



# New Jersey Standards for Prevention Programs: *Building Success through Family Support*

Developed by the New Jersey Task Force on Child Abuse and Neglect

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## Preface

The New Jersey Task Force on Child Abuse and Neglect is proud to partner with the Department of Children and Families and the State of New Jersey to strengthen families and communities and to prevent child abuse and neglect. This collaboration has a long history and precedes the establishment of the Department of Children and Families and the Division of Family and Community Partnerships. The original Standards for Prevention Programs were copyrighted by the State of New Jersey, Department of Human Services in 2003.

Recognizing the importance of preventing child maltreatment and the need for evidence based prevention programs and strategies the Prevention Subcommittee of the New Jersey Task Force on Child Abuse was charged with developing Standards for Prevention Programs. The Prevention Program Standards Work Group was created in 2001. The Work Group, under the able leadership of Chairperson Sharon B. Copeland, MSW, LSW (formerly Executive Director of Prevent Child Abuse New Jersey and currently Executive Director of Enable, Inc.) reviewed the existing literature on effective prevention programs from multiple fields including child welfare, public health, juvenile justice, substance abuse, and mental health. The Standards were meant to provide a broad overview of the critical components of any prevention program, and not a critique of individual programs. The Standards for Prevention Programs: Building Success through Family Support is a required component of all programs funded by the Division of Family and Community Partnerships.

Over the past decade there has been much progress made in our knowledge of how to support and strengthen families, promote well-being and ensure healthy childhoods. Advancements in the prevention field in the last ten years necessitated a thorough evaluation of New Jersey's Standards for Prevention Programs. We now understand more about the nature of child abuse and neglect, the long term impact of child maltreatment, the risk factors that contribute to its occurrence and the protective factors that can prevent it from ever occurring. Research has informed and changed how we implement prevention efforts.

In 2012 The New Jersey Task Force on Child Abuse and Neglect, in collaboration with the Division of Family and Community Partnerships was authorized to review and revise these Prevention Standards. The Standards reflect the most current research and best available clinical practice information. They also incorporate elements of the prior Standards that are still relevant. They are founded on strength based family support principles which are consistent with family and individual values. They reflect the emphasis the Division of Family and Community Partnerships places on Protective Factors and incorporate the Center for Diseases Control Essentials for Childhood which promote Safe and Stable Nurturing Relationships and Environments for Children and Families. Together with parents, caregivers,

public and private organizations and communities, they can ensure an effective network of proven family support services, public education and local neighborhood involvement to promote healthy children, youth and families.

The successful completion of this report occurred with the input and hard work of a number of people. Our gratitude and appreciation to all of the Standards Work Group members for the information and discussion they contributed. A special thank you must be extended to Chairperson Kerrie Ocasio, who spent many hours researching, writing and synthesizing our deliberations. The perseverance and dedication of the Work Group and the Prevention Committee of the New Jersey Task Force on Child Abuse and Neglect is acknowledged for their unrelenting efforts to advance the wellbeing of children, youth and families.

## Introduction to the Standards

### The Importance of Prevention

Child welfare and other state systems of service have tremendous potential to bring about family and community well-being by supporting and strengthening families and preventing child abuse and neglect. The factors that put families at risk of abuse and neglect are well known. State and local systems as well as community partnerships can be powerful forces in ameliorating these risks. The effectiveness of prevention approaches is also well known; they enable all systems to better accomplish their goals for improving child, family, and community outcomes. Investments in prevention support healthy child development and lower the number of children affected by abuse and neglect. Effective prevention programs, services and strategies enhance family functioning by reducing risk and building protective factors.

A 2013 report entitled *New Directions in Child Abuse and Neglect Research* produced at the request of the US Department of Health and Human Services reported the damaging consequences of abuse and neglect can not only reshape a child's brain but also last a lifetime (National Research Council, 2013). This is a clarion call to increase the infrastructure and incentives for community prevention services and family support that have a body of evidence to support their effectiveness. At a time when the most significant portion of our resources are allocated for child protection; for reporting,



investigating, adjudicating, providing services and foster care after a child has been harmed, we applaud the commitment of the New Jersey Department of Children and Families to preventing child maltreatment with a positive and proactive approach to support parents and strengthen families.

Child abuse and neglect affects over 1.2 million children every year and costs our nation \$220 million every day. In 2012 the United States paid a staggering \$80 billion to address child abuse and neglect. Victims of child maltreatment are at a high risk for a host of adverse short and long-term outcomes, including chronic health problems, mental health issues, developmental delays, poor educational well-being, and future involvement with the criminal justice system. The injuries and adverse outcomes associated with child maltreatment underscore the importance of identifying effective and cost-effective prevention strategies (Gelles, Richard J., & Perlman, Staci, 2012). Most prevention programs, even those that are intense and comprehensive, are less expensive than programs that intervene or treat children who have been abused or neglected. According to DCF, foster care placement for one child in New Jersey in 2014 costs between \$9,024 and \$15,540 for the year. Should the child require residential care, the cost ranged from \$65,800 to \$386,500 for a year. In contrast the Healthy Families America home visitation program averages \$3,500 per family per year. Prevention programs often provide immediate cost savings from reduced medical and social service costs and reductions in foster care placement. Investments in prevention support healthy child development, cultivate and strengthen nurturing parent-child relationships, enhance family dynamics, build and sustain community partnerships. In addition to the individual and personal benefit realized, all these factors contribute to a thriving economy, a strong state and a strong nation. Expanding support for children and families is the logical consequence of over 35 years of research on how to enhance child development and the social and financial benefits of such investments.

In 2012, the NJ Division of Child Protection and Permanency (DCP&P; formerly known as DYFS) responded to 60,615 reports of alleged abuse or neglect, involving just over 76,000 children (U.S. Department of Health and Human Services, 2012). Of the 9,250 substantiations of maltreatment\*, nearly three-quarters were for neglect alone. Further, more than a quarter of substantiations involved children age 2 and under (U.S. Department of Health and Human Services, 2012). The human and economic costs of maltreatment are considerable, both in the Nation and the State.

