Enhancing maternal sensitivity and attachment security in the infants of women in a jail-diversion program. *Attachment and Human Development, 23*(4), 333-353. doi:10.1080/14616730903416955
Research Findings	Intervention reduced attachment disorganization and insecurity. Infants of mothers in a jail-diversion program showed higher rates of secure attachment than the rates typically observed in high-risk populations.
URL	http://circleofsecurity.net/

Families and Schools Together (FAST)	
Structure	Multi-family groups meet for 2.5 hour weekly sessions over 8-10 weeks, followed by monthly meetings for the next two years.
Target audience	Families with children ages 3-18.
Provider/Facilitator	Certified FAST Trainers educate and coach FAST teams. Teams consist of 4-8 parents, teachers, school representatives, community-based professionals, and youth (at the middle and high school levels).
Setting	Schools.
Curriculum	Weekly sessions include: Evidence-based activites to enhance parenting skills and reduce family stress; one-on-one parent-child interaction time; and parent group time. Goals of the program include the development of interpersonal bonds, parent-to-parent support, and parent peer social network.
Research on Effectiveness	Kratochwill, T. R., McDonald, L., Levin, J. R., Scalia, P. A., & Coover, G. (2009). Families and schools together: An experimental study of multi-family support groups for children at risk. *Journal of School Psychology, 47*(4), 245-265. doi:10.1016/j.jsp.2009.03.001
Research Findings	Compared to parents in control group, those in intervention group reported greater reductions in children's aggresive behaviors and less decline in family adaptability (i.e., family's ability to be flexible with power structures, roles, and rules to meet developmental needs of children).
URL	http://www.familiesandschools.org/

Incredible Years	
Structure	12-20 weekly sessions, 2-3 hours each (videos, questions and discussion, brainstorming and value exercises, role play practice exercises, home activities, handouts).
Target audience	Parents and children (five programs for specific child age groups; 0-12 months; 1-3 years; 3-6 years; 6-12 years, and 4-12 years.
Provider/Facilitator	Helping professionals in social work, psychology, nursing, medicine, or education.
Setting	Variety of settings, including Head Start Centers, preschools, primary grade schools, mental health centers, social service centers, community health centers, foster parent agencies, homes, churches, housing centers, businesses or employee benefits, hospitals and primary care practices, homeless shelters, jails, YMCAs.
Curriculum	Sessions focus on: strengthening parent-child interactions; nurturing relationships; reducing harsh discipline; and fostering parents' ability to promote children's social, emotional, and language development.
Research on Effectiveness	Letarte, M., Normandeau, S., & Allard, J. (2010). Effectiveness of a parent training program "Incredible Years" in a child protection service. *Child Abuse & Neglect, 34*(4), 253-261. doi:10.1016/j.chiabu.2009.06.003 Hurlburt, M. S., Nguyen, K., Reid, J., Webster-Stratton, C., & Zhang, J. (2013). Efficacy of the Incredible Years group parent program with families in Head Start who self-reported a history of child maltreatment. *Child Abuse & Neglect, 37(*1), 531-543. doi:10.1016/j.chiabu.2012.10.008
Research Findings	Intervention group decreased in harsh discipline, physical punishment and increased on praise and incentives, appropriate discipline, and positive verbal discipline compared to the control group.
URL	http://incredibleyears.com/

Nurturing Parenting Programs	
Structure	5-55 sessions (depending on the level of need) that are generally 2 hours in length. Most primary prevention programs are group-based, though some can be delivered in the home. Intervention (secondary prevention) and treatment (teriary prevention) programs generally include both group and individual/home-based sessions.
Target audience	There are a number of programs available for different audiences, such as: Prenatal families; Parents with children 5-8 years old; Parents of teenagers; Parents with children with special needs or health challenges; Military families; and Families with substance abuse issues.
Provider/Facilitator	Professionals or paraprofessionals in fields such as social work, education, recreation, and psychology who have undergone facilitator training and have related experience.
Setting	Primary prevention programs take place at a community location. Intervention and treatment programs may include in-home sessions.
Curriculum	Specific curriculum varies by target audience and prevention level (primary, secondary/intervention, or tertiary/treatment), but all programs teach age-appropriate expectations; empathy, bonding, and attachment; nonviolent nurturing discipline; self-awareness and self-worth; and empowerment, autonomy, and healthy independence. Activities include questionnaires, discussion, role-play, audiovisual exercies, self-nurturing techniques.
Research on Effectiveness	Devall, E. L. (2004). Positive parenting for high-risk families. *Journal of Family and Consumer Sciences, 96*(4), 22-28. Palusci, V. J., Crum, P., Bliss, R., & Bavolek, S. J. (2008). Changes in parenting attitudes and knowledge among inmates and other at-risk populations after a family nurturing program. *Children and Youth Services Review, 30*(1), 79-89. doi:10.1016/j.childyouth.2007.06.006
Research Findings	Participants showed increases in empathy and knowledge of age-appropriate expectations and positive discipline techniques and decreases in belief in corporal punishment and maladaptive parenting practices.
URL	http://nurturingparenting.com/

Parenting Our Children to Excellence (PACE) and Criando a Nuestros Ninos hacia el Exito (CANNE)	
Structure	8, two-hours sessions delivered weekly to 10-15 parents.
Target audience	Parents of children ages 3-6 years.
Provider/Facilitator	Trained facilitator.
Setting	Daycares, preschools, and schools.
Curriculum	8 sessions: Bringing out the best in children; Setting clear limits for children; Helping children behave at home and beyond; Making sure children get enough sleep; Encouraging children's early thinking skills; Developing children's self-esteem; Helping children do well in school; Anticipating challenges and seeking support.
Research on Effectiveness	Begle, A. M., & Dumas, J. E. (2011). Child and parental outcomes following involvement in a preventive intervention: Efficacy of the PACE program. *The Journal of Primary Prevention, 32(*2), 67-81. doi:10.1037/a0021972 Dumas, J. E., Arriaga, X. B., Begle, A. M., & Longoria, Z. N. (2011). Child and parental outcomes of a group parenting intervention for Latino families: A pilot study of the CANNE program. *Cultural Diversity and Ethnic Minority Psychology, 17*(1), 107-115.
Research Findings	Parents who attended more sessions and were more engaged reported less child abuse potential and decreased parenting stress during the year following the completion of the program than parents who attended fewer sessions and were less engaged.
URL	Not available. For more information, contact Dr. Jean Dumas at jean.dumas@unige.ch.