\* Victims may be duplicated.

## History and Philosophy of the Standards

The original Standards for Prevention Programs: Building Success through Family Support was based on a theory and set of principles advanced by Family Support America. The focus of Family Support is to promote the acquisition of knowledge and skills that make the family more competent, thus strengthening family functioning. As a proactive and positive approach, it emphasizes family strengths, informal supports and resources, and partnering with families to mobilize social and community resources, not treating their deficits. Family Support practice is based on an ecological framework – a recognition that child and family development do not occur in a vacuum but rather are embedded within a broader community environment. Children and families are part of communities with unique cultural, ethnic and socio-economic characteristics, which in turn are affected by the values and policies of the larger society. The FRIENDS National Resource Center, a program of the Children’s Bureau, Office on Child Abuse and Neglect in the U.S. Department of Health and Human Services continues to promote this framework.



The current Standards for Prevention Programs augment the original theoretical Family Support premise with the growing body of research on Protective Factors, the principles of Strengthening Families, the CDC’s Essentials for Childhood and the Adverse Childhood Experiences Study (Center for the Study of Social Policy, n.d.; Centers for Disease Control & Prevention, 2013).

The Prevention Committee of the New Jersey Task Force on Child Abuse and Neglect present the following revised Standards in order to advance the consistency, quality and accountability of programs used in New Jersey for the purpose of promoting child well-being and preventing child maltreatment, while building the capacity of the community and stakeholders to strengthen families and support caregivers.

## Intended Purpose of the Standards

It is hoped that the Standards will be used to develop, identify, promote, monitor and fund effective prevention programs. Users of this report may include state Children's Trust Funds and Departments of Children and Families, Juvenile Justice, Human Services, Health, Education, Domestic Violence, Substance Abuse and Corrections. Community planning groups such as human services advisory councils, youth services commissions, commissions on child abuse and missing children, local councils on alcoholism and drug abuse, municipal alliances, and other local organizations may find these Standards useful when researching programs or selecting services to be offered in their communities. They can be utilized by private foundations, corporate giving officers, and elected government officials. The Standards can assist legislators and key decision makers in government as they seek to develop policies and provide support to prevention programs.

Service providers including community based agencies, schools and non-profit organizations can use the Standards to help them select programs they want to offer, to develop new programs, or to strengthen existing programs. Individuals, families and community members can apply the Standards to determine which services are most effective and best meet their needs. To assist individuals and groups to use the Standards, a tool has been provided at the end of the report.

The Standards have been used to ensure quality and accountability and have been used for many purposes. These Prevention principles are valid for multiple agencies and can be applied by other State Departments who have a stake in child well-being and healthy child development. They are a guide to:

- Provide professionals and policymakers with information on the critical components of effective prevention programs
- Guide public and private funders in determining the most efficacious programs to support
- Ensure that families are referred to the most effective programs that the community provides
- Empower families to determine what programs and services best meet their needs
- Integrate prevention into all related systems that affect the lives of children including child protection, child behavioral health services, education, human services, law and law enforcement
- Provide funding incentives for community prevention services and family support that have a body of evidence to support their effectiveness



Additional applications of these Standards by The New Jersey Department of Children and Families and other states' child welfare agencies and non-profit organizations include:

- Requiring that grantees seeking state funding from a variety of agencies adhere to the Standards
- Applying language from the Standards to mission statements and written materials for state agencies and their programs.
- Building the Standards into evaluation and review processes for state agencies and the programs they administer
- Integrating the Standards into policy development at the state and community levels.
- Incorporating the philosophy and elements of the Standards into the Statewide Child Abuse and Neglect Prevention Plan which, in New Jersey, is required by statute.

The Standards described here endeavor to bring together systems and agencies dealing with child protection and child well-being, as well as domestic violence, substances abuse, mental health and other family issues to make family-supportive prevention of negative outcomes the norm in state policies and programs. We are confident that training, disseminating, promoting and forging consensus around these Standards will effect positive change at the state and community levels and for individual children and families.

## Part One: Defining Prevention

### Introduction

Prevention is “coordinated actions seeking to prevent predictable problems, to protect existing states of health and health functioning, and to promote desired potentialities in individuals and groups in their physical and sociocultural settings over time” (Bloom, 1996). The field of child abuse and neglect prevention has developed significantly over the past 30 years (U.S. Department of Health and Human Services, 2011). Research on abuse and neglect etiology implicates a multitude of risk and protective factors related to various ecological systems (i.e. parents, the parent-child dyad/triad, social support network, community, society-at-large) (Goldman, Salus, Wolcott, & Kennedy, 2003)). Numerous approaches and programs have been developed to ameliorate risk and promote protective factors. This section will discuss the scope and defining characteristics of child abuse and neglect prevention.



## Primary, Secondary, and Tertiary Prevention

The predominant means of classifying prevention programs is to use a variation on a public health approach that classifies programs based on the stage in problem development it engages (U.S. Department of Health and Human Services, n.d.). Primary prevention programs are universally available to the general public and are intended to create societal conditions that promote positive parenting. Secondary prevention programs are provided to targeted families that have high-risk characteristics and are intended to reduce risk factors and promote protective factors that may ameliorate the negative impact of risk factors. Tertiary prevention programs are treatment and intervention oriented programs that address abuse and neglect once it has already occurred to reduce the likelihood of reoccurrence.