Parenting Wisely	
Structure	Online program takes approximately 2 hours to complete (viewing video clips, choosing scenarios, and viewing consequences of parent actions).
Target audience	Parents of children ages 3-18.
Provider/Facilitator	N/A (delivered online or via CD-ROM).
Setting	Online or via CD-ROM.
Curriculum	Program addresses Helping children to do housework and do better in school; Curfew; Stepparenting; School, homework, and friends; Chores; Sibling conflict; and Finding drugs.
Research on Effectiveness	Segal, D., Chen, P. Y., Gordon, D. A., Kacir, C. D., & Gylys, J. (2003). Development and evaluation of a parenting intervention program: Integration of scientific and practical approaches. *International Journal of Human-Computer Interaction, 15*(3), 453-467. doi:10.1207/S15327590IJHC1503_09
Research Findings	Following intervention, reductions in child problem behavior and improvements in parental behavior and knowledge have been observed.
URL	https://www.parentingwisely.com/

Second Time Around	
Structure	8 to 16 sessions delivered to a small group by a facilitator.
Target audience	Grandparents raising their grandchildren.
Provider/Facilitator	Parent educator or social service agency staff member who has studied the curriculum guide, reaching resources, and instructional materials.
Setting	Community location.
Curriculum	Sessions address: Understanding your "not-so-new" role; Personal well-being; Refining parenting skills; Working with schools and Community; and Finances and legal issues.
Research on Effectiveness	Vacha-Haase, T., Ness, C. M., Dannison, L., & Smith, A. (2000). Grandparents raising grandchildren: A psychoeducational group approach. *Journal for Specialists in Group Work, 25*(1), 67-78. doi:10.1080/01933920008411452
Research Findings	Participants met objectives of content areas such as parenting skills, relationships, and finances. Participants rated the experience positively.
URL	http://homepages.wmich.edu/~dannison/grandparents.html

Strengthening Families Program (SFP)	
Structure	7, 10, 12, or 14 two-hour sessions (plus family dinner); parents and teens attend sessions separately for first hour, and attend second hour together.
Target audience	General and high-risk parents and children; separate versions for parents of children ages 3-5, 6-11, and 12-16.
Provider/Facilitator	Trained facilitators.
Setting	Variety of settings including schools, drug treatment centers, family and youth service agencies, child protection and foster care agencies, community mental health centers, housing projects, homeless shelters, churches, drug courts, family courts, juvenile courts, and prisons.
Curriculum	Parent curriculum: Using love and limits; Making house rules; Encouraging good behavior; Using consequences; Building bridges; Protecting against substance abuse, and Using community resources. Youth curriculum: Having goals and dreams; Appreciating parents; Dealing with stress; Following rules; Handling peer pressure; Reaching out to others Family curriculum: Supporting goals and dreams; Appreciating family members; Using family meetings; Understanding family values; Building family communication; Reaching our goals.
Research on Effectiveness	Kumpfer, K. L., Greene, J. A., Bates, R. F., Cofrin, K., & Whiteside, H. (2007). *State of New Jersey DHS division of addiction services strengthening families program substance abuse prevention initiative: Year three evaluation report*. Salt Lake City, UT: LutraGroup.
Research Findings	Parents in intervention group had lower scores on inconsistent discipline and verbal abuse and higher scores on positive parenting, parental involvement, and parenting skills than parents in the control group.
URL	http://www.strengtheningfamiliesprogram.org/

Teaching Important Parenting Skills (TIPS) for Great Kids	
Structure	Early childhood educators and care providers participate in training on the TIPS model and how to use the TIPS toolkit. Toolkit includes artices for providers and tip cards for parents.
Target audience	Parents, teachers, and other caregivers of children ages birth to 5 years.
Provider/Facilitator	Teachers and childcare providers.
Setting	Early childhood education and care facilities.
Curriculum	Addresses 12 parenting categories: health and growth; school readiness; guidance and discipline; home environment; supervision and safety; family, friends, and community; parenting styles; protection from violence; parent support; family relationships; protection from drug and alcohol abuse; and mental health.
Research on Effectiveness	None.
Research Findings	None.
URL	http://www.tipsforgreatkids.com/

Triple P (Positive Parenting Program)	
Structure	5 levels of intervention (from minimal, univeral to highly intensive) offered in a variety of structures (brochures, self-guided workbooks, DVDs, web-based sessions, seminars, group sessions, one-on-one consultations).
Target audience	Parents of children ages 0-16; a unique version (Pathways Triple P) adapted for families at high risk of child maltreatment.
Provider/Facilitator	Trained practitioners.
Setting	Varies by intervention level. Ranges from coordinated media campaign to face-to-face or telephone contact with facilitator to weekly group sessions to intensive, individually tailored sessions.
Curriculum	Varies depending on level of intervention, but generally includes: developing positive relationships; cncouraging desirable behavior; teaching new skills and behaviors, and managing misbehavior. For families at-risk of child maltreatment, focus is on anger management and other behavioral strategies to improve a parent's ability to cope with raising children.
Research on Effectiveness	Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009). Population-based prevention of child maltreatment: The U.S. triple p system population trial. *Prevention Science, 10*(1), 1-12. doi:10.1007/s11121-014-0538-3. Nowak, C., & Heinrichs, N. (2008). A comprehensive meta-analysis of Triple P-positive parenting program using hierarchical linear modeling: Effectiveness and moderating variables. *Clinical Child and Family Psychology Review, 11*(3), 114-144. doi:10.1007/s10567-008-0033-0
Research Findings	The intervention group had significantly fewer substantiated cases of child maltreatment, fewer child out-of-home placements, and fewer child maltreatment injuries after the program compared to the control group. Meta-analysis shows increases in positive parenting and parental well-being and decreases in child problems for parents in intervention group but not in control group.
URL	http://www.triplep.net/glo-en/home/

Appendix C Military-specific Programs

ADAPT4U - After Deployment: Adaptive Parenting Tools	
Type	Parenting Education and Family Program.
Structure	Three program formats: Group-based: 10-12 families meet with 2-3 facilitators for 14 weekly sessions. Childcare and homework help are available while parents attend group sessions. Online: Self-directed curriculum. Tele-health: Families meet individually with a facilitator via confidential video-conferencing for 14, one-hour weekly meetings.
Target audience	Military families with children ages 5-12 who had at least one parent deploy to Iraq or Afghanistan.
Provider/Facilitator	Clinical psychologists, social workers, child welfare professionals.
Setting	Community location or home, depending on format.
Curriculum	Parenting skills, couple relationships, problem-solving, and effective communication.
Research on Effectiveness	Gewirtz, A. H., Pinna, K. L., Hanson, S. K., & Brockberg, D. (2014). Promoting parenting to support reintegrating military families: After deployment, adaptive parenting tools. *Psychological Services, 11*(1), 31-45. doi:10.1037/a0034134
Research Findings	Early findings from a randomized controlled effectiveness study shows high participation and satisfaction rates among families assigned to the intervention group.
URL	http://www.cehd.umn.edu/fsos/projects/ADAPT/default.asp

Child Parent Relationship Therapy with Military Families	
Type	Parenting Education and Family Program.
Structure	A 10-session, multi-family intervention. Weekly sessions last 1.5 hours.
Target Audience	Military families.
Provider/Facilitator	Social worker or mental health professional with training in play therapy.
Setting	Classroom.
Curriculum	Structured play to support relationship building, empathic listening, imaginative play, and limit-setting.
Research on Effectiveness	Jensen-Hart, S. J., Christensen, J., Dutka, L., & Leishman, J. C. (2012). Child parent relationship training (CPRT): Enhancing parent-child relationships for military families. *Advances in Social Work, 13*(1), 51-66. Landreth, G., & Bratton, S. (2006). *Child parent relationship therapy (CPRT).* New York: Routledge.
Research Findings	Additional research on the implementation of CPRT with military families is necessary.
URL	http://cpt.unt.edu

FOCUS:Families OverComing Under Stress	
Type	Parenting Education and Family Program.
Structure	An 8-session program. Some sessions are parents-only (90 minutes), some are children-only (30-60 minutes), and the final three sessions are for the whole family (90 minutes). An online version is also available; FOCUS World.
Target audience	Military families with children (from preschoolers to teenagers) facing wartime deployments.
Provider/Facilitator	Family Resiliency Trainers with educational backgrounds in social work, mental health, and family counseling, usually at the master's level.
Setting	Installation location or online.
Curriculum	5 key skills: Emotion regulation; Communication; Problem-solving; Goal-setting; Managing deployment and combat stress reminders. Handouts and videos are available online.
Research on Effectiveness	Lester, P., Saltzman, W. R., Woodward, K., Glover, D., Leskin, G. A., Bursch, B., ... & Beardslee, W. (2012). Evaluation of a family-centered prevention intervention for military children and families facing wartime deployments. *American Journal of Public Health, 102*(S1), S48-S54. doi:10.2105/AJPH.2010.300088
Research Findings	Pre- and post-intervention questionnaires showed improvements in parental distress and family functioning. Children's prosocial and coping behaviors also improved.
URL	www.focusproject.org