## Voluntary and Non-Voluntary Prevention

The Standards were developed to guide primary and secondary prevention programs. An essential difference between these programs and tertiary programs is the degree of voluntary choice and autonomy in participation. Tertiary programs are generally provided by child protective service agencies or their affiliates. Clinical and professional judgments are made about what families need in order to achieve adequate parenting standards and there are serious consequences for families that do not participate and make the needed changes. This is in stark contrast to the primary and secondary prevention arena, where parents are typically free to choose whether to participate and whether to implement the concepts they are exposed to in the program. Of course, there are gray areas, where a parents' behavior or a situation may become a child protective service matter if it continues or escalates. In these cases, service providers have been known to apply pressure on parents. Additionally, programs sometimes offer incentives to participate that can meet significant needs and parents may feel they have very little choice in whether to participate in the program. Regardless, the element of autonomous choice is a very important component of primary and secondary prevention programs that distinguishes them from tertiary prevention. Tertiary programs may adopt some elements of the Standards, but are inhibited from full-scale implementation and are consequently not the focus of the Standards.

## Prevention vs. Family Support Frame

A movement is currently underway to broaden the conceptualization of prevention. The term "prevention" could be considered stigmatizing to parents engaging in services, limiting in its vision, under inclusive of the range of providers engaged in it, and unable to move the public to action. Framing these services as family support or child well-being could address these concerns. However, the term "prevention" has an historical context and sends a clear message

to policy makers that if they don't fund these services, more children will be at risk for child welfare involvement and negative outcomes as a result of the abuse and neglect.

An alternative is to combine the prevention and promotion language. A number of organizations noted for their work in the field of prevention have incorporated both frames into their messaging. For example, the Centers for Disease Control list "child maltreatment prevention" as one of their agendas. Their five-year vision for the CDC's prevention work is to "prevent child maltreatment through the promotion of safe, stable, and nurturing relationships between children and caregivers", which they term SSNRs. The CDC has also popularized the term "adverse childhood experiences" in their study of the effects of child maltreatment. Prevent Child Abuse – America has an organizational website with the heading "Making the Case: Why Prevention Matters". The first sentence under that heading states, "Across the nation there has been great progress in work to improve the health and well-being of children". The Doris Duke Charitable Foundation lists one of their goals "to promote children's healthy development and protect them from abuse and neglect". The fellowship funded by the Foundation at Chapin Hall was renamed in 2012 from the "Doris Duke Fellowship for the Prevention of Child Abuse and Neglect" to the "Doris Duke Fellowship for the Promotion of Child Well-being: Seeking innovations to prevent abuse and neglect". Further, Parents Anonymous' describes themselves as a "family strengthening organization dedicated preventing child abuse and neglect". These leaders in the field of child abuse and neglect prevention are clearly striving to combine prevention and promotion language.



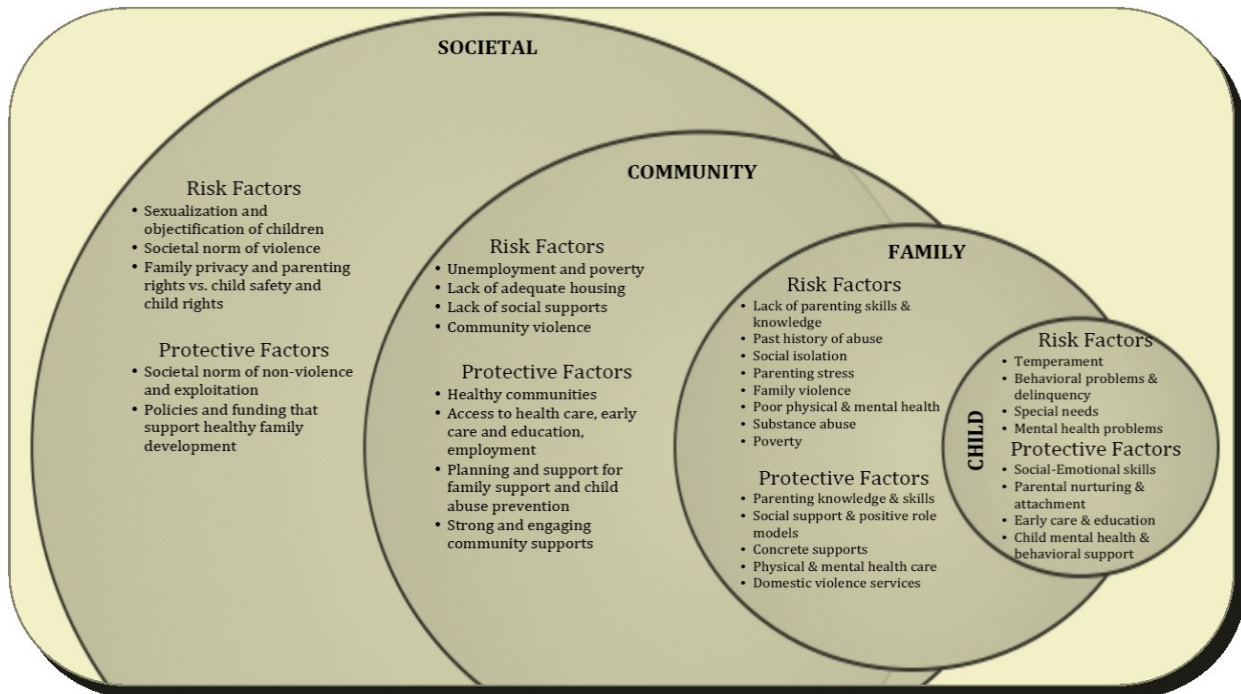
## Focus of Prevention Efforts

A broader frame, such as those discussed, may be more engaging to parents and partners in this work. However, the focus must remain on those activities that ultimately prevent child abuse and neglect. Research has established a multitude of risk and protective factors for abuse and neglect (Goldman, Salus, Wolcott, & Kennedy, 2003). Risk factors are conditions that are associated with abuse and neglect, while protective factors are conditions and services that may serve to buffer children and families from the negative effects of risk factors (U.S. Department of Health and Human Services, 2013).

Risk and protective factors stem from the child, family, communities, and broader society. Each of these entities is interconnected in what is known as the ecological perspective (Bronfenbrenner, 1979). The figure below summarizes the risk and protective factors by domain. Protective factors that may be particularly important<sup>1</sup>, malleable, and accessible by local prevention strategies include:

- Nurturing and attachment between the caregiver and child,
- Parental knowledge of parenting and child/youth development,
- Parental resilience (i.e. coping with stress and problem solving strategies),
- Social connections,
- Concrete supports for parents (i.e. basic needs assistance and access to services - physical and mental health care, substance abuse treatment, and domestic violence services), and
- Social and emotional competence of children

(U.S. Department of Health and Human Services, 2013, Center for the Study of Social Policy, 2013).



Source: Based on ecological frameworks for child abuse and neglect prevention by The Family Tree ([http://www.familytreemd.org/files/414\\_ChildAbusePrevTheoryofChangeLogicModel.pdf](http://www.familytreemd.org/files/414_ChildAbusePrevTheoryofChangeLogicModel.pdf))

and Centers for Disease Control (<http://www.cdc.gov/ViolencePrevention/overview/social-ecologicalmodel.html>).

<sup>1</sup>All six are endorsed by the U.S. Department of Health and Human Services, Administration for Children and Families, and all but the first are also endorsed by the Center for the Study of Social Policy.

## Activities that Address Risk and Protective Factors

Numerous approaches and programs have been developed to address risk and protective factors for children and families. The most identifiable approaches are early childhood home visiting programs, group support activities, family resource and support centers, and public education campaigns for parents. Also, some established program approaches seek to educate children, particularly in the areas of sex abuse and domestic violence prevention\*. Additional development is particularly needed to address community-level factors and build service delivery systems (Daro & Benedetti, 2014).

The Standards are intended to guide efforts to develop and implement activities that strengthen families and communities in order to prevent adverse childhood experiences. The next section will discuss the Standards in detail.

\*For more information on effective prevention strategies see:

- The Centers for Disease Control and Prevention (<http://www.cdc.gov/ViolencePrevention/childmaltreatment/prevention.html>)
- Child Welfare Information Gateway (<https://www.childwelfare.gov/preventing/evaluating/results.cfm>)
- GAO Report on Child Abuse Prevention Programs (<http://www.gao.gov/products/HRD-92-99>)
- Child Maltreatment Prevention Reports at Chapin Hall, University of Chicago (<http://www.chapinhall.org/research/areas/Home-Visitation-and-Maltreatment-Prevention>)

For more information on risk and protective factors see:

- Centers for Disease Control and Prevention (<http://www.cdc.gov/ViolencePrevention/childmaltreatment/riskprotectivefactors.htm>)
- Child Welfare Information Gateway (<https://www.childwelfare.gov/can/factors/index.cfm>)

- Center for the Study of Social Policy—Protective Factors Framework (<http://www.cssp.org/reform/strengthening-families/the-basics/protective-factors>)
- The Search Institute’s Developmental Assets (<http://www.search-institute.org/what-we-study/developmental-assets>)
- The Full Frame Initiative (<http://fullframeinitiative.org>)

## Part Two: Standards for Prevention Programs

These Standards for Prevention Programs are applicable to programs, services, and activities (hereafter referred to as activities) that could be considered “Family Resource and Support”. Family Resource and Support activities are also known as primary and secondary prevention and are intended to *promote* strong families and *prevent* adverse childhood experiences.

The Standards reflect an approach to the way in which services should be delivered. There is considerable evidence that the ways in which services are delivered are vitally important to engaging and retaining families in services and impact outcomes. Further, human service providers should be engaged with their communities in ways that promote strong communities and manage their work in ways that promote strong human service organizations. These Standards address all three: practice with families, practice with communities, and administrative standards.



## Practice with Families

### 1. Family-Focused

The ecological context— individuals are part of families and families are part of communities— should inform practice with families. In certain contexts it may be appropriate to take an individual-focused approach. However, family-focused work is more appropriate in many contexts and could include such activities as assessing the needs of the entire family, assisting parents in reaching out to family members and friends for support and providing family activity events. Family-focused might also be considered focusing on the family as the unit of attention\*.

Family-focused approaches are more effective than child only, child focused or parent focused approaches, which do not take into account the ecological nature of child and family life (Kumpfer & Alvarado, 1998; National Center for Missing & Exploited Children, 1999; National Institute on Drug Abuse, 1999). Children are embedded within families, which are embedded within larger social networks, communities and culture, necessitating a broader perspective in prevention work (Dunst, 1995; Hess, McGowan & Botsko, 2000). Further, our use of the term “family” is inclusive of the adults and other family members most intimately involved in raising the child, not just a conventional constellation of two parents.

**See children within the context of families and families within the context of their community and culture.**

Family centered does not mean that every program effort targets the whole family. Rather, it means that sound prevention programs involve the parents and family members at some level or in some components, to help shape and reinforce the work that is being done. Kumpfer and Alvarado purport that the more problems the child and family are having, the more the intervention needs to take this family-centered approach.

\*Note: Family-focused is a term that is often synonymous with family-centered. However, family-centered has been widely accepted at a multi-dimensional concept that includes focusing on the family as the unit of attention, promoting family choice and control, building on family strengths in goal-focused work, individualized service plans, establishing trusting relationships between families and providers (Allen & Petr, 1996; Epley, Summers, & Turnbull, 2010; Rhode Island Coalition for Family support and Involvement, n.d.). The Standards includes these other concepts separately.

**Best Practice** = Program serves the entire family and has mechanisms for regularly including informal / natural supports in activities.

## 2. Strength-based, Goal Setting in Partnerships with Family

There are several facets to this standard; strength-based approach, partnering with families, and goal driven work. Each of these could stand alone. However, together they represent inter-connected principles regarding the way in which activities will be conducted.

All persons have strengths. Programs empower participants by identifying and building on their capabilities and competencies. Successful programs create opportunities for competencies to be learned or displayed, taking advantage of resources and supports already utilized by the family (National Clearinghouse on Child Abuse and Neglect Information, 2000; Weissbourd & Weiss, 1992). They build on the positive functioning of the parents and family rather than see the family as “broken” and “needing to be fixed.” Participants and families become less dependent on professionals.