New Parent Support Programs	
Type	Home Visiting Program.
Structure	Home visiting program, may incorporate Nurturing Parenting Program practices (see below).
Target audience	Active Duty military families who are expecting a new baby or who have children under 3-5 years of age. Age limit depends on branch of military. Some families that have separated from the military may be eligible.
Provider/Facilitator	Nurses, social workers, home visitation specialists.
Setting	Home.
Curriculum	Coping with stress, child development, safe sleep, nutrition, toilet training, age-appropriate discipline, play, newborn care, parenting skills, nurturing parent-child and co-parenting relationships, physical and emotional demands of parenting, especially during separation and deployment, and connections to services and resources.
Research on Effectiveness	No peer-reviewed articles evaluating this particular program, but considerable research documenting the effectiveness of home visiting in general. Krugman, R. D. (1993). Universal home visiting: A recommendation from the US Advisory Board on Child Abuse and Neglect. *The Future of Children*, 184-191.
Research Findings	None.
URL	http://www.militaryonesource.mil/parenting?content_id=266691 Example from the Navy: http://www.cnic.navy.mil/ffr/family_readiness/fleet_and_family_support_program/new_parent_support/new-parent-support-program-overview.html

Nurturing Parenting Programs	
Type	Parenting Education Program.
Structure	Concepts and practices from the Nurturing Parenting Program have been incorporated into the New Parent Support Program (see above).
Target audience	Military families with children ages 0-5.
Provider/Facilitator	Nurses, social workers, home visitation specialists.
Setting	Usually a home-based setting, through some installations may implement the program in groups.
Curriculum	General Nurturing Parenting practices such as bonding with baby, home safety, child development, and parental self-care. Additional military-specific content, including deployment, staying in touch, PTSD, and reunification.
Research on Effectiveness	No peer-reviewed articles evaluating the military family version of this program. Palusci, V. J., Crum, P., Bliss, R., & Bavolek, S. J. (2008). Changes in parenting attitudes and knowledge among inmates and other at-risk populations after a family nurturing program. *Children and Youth Services Review, 30*(1), 79-89. doi:10.1016/j.childyouth.2007.06.006
Research Findings	Among non-military populations, participants showed increases in empathy and knowledge of age-appropriate expectations and positive discipline techniques and decreases in belief in corporal punishment and maladaptive parenting practices.
URL	www.nurturingparenting.com Military-specific information from Nurturing Parenting: http://www.nurturingparenting.com/ecommerce/category/1:2:5/ Example from the Navy: https://www.cnic.navy.mil/ffr/family_readiness/fleet_and_family_support_program/new_parent_support/nuturing_parenting.html

Parenting for Service Members and Veterans	
Type	Parenting Education.
Structure	Free, 6-module online course with companion app called Parenting2Go.
Target audience	Service Member and Veteran parents.
Provider/Facilitator	Self-directed. Curriculum developed by educators and mental health professionals.
Setting	Home/online.
Curriculum	Six modules: Back into the family; Promoting positive parent-child communications; Helping your child with difficult emotions and behaviors; Positive approach to discipline; Managing stress and emotions as a parent; Parenting with emotional and physcial challenges.
Research on Effectiveness	None.
Research Findings	None.
URL	http://militaryparenting.dcoe.mil/

STRoNG Military Families (Support to Restore, Repair, and Nurture Growing Military Families)	
Type	Parenting Education and Family Program.
Structure	A 10-week parent-child program. Multi-family group and home-based options.
Target audience	Military families in Michigan with children under 8 years of age. Available to Active Duty and Guard/Reserve families.
Provider/Facilitator	Parent educator, trained professional, trained children's group volunteers.
Setting	In home or at a community location.
Curriculum	Supported parent-child interaction; Positive parenting; Parental self-care and stress reduction; Age-appropriate coping skills for children; Social support for parents and children; Referrals to local resources.
Research on Effectiveness	None.
Research Findings	None.
URL	http://m-span.org/programs-for-military-families/strong-families/

Web-based Tutorial for Mandated Reporters	
Type	Education for professionals.
Structure	A one-hour web-based tutorial.
Target audience	Teachers, school professionals, and staff at Department of Defense Dependent Schools.
Provider/Facilitator	Developed by Ph.D.-level researcher.
Setting	Online.
Curriculum	Risk factors, signs, symptoms, and reporting procedures for child maltreatment.
Research on Effectiveness	Phipps, L.M. (2009). Preventing child maltreatment in military families: Evaluating the effectiveness of a web-based tutorial for mandated reporters. (Doctoral dissertation). Retrieved from Dissertation Abstracts International. (UMI No. 3386869).
Research Findings	Participants' post-test scores were significantly higher than pre-test scores demonstrating increased knowledge of risk factors, signs, symptoms, and reporting procedures for child maltreatment.
URL	N/A This tutorial is not publicly available. Contact study author at lphipps@email.arizona.edu for more information.

Zero to Three - Babies on the Homefront mobile app	
Type	Parenting Education Program.
Structure	This app is free and available in Spanish and English.
Target audience	Military families with infants.
Provider/Facilitator	Zero to Three has created the content.
Setting	Mobile.
Curriculum	Behavior tips, parent-child activites, and parental self-care strategies. Information can be sorted by child's age and situation (e.g., service member parent at home, leaving soon, deployed, or home again).
Research on Effectiveness	None.
Research Findings	None.
URL	www.babiesonthehomefront.org

Appendix D. Parent Mutual Support Programs

Circle of Parents	
Structure	Ongoing, free, confidential, peer self-help groups for parents. Foster exchange of ideas, support, information, and resources. Organized and supported by state or regional networks. Most locations have simultaneous free children's programs; if not, quality childcare is provided.
Target audience	All parents.
Provider/Facilitator	A trained group facilitator and parent leader.
Setting	Varies depending upon location.
Curriculum	As they are peer support groups, there is no set curriculum. The mission is to prevent child abuse and neglect and strengthen families.
Research on Effectiveness	Circle of Parents (2011). National evaluation. Retrieved from http://circleofparents.disscada.com/resources/network-resources/
Research Findings	Participants had significant improvements in four protective factors, including family functioning/resiliency, social support, nurturing/attachment, and knowledge of parenting and child development.
URL	http://www.circleofparents.org/