**With families in the “driver’s seat”, identify and build on their capacities and competencies.**

Goal focused or goal driven is a concept that is widely used in numerous programs and approaches, such as family preservation services and family support centers. It suggests that the work is purposeful and based on an agreed upon set of goals and activities. Goal setting and attainment contributes to confidence in the ability to achieve one’s goals, in contrast to feelings of helplessness and powerlessness. Goals should be short-term, leading to longer term goals, so that parents have opportunity to experience and celebrate

success (Scarborough, Lewis, & Kulkarnie, 2010).

An essential philosophy of partnering with parents is one of the most critical differences between family resource and support activities and tertiary treatment activities that are provided after maltreatment has occurred. In this locus, prevention programs can allow participants to “drive” the service rather than insist that the provider or professional prescribe the services. The parents and family are held in respect and considered equal to staff. They should be involved in program planning and development, especially the planning of their own service goals. Parents are encouraged to serve on task forces, committees, or boards (Dunst, 1995; National Clearinghouse of Child Abuse and Neglect Information, 2000). Often, participants who have received services evolve to become the provider of services—the home visitor, parent educator, or group facilitator. This evolution promotes the use of paraprofessionals in prevention services, many of whom go on to receive formal training, certification, and higher education.



The Standards links these three concepts together, as they are essential in every interaction with families. Each could be seen as a stand-alone concept, but together they represent essential characteristics of family resource and support work.

**Best Practice** = Program uses strengths-based language throughout, places an emphasis on building strengths, and goals are developed in partnership with the participant, to the extent feasible under ethical and programmatic guidelines.

### 3. Flexible and Responsive

Flexibility in planning and delivering services is a key element in prevention programs (Hess, McGowan & Botsko, 2000). This allows for the evolution of a program over time, improving its responsiveness to the changing needs of individuals, families, and communities (Schorr, 1997).

However, providers should be aware of what components have been demonstrated to achieve results (ex. core activities, frequency, length, and credentials). Activities based on research should be implemented with at least minimum adherence to their design (Nation, Keener, Wandersman, & DuBois, 2003), but should be flexible to families that have a greater or lesser need over time. Further, it may be possible for providers to be trained to adapt within the parameter of their evidence-based program (Daro & Benedetti, 2014; Mazzucchelli & Sanders, 2010).

**Tailor  
practices to  
the needs of  
participants.**

**Best Practice** = Program is flexible to meet the need of participants, such as increasing meetings from monthly to weekly. Workers are easily accessible, return phone calls within 24 hours, and respond to request for further referrals or information promptly

#### 4. Accessible and Incentivized

Activities should be accessible, which entails removing barriers to participation. Retention of families is improved when transportation, meals or snacks, and child care are provided (Kumpfer and Alvarado, 1998). When planning a parenting education class for working parents, supports are essential. Conducting the class at the child care center and providing the evening meal and child care makes it possible for parents to attend at the end of a busy day. It is unlikely that parents will go home, make dinner, get a babysitter, and then return for a class.

**Protect and facilitate parental choice in participation of services.**

Providing incentives takes this one step further, enticing and encouraging families to engage in family resource and support activities. Many who participate in services do so when they are experiencing an acute need or feel some external pressure. Incentives, such as gift cards and raffles, could be used to encourage participation and retention in activities, particular those of a less acute nature.

**Best Practice** = Services are barrier free; offered at times that are accessible to parents' schedules and supports are routinely provided to improve participation likelihood (i.e. food, transportation, and child care if needed).

#### 5. Voluntary and Non-Stigmatizing

Prevention programs are most effective when participation is voluntary (Guterman, 1997; Weissbourd and Weiss, 1992). Families that choose to participate typically have more meaningful engagement in services and outcomes are more likely to be long-term, as a result of their internal motivation to participate (Littell and Tajima, 2000; Dawson and Berry, 2002; Yatchmenoff 2005). Elective participation allows for a greater sense of ownership and autonomy. Conversely, participation driven in response to leverage or coercion often results in lower quality engagement in services and follow-through.

**Facilitate and encourage participant involvement.**

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

Providers should be aware that certain practices will limit participation by undocumented parents, such as requiring IDs to gain entry to the building.

Further, prevention programs should be offered to the broad community, not just to persons or families with “problems.” Services should be seen as ways to strengthen and improve functioning rather than something a participant or family must do to address its dysfunction. Guterman (1997) noted that there appears to be a clinical advantage for programs that do not target services based on “psychosocial risk.” MacLeod and Nelson (2000) found in their review of prevention programs that there was a higher likelihood of success when working with families of mixed incomes instead of just targeting low socioeconomic status families. Still, effect sizes are often larger when working with families in need, which could contribute to a preference to target at-risk families (Daro & Benedetti, 2014).

**Best Practice** = Program is universally available and provided in a supportive, non-threatening environment, such as a public space that is safe and convenient.

## 6. Comprehensive and Integrated

Multi-component, multi-system services are stronger than quick-one shot interventions, addressing a wide-range of risk and protective factors (Chemers, 1995; Hess, McGowan and Botsko, 2000; Nation, Keener, Wandersman, & DuBois, 2003; Schorr, 1997; Weissbourd and Weiss, 1992). According to Kumpfer & Alvarado (1998). It is often necessary to meet parents’ basic and immediate needs before or in conjunction with development of parenting or life skills. Further, different types of activities can be used to reinforce and extend skill development. For example, family-based activities can be complemented with large group activities, developing social support and leveraging positive social pressure.

Use  
multiple  
supports to  
reinforce  
positive  
outcomes.

**Best Practice** = Program provides comprehensive services through multiple program components, active case management to support goal attainment and successful linkages to a continuum of services, and flexible funding to meet gaps in service availability.

## 7. Developmentally Informed

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

**Combine length of service intensity to maintain positive outcomes over time.**

**Best Practice:** Stages of family development, related to ages of children, transitions, families experience, and the adult aging process are consistently reflected in materials and approaches.