Parents Anonymous	
Structure	As both an intervention and prevention program, it involves 90-120 minute weekly meetings. Participants can attend as often and as long as they wish. Recommended duration is approximately 12 meetings. Hosts a separate group for their children and youth (ages 0-18).
Target audience	Parents, grandparents, relative and kin providers, foster parents, or anyone serving in a caregiver role for children and youth of all ages.
Provider/Facilitator	A trained facilitator and parent group leader are present in every meeting. Group facilitators are children & youth workers who have a Bachelor's and/or Master's degree in social work, psychology, early childhood education, or other behavioral science or credentials as a teacher, clergy, or nurse.
Setting	Various, such as child abuse/family reunification program, child care center, community agency, community daily living settings, day treatment program, department of social service, homeless shelter, prison/pre-release center, religious organization, residential care facility, residential treatment center, school, domestic violence shelter.
Curriculum	Parenting groups address child development, communication skills, positive discipline, parental roles, age appropriate expectations, effective parenting strategies, anger management techniques, mental health concerns, drug/alcohol, safety, and self-care. Child/youth programs are designed to build self-esteem, improve emotional well-being, change behavior, achieve permanency, and strengthen family and peer relationships.
Research on Effectiveness	Polinsky, M. L., Pion-Berlin, L., Williams, S., & Wolf, A. M. (2010). Preventing child abuse and neglect: A national evaluation of Parents Anonymous® groups. *Child Welfare, 89*(6), 43-62. Polinsky, M. L., Pion-Berlin, L., Long, T., & Wolf, A. M. (2011). Parents Anonymous outcome evaluation: Promising findings for child maltreatment reduction. *Journal of Juvenile Justice, 1*(1), 33-47.
Research Findings	Studies have documented a range of positive outcomes, including decreases in physical and verbal abuse, improvements in parents' abuse-related atttitudes and behaviors, and decreases in risk factors known to be associated with child maltreatment.
URL	http://parentsanonymous.org/

Appendix E. Therapy-oriented Programs

Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT)	
Structure	Caregivers and children receive joint and individual skills-training sessions including role-playing exercises, performance feedback, and home practice exercises. Delivered once or twice per week over 6 to 12 months (total of 18-24 hours).
Target audience	Caregivers and children (ages 5-17) who are involved in arguments, frequent conflict, physical force/discipline, or child physical abuse.
Provider/Facilitator	Certified, licensed clinicians with a master's degree in mental health or a related field.
Setting	Most commonly in outpatient clinics and homes. Sometimes in inpatient and residential settings.
Curriculum	Sessions address anger and behavior management, affect regulation, problem solving, social skills training, cognitive restructuring, and communication skills training.
Research on Effectiveness	Kolko, D. J. (1996). Individual cognitive behavioral treatment and family therapy for physically abused children and their offending parents: A comparison of clinical outcomes. *Child Maltreatment, 1*(1),322-342. doi:10.1177/1077559596001004004
Research Findings	Decreased parent-to-child aggression, child abuse potential ratings, and family conflict.
URL	www.afcbt.org/

Attachment and Biobehavioral Catch-up (ABC)	
Structure	Parent coaches provide parenting training in weekly 60-minute sessions over 10 weeks, providing "in the moment" feedback on parent-child interactions.
Target audience	Caregivers of young children (age 6 months to 2 years) who have experienced early adversity.
Provider/Facilitator	Parent coaches who attend a 2-3 day training and a year of supervision.
Setting	Participants' home.
Curriculum	Program targets increasing parental nurturance, following the child's lead, and reducing frightening caregiving behavior. Includes review of video-recorded mother-child interactions and explicit parenting coaching.
Research on Effectiveness	Sprang, G. (2009). The efficacy of a relational treatment for maltreated children and their families. *Child and Adolescent Mental Health, 14*(1), 81-88. doi:10.1111/j.1475-3588.2008.00499.x Berlin, L. J., Shanahan, M. and Appleyard Carmody, K. (2014), Promoting supportive parenting in new mothers with substance-use problems: A pilot randomized trial of residential treatment plus an attachment-based parenting program. *Infant Mental Health Journal, 35*(2), 81–85. doi:10.1002/imhj.21427
Research Findings	Significantly lower scores on total child abuse potential, parenting stress, and child internalizing and externalizing behavior. Another study found mothers displayed more supportive parenting behaviors after treatment.
URL	http://www.infantcaregiverproject.com/#!

Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT): Empowering Families Who Are at Risk for Physical Abuse	
Structure	16-20 sessions, including both individual sessions and joint parent-child therapy. Goals are to help children heal from past abusive experiences, empower parents use non-coercive discipline, strengthen parent-child relationships, and enhance the safety of all family members.
Target audience	Children (ages 3-17) and their parents who are at-risk for or who have already engaged in physically abusive behavior towards their children. May also be parents who experience high levels of stress, perceive their children's behavior as extremely challenging, and fear they are going to lose their temper with their children.
Provider/Facilitator	Trained mental health providers.
Setting	Outpatient setting.
Curriculum	Manualized treatment; can be offered in individual or group format. Grounded in cognitive behavioral theory and incorporates elements (e.g., trauma narrative and processing, positive reinforcement, timeout, behavioral contracting) from empirically supported cognitive behavioral therapy.
Research on Effectiveness	Runyon, M. K., Deblinger, E., & Steer, R. A. (2010). Group cognitive behavioral treatment for parents and children at-risk for physical abuse: An initial study. *Child and Family Behavior Therapy, 32*(3), 196-218. Runyon, M., Deblinger, D., & Schroeder, C. (2009). Pilot evaluation of outcomes of combined parent-child cognitive-behavioral group therapy for families at-risk for child physical abuse. *Cognitive Behavioral Practice, 16*, 101–118. doi:10.1016/j.cbpra.2008.09006
Research Findings	Improved parenting skills, reductions in the use of physical punishment, and decreases in PTSD symptom scores among participants.
URL	http://www.caresinstitute.org/services_parent-child.php

Multisystemic Therapy - Child Abuse and Neglect (MST-CAN)	
Structure	Intensive 6-9 month therapy involving at least 3 sessions / week. Goals are to keep families together, assure children are safe, prevent abuse and neglect, reduce mental health difficulties, and increase natural social supports.
Target audience	Youth ages 6-17 and their families who have come to the attention of Child Protective Services due to physical abuse and/or neglect.
Provider/Facilitator	Trained mental health providers.
Setting	Participants' home and community settings.
Curriculum	Treatment strategies include safety planning, cognitive behavioral therapy for managing anger and addressing the impact of trauma, family therapy focused on communication and problem solving, and sessions to support the parent in taking responsibility for the events that brought the family to child protection.
Research on Effectiveness	Swenson, C. C., Schaeffer, C. M., Henggeler, S. W., Faldowski, R., & Mayhew, A. (2010). Multisystemic therapy for child abuse and neglect: A randomized effectiveness trial. *Journal of Family Psychology, 24*(1), 497-507. doi.org/10.1037/a0020324
Research Findings	Parents are more likely to use non-violent discipline. Reductions in neglectful parenting, assault of child, and psychological aggression.
URL	http://mstservices.com/target-populations/chld-abuse-and-neglect and http://www.mstcan.com/

Parent Child Interaction Therapy	
Structure	Parent-child psychotherapy that focuses on improving the quality of the parent-child relationship through skill-building and promoting positive parent-child interaction. Includes use of a one-way mirror and live coaching by the therapist via a bug in the ear. Duration of treatment varies, but is approxmately 12 one-hour sessions.
Target audience	Originally developed for young children (ages 3-6) experiencing emotinoal and behavioral disorders; has subsequently been applied to a range of parent and child issues, including child maltreatment.
Provider/Facilitator	Trained mental health providers.
Setting	Outpatient setting.
Curriculum	The treatment focuses on two basic interactions: 1. Child Directed Interaction in which parents engage their child in a play situation with the goal of strengthening the parent-child relationship and 2. Parent Directed Interaction in which parents learn to use specific behavior management techniques as they play with their child.
Research on Effectiveness	Kennedy, S., Kim. J., Tripodi, S., Brown, S., Gowdy, G. (2014). Does parent–child interaction therapy reduce future physical abuse? A meta-analysis. *Research on Social Work Practice 12*(2), 46-67. doi:10.1177/1049731514543024 Timmer, S.G., Urquiza, A.J., Zebell, N.M., McGrath, J.M. (2005). Parent-child interaction therapy: Application to maltreating parent-child dyads. *Child Abuse & Neglect, 29*(1),825-842. doi:10.1016/j.chiabu.2005.01.003
Research Findings	PCIT participants had fewer physical abuse recurrences and greater reductions in parenting stress than comparison parents.
URL	www.pcit.org/