## 8. Long Term and Adequate Intensity

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

**Relevant to the ages and development stages of participants.**

**Best Practice:** Frequency, intensity, and length of service have been and continue to demonstrate adequacy to meet and maintain desired outcomes as evidenced by quantitative outcomes research.

## 9. Culturally Responsiveness/Reciprocity

**Affirm,  
strengthen  
cultural  
identity and  
diversity.**

Human service programs are familiar with the concept of cultural sensitivity and cultural competence. Whereas cultural sensitivity is an awareness of and tolerance for diversity, cultural competence goes further. Competency is knowledge about the culture that is used to assist participants in programs. It is showing respect for customs and practices, utilizing unique roles of family members and gaining the acceptance of the leaders within the cultural group. Cultural competence should be strengthened, not just tolerated (Chemers, 1995; Dunst, 1995; Weissbourd & Weiss, 1992). When programs are tailored to the cultural traditions of the families, improvement is found in recruitment and retention of the families as well as overall outcomes (Kumpfer & Alvarado, 1998).

However, an emerging concept that is common in the special education field is cultural reciprocity. Cultural reciprocity entails understanding the cultural assumptions that are rooted in the service provider's thinking and behavior, as well as those that undergird the activities of human service organizations. Workers should be open to examining cultural assumptions regarding goals and activities with families and avoid stereotypical solutions (Leake & Black, 2005).

**Best Practice:** Staff demonstrates awareness, knowledge, attitudes, and skills related to impact of culture – theirs' and that of the family – on the working relationship engagement of families in services and assumptions about the process / goals of services. Organizations tailor services, materials, and staffing to facilitate this and promote cultural exchanges.

## Practice with Communities

### 1. Participatory Development Planning

Participatory development planning is the practice of including the intended recipients of programs in the planning process through various means: planning councils, advisory groups, positions on agency boards, representation at strategic planning and other program planning activities (Rietbergen-McCracken, n.d.). The popular phrase “nothing about me without me” epitomizes the rejection of benevolent efforts to “help” poor and minority groups from a position of power and authority.

**Nothing  
about me  
without  
me.**

The practice of participatory planning has its roots in the 1960s civil rights movement (Chin, 2009). The philosophy behind the practice is embraced by the United Nations, which promotes stakeholder involvement in urban planning projects, and has expanded into research design methods (i.e. participatory action research and participatory mapping).

However, the degree of decisional authority shared with participants needs to be clear and activities to support this commensurate with the expectations. Participants and providers may have different goals and participants may be reluctant to utilize objective data regarding their communities that is incongruent with their own perceptions (Haumann, 2011). Organizational and funding goals should be shared and care taken to educate and establish appropriate expectations with families regarding the degree of discretion available in the planning process and goals of participant involvement.

Also, groups that have multiple providers and participants may fail to empower participants, as providers develop networks and have skills (i.e. framing their concerns and managing the volume of information) that facilitate their success in that environment (Chin, 2009). In order to facilitate meaningful participation, participants may need coaching and structures may need to be modified to facilitate participant voice. Finally, the intent of involving participants should be transparent, so that participants are not frustrated with the results.

**Best Practice** = Program is designed collaboratively with the intended participants.

## 2. Community Integration

Preventing child maltreatment requires a broad societal commitment to children that involves seeking the ownership of all sectors of the community in prevention efforts (National Committee to Prevent Child Abuse, 1995). Defined geographically, a community may be a neighborhood, municipality, or region. All who receive services, reside, or work in that defined community should be invited to participate and, hopefully, will become involved in preventing child abuse. Further, community based programs should be known throughout the community.

At a minimum, community programs should network to ensure that families in the community have access to the services they need. In addition, communities typically have human services planning groups and prevention/family support programs should be active in these. However, community-wide strategic planning to address prevention of health and substance abuse problems is becoming common. Ideally, family support programs should take a leadership role in organizing providers and families to study, plan, and implement strategies to address risk and protective factors at the community level.

**Programs are actively involved in the communities in which they are located.**

The ultimate goal of these efforts should be to empower the community to have a genuine sense of ownership, which mobilizes the community. When a community is empowered, its members share responsibility with professionals and are seen as experts, providing leadership and support. There is inclusive decision-making and an emphasis on cooperation and collaboration. These activities promote healthy community development and have benefits, as well, for positive youth development (Search Institute, 1998).

**Best Practice** = Program takes a leadership role in organizing efforts to study, plan, and implement strategies to address aspects of the community (i.e. structural and parenting norms) that promote or undermine family functioning.

## 3. Early Start at all developmental stages

In order to prevent child maltreatment, programs need to work with caregivers and parents before negative patterns develop and produce unwanted or poor outcomes. The MacLeod and Nelson (2000) meta-review found a strong indication that gains made through proactive interventions with families were better sustained and even increased over time. However,



families that received help after maltreatment had already occurred tended to lose ground over time.

**Work with target population before negative or abuse patterns are established.**

Ideally, programs should be available to assist new parents right from the start in establishing positive parenting practices and addressing risk factors (Daro & Benedetti, 2014; Guterman, 1997; Kumpfer & Alvarado, 1998). Work can begin prenatally (Guterman, 1997; MacLeod & Nelson, 2000), when many women are eager to learn about effective infant and toddler care and those with substance use often cut-down or stop using for this period of time. Additionally, the greatest period of brain growth is between the ages of birth and three years and early socialization patterns are established during the first years of life.

However, later child development stages can bring their own challenges for parents. For example, as children get older, peer relationships become more important, risk-taking behavior can develop, and they need experiences that will prepare them for adulthood. Programs should be available to meet the needs of parents addressing the full-range of child developmental stages. Further, healthy relationships and life skills are developed in middle and high school years, indicating a need to consider the pre-parenting opportunities to support strong families.