Appendix F. Programs in Collaboration with Pediatric Clinics

Healthy Steps	
Structure	A Healthy Steps Specialist is embedded in the medical setting and collaborates with the physician in conducting joint office visits, administering screenings, helping families manage common behavioral concerns, and promoting the overall physical, emotional, and intellectual growth and development of children. Home visits to promote parent-child interactions and home safety are optional.
Target audience	All parents with children from birth to age 3.
Provider/Facilitator	A Healthy Steps Professional who has a background in child development, nursing, or social work.
Setting	Pediatric or Family Medicine practice locations, which may include community health organizations, federally qualified health centers, private practices, hospital-based clinics, child health and development organizations, and other types of clinics.
Curriculum	Healthy Steps sites customize the following services to best serve their families: enhanced well child care; child development; telephone information line; home visits; informational materials for mothers and fathers that emphasize prevention; child development and family health checkups; parent groups; and inks to community resources.
Research on Effectiveness	Minkovitz, C. S., Strobino, D., Mistry, K. B., Scharfstein, D. O., Grason, H., Hou, W., ... & Guyer, B. (2007). Healthy steps for young children: Sustained results at 5.5 years. *Pediatrics, 120*(3), e658-e668. doi:10.1542/peds.2006-1205 Minkovitz, C. S., Hughart, N., Strobino, D., Scharfstein, D., Grason, H., Hou, W., ... & Guyer, B. (2003). A practice-based intervention to enhance quality of care in the first 3 years of life: The healthy steps for young children program. *JAMA, 290*(23), 3081-3091. doi:10.1001/jama.290.23.3081
Research Findings	Reduced odds of using severe discipline; these positive effects have been maintained at 3 and 5.5 year follow-up evaluations.
URL	http://healthysteps.org/

Safe Environment for Every Kid (SEEK)	
Structure	Online training for pediatricians to help them screen for common problems that can be risk factors for child maltreatment, including parental depression, substance abuse, family violence, harsh punishment, and food insecurity. Also includes SEEK Parent Questionnaire and parent handouts.
Target audience	Families who may have risk factors for child maltreatment and have a child/children ages 0-5.
Provider/Facilitator	Pediatric primary care professionals; having a mental health professional as an adjunct is ideal but not necessary.
Setting	Primary care settings serving children.
Curriculum	Health care providers briefly assess and initially address identified risk factors and make necessary referrals to community resources.
Research on Effectiveness	Dubowitz H., Feigelman S., Lane W., Kim J. (2009). Pediatric primary care to help prevent child maltreatment: The safe environment for every kid (SEEK) model. *Pediatrics, 123*(4), 858-864. doi:10.1542/peds.2008-1376
Research Findings	Participants in SEEK showed lower rates of abuse and neglect than controls.
URL	https://theinstitute.umaryland.edu/SEEK/

Building Healthy Children	
Structure	A hybrid preventive intervention offering parenting education, parent-child attachment and maternal depression therapy, and any needed support services (e.g., food, housing, transportation) for 3 years via home visits. Goal is to decrease the number of families involved with child protection services. Only offered via the University of Rochester Medical Center (New York).
Target audience	Women who gave birth to their first child before age 21 and have no more than two children under the age of three.
Provider/Facilitator	Pediatric social workers and outreach workers.
Setting	Families' homes and primary care clinics.
Curriculum	Tiered model depending on family needs, but may include interpersonal therapy for maternal depression, child-parent psychotherapy to promote strong parent-child attachment, and the parents as teachers parenting program.
Research on Effectiveness	Paradis, H. A., Sandler, M., Manly, J. T., & Valentine, L. (2013). Building healthy children: Evidence-based home visitation integrated with pediatric medical homes. *Pediatrics, 25*(2),132-245. (Supplement 2), S174-S179. doi:10.1542/peds.2013-1021R
Research Findings	Preliminary results show avoidance of child protection reports and high rates of preventive care for children.
URL	http://www.psych.rochester.edu/MHFC/community-services/building-healthy-children/

Appendix G. Other Prevention Initiatives for At-risk Families

Public Awareness Campaigns	
Description	Public awareness campaigns are efforts to change knowledge and behavior using a variety of educational materials and media strategies.
Research on Effectiveness	Example related to Period of PURPLE Crying campaign: Barr, R. G., Rivara, F. P., Barr, M., Cummings, P., Taylor, J., Lengua, L. J., & Meredith-Benitz, E. (2009). Effectiveness of educational materials designed to change knowledge and behaviors regarding crying and shaken-baby syndrome in mothers of newborns: A randomized, controlled trial. *Pediatrics, 123*(3), 972-980. doi:10.1542/peds.2008-0908
Research Findings	In the intervention group, knowledge of infant crying and shaking as well as sharing of information about walking away when frustrated were greater than in the control group. Reported maternal responses to crying were similar in both groups. Mothers in the intervention group reported increased infant distress.
Specific Example	Period of PURPLE Crying.
Websites for Additional Information	http://www.purplecrying.info/

Family Resource and Support Centers	
Description	Offer a range of free or low-cost services to families with young children such as childcare, home visiting, parent skill training, mental health and family counseling, planned respite care, crisis care, job training, and substance abuse prevention.
Research on Effectiveness	None.
Research Findings	None.
Specific Example	The Family Support Center in Taylorsville, Utah.
Websites for Additional Information	http://www.familysupportcenter.org/

Child-Parent Centers	
Description	Provide educational and family support to low-income families with children in preschool through grade 3.
Research on Effectiveness	Reynolds, A. J., Richardson, B. A., Hayakawa, M., Lease, E. M., Warner-Richter, M., Englund, M. M., ... & Sullivan, M. (2014). Association of a full-day vs part-day preschool intervention with school readiness, attendance, and parent involvement. *JAMA, 312*(20), 2126-2134. doi:10.1001/jama.2014.15376.
Research Findings	No findings related to the prevention of child maltreatment. Regarding academic preparation: A full-day CPC preschool intervention was associated with increased school readiness and attendance compated to a part-day program. Parental involvement was the same in both groups.
Specific Example	Child-Parent Centers in Chicago, IL There is currently a midwest expansion project underway.
Websites for Additional Information	https://humancapitalrc.org/midwest-cpc/midwest-cpc-expansion

Planned Respite Care	
Description	Temporary, short-term care for a child who has a disability or chronic illness. Respite services allow parents and family caregivers to attend to their own and other familiy members' needs. Regularly provided in-home with a trained professional or out-of-home in a care facility.
Research on Effectiveness	Mikton, C., Maguire, H., & Shakespeare, T. (2014). A systematic review of the effectiveness of interventions to prevent and respond to violence against persons with disabilities. *Journal of Interpersonal Violence, 29*(17), 3207-3226. doi:10.1177/0886260514534530
Research Findings	Findings about the effectiveness of respite care in preventing maltreatment among people with disabilities were equivocal.
Specific Example	Children's Respite Care Center in Omaha, Nebraska.
Websites for Additional Information	http://crccomaha.org/ http://archrespite.org/

Crisis Child Care/Nurseries	
Description	Temporary, short-term care for a child who is in danger of abuse or neglect or who's family is experiencing an emergency such as a car accidenct, domestic violence, or homelessness.
Research on Effectiveness	Cole, S. A., Wehrmann, K. C., Dewar, G., & Swinford, L. (2005). Crisis nurseries: Important services in a system of care for families and children. *Children and Youth Services Review, 27*(9), 995-1010. doi:10.1016/j.childyouth.2004.12.023
Research Findings	Caregivers reported reductions in stress, perceived improvement in their parenting skills, and perceived decreases in their risk of maltreatment.
Specific Example	Crisis Nursery in Phoenix, Arizona.
Websites for Additional Information	http://www.crisisnurseryphx.org/

Infant Massage	
Description	Classes are available for educators and parents. Infant massage training can be incorporated into home visiting and parent education programs.
Research on Effectiveness	Onozawa, K., Glover, V., Adams, D., Modi, N., & Kumar, R. C. (2001). Infant massage improves mother–infant interaction for mothers with postnatal depression. *Journal of Affective Disorders, 63*(1), 201-207. doi:10.1016/S0165-0327(00)00198-1 Huhtala, V., Lehtonen, L., Heinonen, R., & Korvenranta, H. (2000). Infant massage compared with crib vibrator in the treatment of colicky infants. *Pediatrics, 105*(6), e84-e84. doi:10.1542/peds.105.6.e84
Research Findings	Infant massage may improve mother-infant interaction in mothers with postnatal depression and seems to be as effective as a crib vibrator in reducing crying in colicky infants.
Specific Example	Example 1: Infant Massage USA training programs for parents and educators. Example 2: Early Childhood Family Education: New Parent Connection with Infant Massage class sponsored by the Minneapolis, MN public school system.
Websites for Additional Information	http://www.infantmassageusa.org/ http://ecfe.mpls.k12.mn.us/basic3

Appendix H. Bystander Mobilization Programs

Communities NOW	
Structure	The program educates and empowers concerned citizens regarding their role in supporting families and protecting children from abuse and neglect. The Butler Insitute for Families at the University of Denver helps local communities implement and sustain the program via a two-day Communities NOW training, a two-day train-the-trainer workshop, and ongoing evaluation and technical assistance. Community organizations and agencies (e.g., state health departments, parent-child centers, and child welfare coalitions) that have completed the above trainings offer 14-hour courses to local community members and service providers who can earn certificates or continuing education credits.
Target audience	Social service providers and concerned citizens who are interested in protecting children, supporting families, and intervening with struggling parents.
Provider/Facilitator	Local trainers (often social service providers or behavioral health specialists) who has participated in a 2-day train-the-trainer workshop.
Setting	In the community and at the offices of the local partner organizations and agencies.
Curriculum	Trainings address: Identifying child abuse and neglect; Understanding the child welfare system; When and how to get involved; Assessing one's comfort level with intervening; Parenting approaches; Disciplining and caring for children; Personal safety; Challenges to intervening safely; Role of culture, gender, and socioeconomic status; Complex issues facing families; possible responses, interventions, and problem solving strategies.
Research on Effectiveness	No peer-reviewed articles. Report conducted by the Butler Institute for Families: Lane, M., Bruce, L., & Deaton, A. (2014). *Cross-site evaluation data report: Communities NOW: Connecting for Kids*. Denver, CO: University of Denver, Graduate School of Social Work, Butler Institute for Families.
Research Findings	Participants show increased understanding of child abuse and neglect and knowledge of intervention strategies. Participants report that they would be more likely to intervene in the future. At follow-up, they report that because of their actions, possible injuries or abuse were prevented, safety was promoted, and alternative parenting strategies were taught.
URL	http://www.thebutlerinstitute.org/communitiesnow/

Darkness to Light - Stewards for Children	
Structure	Child sexual abuse prevention trainings are offered online and face-to-face. Educational videos also available. Online course take 2 hours to complete and is available in English and Spanish.
Target audience	Organizations that serve youth, teachers, parents, and individuals who want to prevent child sexual abuse.
Provider/Facilitator	Online or with an authorized facilitator (often a social worker or counselor) who has received 7 hours of training.
Setting	Online or face-to-face in community settings.
Curriculum	Curriculum covers: Prevalence and consequences of childhood sexual abuse; Situations that create the risk for abuse; warning signs of abuse; Strategies for protecting children; and How to intervene and react responsibly.
Research on Effectiveness	Rheingold, A. A., Zajac, K., Chapman, J. E., Patton, M., de Arellano, M., Saunders, B., & Kilpatrick, D. (2014). Child sexual abuse prevention training for childcare professionals: An independent multi-site randomized controlled trial of stewards of children. *Prevention Science, 16*(3), 374-385.
Research Findings	Exposure to program increased knowledge of child sexual abuse, changed attitudes, and impacted preventive behaviors of childcare professionals.
URL	www.d2l.org

Stop It Now! Circles of Safety	
Structure	Child sexual abuse prevention training is provided via webinars and train-the-trainer programming. Programs are available for multiple audiences (e.g., childcare providers and leaders of higher education systems). Trainings are usually 2 days long. Ongoing consultation is available.
Target audience	Care providers, educators, and organizations that serve youth. Program has been customized for higher education systems. This version trains university leaders and cross-disciplinary teams in how to create safer environments for children.
Provider/Facilitator	Circle of Safety staff provides training and technical assistance.
Setting	Online or face-to-face in community location.
Curriculum	5-module curriculum covers education about child sex abuse, warning signs, communication skills, healthy sexuality, and facilitated discussions about how work at the community level can prevent child sexual abuse.
Research on Effectiveness	Schober, D. J., Fawcett, S. B., Thigpen, S., Curtis, A., & Wright, R. (2012). An empirical case study of a child sexual abuse prevention initiative in Georgia. *Health Education Journal, 71*(3), 291-298. doi:10.1177/0017896911430546
Research Findings	Incidence of child sexual abuse reports decreased four of the five years of the implementation period.
URL	http://www.stopitnow.org/circles-of-safety

Appendix I. School-based Curricula for Students

Body Safety Training Program	
Structure	10 lessons in a workbook. Also has a parent and teacher version. Each lesson is 15-20 minutes.
Target audience	Children ages 3-8 years.
Provider/Facilitator	Parents and teachers.
Curriculum	General safety topics such as fire, gun, pedestrian, and poison safety. Also addresses body safety, including recognizing, resisting, and reporting inappropriate touching.
Research on Effectiveness	Kenny, M. C., Wurtele, S. K., & Alonso, L. (2012). Evaluation of a personal safety program with Latino preschoolers. *Journal of Child Sexual Abuse, 21*(4), 368-385. doi:10.1080/10538712.2012.675426 Kenny, M. C., & Wurtele, S. K. (2010). Children's abilities to recognize a "good" person as a potential perpetrator of childhood sexual abuse. *Child Abuse & Neglect, 34*(7), 490-495.
Research Findings	Participants were better able than controls to recognize inappropriate touches and inappropriate touch requests from "good" people, know correct genital terminology, and have learned both personal and general safety skills. Knowledge gains maintained at 3-month follow-up.
URL	www.sandywurtele.com

Childhelp Speak Up Be Safe	
Structure	In-school curriculum over the course of two 25-50 minute sessions. Letters are sent home for parents describing concepts learned.
Target audience	Children in grades 1-6. Curriculum for Pre-K, kindergarten, and grades 7-12 in development.
Provider/Facilitator	A certified facilitator, usually a teacher.
Curriculum	Curriculum varies by grade level. Topics include: Internet and cell phone safety; private body parts; emotional abuse; responsibility of adults for keeping children safe; self-esteem; bullying and cyberbullying; and puberty.
Research on Effectiveness	None.
Research Findings	None.
URL	http://www.speakupbesafe.org/index.html https://www.childhelp.org/speak-up-be-safe-for-educators/