**Best Practice** = Program is aimed at the general population for the purpose of keeping child maltreatment from happening before it has occurred, at every developmental stage (i.e. prenatally, positive youth development, etc.)

## Administrative Standards

### 1. Long-range and On-going Planning

Organizations that engage in strategic planning are able to adapt to the changing needs of their communities and keep abreast of innovations in the field. Strategic planning should be conducted every 3-5 years and involves\*:

- Identification of stakeholders, which could include participants, board of directors, community members/public-at-large, funders, and state/federal policy makers.

- A review of the requirements and expectations of the various stakeholders, both formal (written) and informal.
- Review and revision of the mission, vision and values of the organization.
- Identification of strategic issues, which could include strengths and weaknesses of the organization, opportunities and challenges in the external environment (i.e. changes in population and funding opportunities).
- Establishment of short- and long-term goals, objectives, and activities.
- Identification of measures of successful attainment of goals.
- Regular tracking and adjusting.

**Organizations remain stable and productive by regularly assessing their internal and external environment and establishing goals.**

Further, participants and community members should be involved meaningfully in the process. This is consistent with the practice of participatory planning and it promotes community-wide impact. \*Note: For more detailed steps and activities, see Bryson (2004).

**Best Practice** = The organization engaged in comprehensive, on-going cycle as of assessment, planning, intentional decision-making, implementation, and evaluation of the organization in all its aspects.

**Skill and knowledge development keeps staff current and engaged.**

## **2. Supervision, Organization Management, and Professional Development**

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

in prevention programs need to be taught on the job and staff need opportunities to pursue continuing education opportunities whenever possible.

Supervisors need to be capable of supporting workers in their growth and meet frequently with their staff. Further, workers tend to mirror supervisory practices with the families they serve. Collaborative and participatory principles should be utilized and modeled in supervision, to promote this practice with families.

**Best Practice** = Supervisors and the organization engage in collaborative decision-making with staff, provide opportunities for professional growth and development. Management policies are documented and organizational finances are well managed

### 3. Parent and Community Leadership

Administrative practices need to provide for participant and community participation (National Clearinghouse on Child Abuse and Neglect Information, 2000). This can take many forms; including participant focus groups, surveys, and episodic volunteerism. Increasingly, organizations are ensuring systematic inclusion and increasing consumer power through advisory groups and seats on governing boards.

**Advisory groups, collaborations, and input foster participant and community involvement.**

There are multiple benefits of this practice. It empowers the participants and community to have a voice in the types of activities that are provided to their community. Parent and community members can be coached to take leadership roles and become ambassadors for family resource and support activities; building support for sustainable funding and nurturing family engagement (Family Support America, 2002).

**Best Practice** = Program participants and community leaders are on governing and/or advisory boards and are developed and given meaningful opportunities to engage in program activities.

### 4. Fidelity to an Established, Appropriate Model

**Core components needed to achieve promised outcomes are provided.**

Effectiveness of the services being implemented is essential. When possible, organizations should implement programs and approaches that have research evidence to establish their efficacy and these programs or approaches should be implemented with fidelity to the core, critical components. Research and development of effective prevention programs is ongoing. It might not always be possible to identify an established program that fits the need or an adaption might be necessary. However, established programs or approaches should always be considered first. Further, the program should have been studied with the population characteristics intended to participate.

Fidelity is measurable by identifying the core, critical components, such as session length, frequency, credentials of staff, materials, and activities, and gathering data on adherence. In addition, when adopting a new practice, organizations should consider their “readiness”. The effectiveness of a new intervention is partially dependent on the readiness of the organization to change their current practice and adopt the new practice. An assessment developed by the National Implementation Research Network is recommended. The Full Implementation Stage Assessment, includes aspects of organizational readiness, including staffing, training, supervision, performance assessment, data supported decision-making, procedures, external organization change, leadership, and implementation climate (Fixsen, Panzano, Naoom, & Blasé, 2008).

**Best Practice** = Program is being provided with fidelity to an established model that has been researched as effective with the population being served and for the purpose intended.

## 5. Highly Qualified, Competent and Caring Staff

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

**Quality of staff and their interactive ability is a key factor.**

Successful programs encouraged practitioners to build strong relationships based on mutual trust and respect (Schorr, 1989). It was the quality of these relationships that most profoundly differentiated effective from ineffective programs. Staff needs to be there long enough, close enough, and persevering enough to forge authentic relationships that help to turn lives around. Successful programs are managed by competent and committed individuals willing to: experiment and take risks; manage by “groping around”; tolerate ambiguity; win the trust of line workers, politicians, and the public; be responsive to the demands for prompt, tangible evidence of results; be collaborative; and allow for discretion of staff on the front lines. Staff that work with families should have the same respect, nurturing, and support from their managers that they are expected to extend to those they serve.

**Best Practice** = Staff demonstrate excellent engaging families in services and demonstrating caring, empathy, sensitivity, and knowledge, as evidenced by participant reports, retention in services, and supervisor observation.

## 6. Data Collection and Documentation

It is essential from the start of the program to articulate anticipated levels of service and to

**Collect and report service level and outcome data.**

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

- **At initial engagement:** source of referral; family structure; major strengths and/or presenting problem; and whether family/individual voluntarily agreed to participate
- **Service summary:** units of service over each week/month; number of families receiving services
- **Descriptive Data:** length of time of service, level of family's participation, percentage of goals achieved, reason for termination of service

Collecting descriptive data and measuring outcomes is necessary to keep the program on course. The types of data to be collected should reflect the anticipated needs for descriptive and quantitative information. Staff should be trained in record keeping and in report preparation. Some organizations prepare an annual work plan that articulates the expected levels of service for the program. The levels of service are targets for staff to achieve during the coming year.

**Best Practice** = Records are maintained electronically on individual and program-level activities, as well as outcomes data.

## 7. Measures Outcomes and Conducts Evaluation

Programs must have an evaluation component that gathers quantitative and qualitative data to determine if the program is achieving anticipated outcomes and to what extent. The

National Clearinghouse on Child Abuse and Neglect Information recommends that funding be provided only to those programs that have some evidence of effectiveness.