The Safe Child Program	
Structure	Teachers deliver 5-10 sessions per year, including viewing videotapes and scripted classroom role plays.
Target audience	Children in preschool through grade 3.
Provider/Facilitator	Teacher who has studied the training CD/DVD.
Curriculum	Skills to reduce children's vulnerability to sexual, emotional, and/or physical abuse by strangers or people known to the child. Includes focus on self-esteem and self-reliance; speaking up for oneself; where and how to get help; and practice with safety skills via role playing.
Research on Effectiveness	Fryer, G. E., Kraizer, S. K., & Mlyoshi, T. (1987). Measuring actual reduction of risk to child abuse: A new approach. *Child Abuse & Neglect, 11*(2), 173-179.
Research Findings	This evaluation study examined an program called Children Need to Know Personal Safety Training Program, a precursor to The Safe Child Program. Participants showed improvements in a simulation in which the child was asked to leave the school building with a stranger.
URL	http://safechild.org/educators-2/safe-child-program-prevention-of-child-abuse/

Appendix J. Initiatives that Build Protective Factors

Parent and Community Cafés	
Specific Example	Parent Cafés by Be Strong Families.
Description	Parent leaders complete an orientation training and then serve as hosts for structured, small group conversations in child care sites, neighborhood centers, schools, and places of worship. Be Strong Families offers a set of cards to use to stimulate conversation. Cards have questions printed on them such as "What do you do when you don't understand what is going on with your child?" Conversations are intended to reduce parental stress, increase parenting knowledge and skills, build protective factors, facilitate relationships and community-building, and provide opportunities for parent leadership.
Research on Effectiveness	None. Be Strong Families provides an overview of impacts on its website.
Research Findings	According to Be Strong Families, 85% of participants report that the café increased their knowledge of protective factors.
Websites	Information: http://www.bestrongfamilies.net/build-protective-factors/parent-cafes/ Impacts: http://www.bestrongfamilies.net/build-protective-factors/parent-cafes/parent-cafe-results-impact/
Specific Example	Community Cafés by The Community Café and National Alliance of Children's Trust and Prevention Funds.
Description	Similar to Parent Cafés, these are parent-hosted gatherings in which participants take part in a guided conversation about strengthening families. Cafés take place in schools, early learning centers, parks, churches, public agencies, libraries, and living rooms. Hosts participate in an 8-hour training on protective factors, leadership skills, and building and maintaining partnerships. They leave the training with conversation kits, evaluation tools, sample invitations, and handouts.
Research on Effectiveness	None.
Research Findings	None.
Websites	http://thecommunitycafe.com http://www.ctfalliance.org/initiative_parents-2.htm

Protective Factors Training	
Specific Example	Living the Protective Factors by Be Strong Families.
Description	This training program is for parents and service providers. It consists of a book, a 1-2 day workshop, and a workbook containing a 7-week, self-directed program with daily activities for families. The program helps parents assess their own childhood trauma and then provides education about protective factors and resiliency. Parents learn that because of protective factors, risk factors need not be predictive factors. Follow-up half-day trainings are available for service providers who want to apply a protective factors approach in their work with families.
Research on Effectiveness	None.
Research Findings	None.
Websites	Workshop: http://www.bestrongfamilies.net/build-protective-factors/training/living-the-protective-factors/ Book: http://www.bestrongfamilies.net/build-protective-factors/printed-materials/living-the-protective-factors/ Workbook: http://www.bestrongfamilies.net/living-the-protective-factors-workbook/
Specific Example	Training offered by National Alliance of Children's Trust and Prevention Funds.
Description	This training program is for service providers who want to use a protective factors approach in their work. The program consists of 7, 2-hour modules that are available online or in person. The modules include an introduction/overview, the five protective factors (concrete support in times of need, knowledge of parenting and child development, parental resilience and social connections, social and emotional competence of children, and social connections), and a final review and reflection. Participants can become certified trainers and receive a limited license to use course materials train others.
Research on Effectiveness	None.
Research Findings	None.
Website	http://www.ctfalliance.org/onlinetraining.htm

Protective Factors Assessments	
Specific Example	Strengthening Families Self-Assessment (for Programs).
Description	The assessment is available for various types of programs and agencies, including center-based early care and education programs, family child care providers, home visiting programs, and community-based programs. It helps program staff determine what changes can be made to their practice to support protective factors. It is available in Spanish and English.
Research on Effectiveness	N/A
Research Findings	This is a research-informed approach based on the idea that childcare workers can play an active role in the prevention of child maltreatment in addition to being mandatory reporters of child abuse and neglect.
Websites	http://www.cssp.org/reform/strengthening-families/resources
Specific Example	Strengthening Families Parents' Assessment of Protective Factors Instrument (for parents and caregivers).
Description	The instrument is a 36-item inventory that measures parental resilience, social connections, concrete support in times of need, and social and emotional competence of children. It is appropriate for parents and other primary caregivers of children from birth through age eight. It is available in English and Spanish. It is a paper-and-pencil, self-administered instrument, but may be administered by service provider staff, if the respondent has difficulty reading.
Research on Effectiveness	Kiplinger, V. L. & Browne, C. H. (2014). Parents' Assessment of Protective Factors: User's Guide and Technical Report. Washington, D.C.: Center for the Study of Social Policy.
Research Findings	The instrument is a reliable and valid measure of four protective factors.
Website	http://www.cssp.org/reform/child-welfare/pregnant-and-parenting-youth/Parents-Assessment-of-Protective-Factors.pdf
Specific Example	FRIENDS Protective Factors Survey (for caregivers and parents receiving prevention services).
Description	The survey can be used with caregivers who are receiving child maltreatment prevention services. It is available in Spanish and English and is administered by an agency representative. It measures protective factors (pre- and post-intervention) in five areas: family functioning/resiliency, social support, concrete support, nurturing and attachment, and knowledge of parenting and child development.
Research on Effectiveness	Counts, J. M., Buffington, E. S., Chang-Rios, K., Rasmussen, H. N., & Preacher, K. J. (2010). The development and validation of the protective factors survey: A self-report measure of protective factors against child maltreatment. Child Abuse & Neglect, 34(10), 762-772.
Research Findings	The survey is a valid and reliable tool for measuring family protective factors against child maltreatment.
Website	http://friendsnrc.org/protective-factors-survey

Resource Guide	
Specific Example	*2015 Prevention Resource Guide: Making Meaningful Connections* published by the Children's Bureau (U.S. Department of Health and Human Services).
Description	This guide offers up-to-date information for service providers who are interested in implementing a protective factors approach to preventing child maltreatment in their work with parents and caregivers. The guide also contains tip sheets for parents and caregivers in both Spanish and English. Tip sheets cover topics such as keeping your family strong, preventing child sexual abuse, managing stress, and helping your child heal from trauma. There is a special tip sheet for military families.
Research on Effectiveness	N/A
Research Findings	This is a research-informed document.
Website	https://www.childwelfare.gov/topics/preventing/preventionmonth/resource-guide/

Appendix K. Clearinghouse for Military Family Readiness Rating

This appendix addresses the same programs as provided in the text, but includes effectiveness ratings for those programs that have been vetted by the Clearinghouse for Military Family Readiness. The clearinghouse classifies programs as effective, promising, unclear (unclear +, unclear Ø, or unclear -), or ineffective. Unclear + means that the program has promising features, unclear Ø means that no evaluations have been performed or that studies have produced mixed results, and unclear – means that the program has potentially ineffective features. Not available (N/A) indicates that the program is not listed in the Clearinghouse.

Selective Programs	
Home Visiting Programs	**Clearinghouse Rating**
Child First http://www.childfirst.com	N/A
Early Head Start – Home Visiting http://homvee.acf.hhs.gov/	N/A
Exchange Parent Aide https://www.preventchildabuse.com/	N/A
Family Connections http://www.family.umaryland.edu/	N/A
Family Spirit http://www.jhsph.edu/research/affiliated-programs/family-spirit/	N/A
Health Access Nurturing Development Services http://www.kyhands.com	N/A
Healthy Families America http://www.healthyfamiliesamerica.org	Unclear +[1]
Healthy Start – Home Visiting http://healthystartepic.org/	N/A
Maternal Infant Health Outreach Worker http://www.mihow.org/	N/A
Minding the Baby http://mtb.yale.edu/	N/A
Nurse Family Partnership http://www.nursefamilypartnership.org/	Promising
Parents as Teachers http://www.parentsasteachers.org	Unclear +
Play and Learning Strategies https://www.childrenslearninginstitute.org/programs/play-and-learning-strategies-pals/	N/A
SafeCare and SafeCare Augmented http://safecare.publichealth.gsu.edu/	Unclear Ø[2]

[1] Evaluation of Healthy Families New York program.
[2] Referred to as The SafeCare Model in the Clearinghouse database.

Parenting Education and Family Programs	Clearinghouse Rating
Adults and Children Together Raising Safe Kids http://www.actagainstviolence.apa.org	Unclear +[3]
Celebrating Families! http://www.celebratingfamilies.net/	Unclear Ø
Chicago Parent Program http://www.chicagoparentprogram.org/	Promising
Circle of Security Parenting Training http://circleofsecurity.net/	N/A
Families and Schools Together http://www.familiesandschools.org/	Unclear Ø to Promising[4]
Incredible Years http://incredibleyears.com/	Promising to Effective
Nurturing Parenting Programs http://nurturingparenting.com/	Unclear Ø to Unclear +[5]
Parenting our Children to Excellence and Criando a Nuestros Niños hacia el Exito http://www.wingsforkids.org/	Unclear +
Parenting Wisely https://www.parentingwisely.com	Unclear +
Second Time Around http://homepages.wmich.edu/~dannison/grandparents.html	N/A
Strengthening Families Program http://www.strengtheningfamiliesprogram.org/	Unclear Ø to Unclear +[6]
Teaching Important Parenting Skills for Great Kids http://www.tipsforgreatkids.com/	N/A
Triple P http://www.triplep.net/glo-en/home/	Unclear Ø to Promising[7]
Military-specific Programs	**Clearinghouse Rating**
ADAPT – After Deployment: Adaptive Parenting Tools http://www.cehd.umn.edu/fsos/projects/ADAPT/default.asp	Unclear Ø
Child Parent Relationship Therapy with Military Families http://cpt.unt.edu/	N/A
FOCUS – Families OverComing Under Stress http://www.focusproject.org	Unclear +
New Parent Support Programs http://www.militaryonesource.mil/parenting?content_id=266691	N/A
Nurturing Parenting Programs http://www.nurturingparenting.com	Unclear Ø
Parenting for Service Members and Veterans http://militaryparenting.dcoe.mil/	N/A

[3] Referred to as ACT Raising Safe Kids in the Clearinghouse database.
[4] Rating varies by version of program (e.g., elementary school, middle school, or high school).
[5] Rating varies by version of program (e.g., for parents of adolescents or infants and toddlers).
[6] Rating varies by version of program (e.g., for parents and youth ages 10-14).
[7] Rating varies by program level (e.g., level 2, 3, 4, or 5).

STRoNG Military Families http://m-span.org/programs-for-military-families/strong-families/	N/A
Web-based Tutorial for Mandated Reporters Contact Dr. Phipps at lphipps@email.arizona.edu	N/A
Zero to Three - Babies on the Homefront (mobile app) http://www.babiesonthehomefront.org	N/A
Parent Mutual Support Programs	**Clearinghouse Rating**
Circle of Parents http://www.circleofparents.org/	N/A
Parents Anonymous http://parentsanonymous.org/	N/A
Therapy-oriented Programs	**Clearinghouse Rating**
Alternatives for Families: A Cognitive-Behavioral Therapy http://www.caresinstitute.org/services_parent-child.php	Unclear Ø
Attachment and Biobehavioral Catch-up http://mstservices.com/target-populations/chld-abuse-and-neglect	N/A
Combined Parent-Child Cognitive Behavioral Therapy http://www.caresinstitute.org/services_parent-child.php	Unclear +
Multisystemic Therapy – Child Abuse and Neglect http://mstservices.com/target-populations/chld-abuse-and-neglect	N/A
Parent Child Interaction Therapy http://www.pcit.org/	Promising
Programs in Collaboration with Pediatric Clinics	**Clearinghouse Rating**
Healthy Steps http://healthysteps.org/	Unclear +
Safe Environment for Every Kid https://theinstitute.umaryland.edu/SEEK/	N/A
Building Healthy Children http://www.psych.rochester.edu/MHFC/community-services/building-healthy-children/	N/A
Other Prevention Initiatives for At-risk Families	**Clearinghouse Rating**
Public Awareness Campaigns http://www.purplecrying.info/	Unclear Ø
Family Resource and Support Centers http://www.familysupportcenter.org/	N/A
Child-Parent Centers https://humancapitalrc.org/midwest-cpc/midwest-cpc-expansion	Promising
Planned Respite Care http://crccomaha.org/ and http://archrespite.org/	N/A
Crisis Child Care/Crisis Nurseries http://www.crisisnurseryphx.org/	N/A
Infant Massage http://www.infantmassageusa.org/	N/A

Universal Programs	
Bystander Mobilization Programs	**Clearinghouse Rating**
Communities NOW http://www.thebutlerinstitute.org/communitiesnow/	N/A
Darkness to Light http://www.d2l.org	N/A
Stop it Now! Circles of Safety http://www.stopitnow.org/circles-of-safety	N/A
School-based Curricula for Students	**Clearinghouse Rating**
Body Safety Training Program http://www.sandywurtele.com	N/A
Childhelp Speak Up Be Safe http://www.speakupbesafe.org/index.html	N/A
The Safe Child Program http://safechild.org/educators-2/safe-child-program-prevention-of-child-abuse/	Promising

Programs that Build Protective Factors
Cafés
Be Strong Families' Parenting Cafés http://www.bestrongfamilies.net/build-protective-factors/parent-cafes/
The Community Café http://thecommunitycafe.com
Protective Factors Trainings
Living the Protective Factors http://www.bestrongfamilies.net/build-protective-factors/training/living-the-protective-factors/
National Alliance of Children's Trust and Prevention Funds http://www.ctfalliance.org/onlinetraining.htm
Protective Factors Assessments
Strengthening Families Self-Assessment (for programs) http://www.cssp.org/reform/strengthening-families/resources
FRIENDS Protective Factors Survey (for parents/caregivers) http://friendsnrc.org/protective-factors-survey.
Strengthening Families Parents' Assessment of Protective Factors Instrument (for parents/caregivers) http://www.cssp.org/reform/strengthening-families/resources
Resource Guide
2015 Prevention Resource Guide: Making Meaningful Connections http://www.childwelfare.gov/

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