In addition to descriptive information about the participants and levels of service, the program should gather information that indicates whether or not the program is achieving

**Use of qualitative and quantitative data to evaluate if anticipated outcomes are being achieved.**

the outcomes intended for the participants. Outcome information is different from levels of service data. Outcomes measure some type of change—circumstances, knowledge, skills, behaviors, or attitudes. Outcome measures need to be used at the onset and at the end of the duration of the service. Some measures are also used intermittently throughout the time of service.

Many different valid and reliable tests and measurements are available for evaluation purposes. Some of these instruments can be scored by the organization; others can be sent “outside” to be scored and analyzed. Programs may also establish their

own measurements. However, evaluation expertise is needed to determine the reliability of new instruments. The sophistication of the program evaluation will depend on the program’s resources.

At a minimum, pre– and post-assessments should be used to determine if the program is at least achieving the desired outcomes for the participants in that specific program at that period in time. This data are considered clinical data that service providers may use to evaluate their own activities and better understand the characteristics of families they serve.

Choosing assessment can be daunting. However, the Children’s Bureau provides an on-line tool\* for developing a logic model and choosing validated measures. Prior research regarding the program or similar activities could be instructive. To engage in more rigorous research, such to compare the outcomes of one set activities to the outcomes of another or to compare those that participate from those that do not, it is recommended that providers engage a trained researcher.

\*<https://toolkit.childwelfare.gov/toolkit/>

**Best Practice** = Scales are administered at baseline and completion of services. Data are analyzed to determine outcomes, which are changes in knowledge, skills, behavior, etc. related to promotion of protective factors and reduction of risk factors. Data might also be analyzed to determine who benefits and under what circumstances.

## 8. Adequate Funding and Long-term Commitment to Sustainability of the Program

There do not appear to be any studies that specifically look at the impact of the level of funding as it relates to program effectiveness. However, communities can become distrustful when initiatives unexpectedly end. Other information (already noted above) also point to the need for comprehensive, long-term, and intense services, which suggests that sound prevention programs need adequate funding and are not inexpensive.

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

**Stable and long-term funding provide for ongoing program implementation.**

**Excellent** = Program is fully fund with renewable funds or there is a solid plan for continued public and private funding.



**Self-Assessment Instructions:** This is intended as a self-study and program improvement tool. Please choose the score that best reflects your current practice at the end of each section – Families, Communities, and Administration – identify several areas for improvement and steps to support those goals.

### Practice with Families

	<b>Foundation 1</b>	<b>Emerging 2</b>	<b>Established 3</b>	<b>Best Practice 4</b>
<b>1. Family-focused</b>  <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">Score:</div>	Program is focused on the individual only.	Program addresses needs of the entire family, but primarily through the individual that initiates services for the family.	Program serves the entire family. Materials encourage workers to speak to participants about their informal supports (i.e. friends and family).	Program serves the entire family and has mechanisms for regularly including informal/natural supports (i.e. friends and family) in activities.
<b>2. Strength-based, goal setting in partnerships with family</b>  <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">Score:</div>	Decisions regarding individual service plans are based primarily on professional judgment.	Professional judgment is used, but strength-based and parent determined goal setting is also minimally utilized.	Goal setting is based on parent strengths and personal goal, but with some influence from professional judgment.	Program uses strength-based language throughout, places an emphasis on building strengths, and goals are developed in partnership with the participant, to the extent feasible under ethical and programmatic guidelines.
<b>3. Flexible and responsive</b>  <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">Score:</div>	Program activities are provided based on a standardized approach that does not allow for deviation from the model.	Program has limited flexibility in activities.	Program has some flexibility in activities to meet the needs of participants, such as spending more time with certain families than others based on individual needs.	Program is flexible to meet the needs of participants, such as increasing meeting from monthly to weekly. Workers are easily accessible, return phone calls within 24 hours, and respond to requests for further referrals or information promptly.

<b>Practice with Families</b>				
	<b>Foundation</b>	<b>Emerging</b>	<b>Established</b>	<b>Best Practice</b>
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>4. Accessible and incentivized</b>  <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: auto; margin-right: auto;">Score:</div>	Services are only ever offered during the weekday. Services that facilitate involvement, such as child care, transportation, and food are not provided.	Services are occasionally offered on the evenings or weekends, but child care, transportation, and food are not provided.	Services are offered at times that are accessible to parents' schedules and supports are sometimes provided to improve participation likelihood (i.e. food, transportation, and child care if needed).	Services are barrier free; offered at times that are accessible to parents' schedules and supports are routinely provided to improve participation likelihood (i.e. food, transportation, and child care if needed).
<b>5. Voluntary and incentivized</b>  <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: auto; margin-right: auto;">Score:</div>	Program is provided exclusively to child protective service involved parents.	Program is a requirement of families in order to obtain other desired services.	Program is provided to at-risk families in a supportive, non-threatening environment. However, due to the way families were referred to services, they may feel they do not have a choice.	Program is universally available and provided in a supportive, non-threatening environment, such as a public space that is safe and convenient.
<b>6. Comprehensive and integrated</b>  <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: auto; margin-right: auto;">Score:</div>	Program provides one discrete service component.	Program provides multiple service components and referrals to other services.	Program provides multiple service components and active case management to support goal attainment and successful linkages to a continuum of services.	Program provides comprehensive services through multiple program components, active case management to support goal attainment and successful linkages to a continuum of services, and flexible funding to meet gaps in service availability.

<b>Practice with Families</b>				
	<b>Foundation</b>	<b>Emerging</b>	<b>Established</b>	<b>Best Practice</b>
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>7. Developmentally informed</b>  <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: 20px;">Score:</div>	It is at least unclear whether program design, materials and activities are informed by developmental (ages/stages of children, family transitions, adult aging) knowledge.	Program materials and activities are informed by developmental (ages/stages of children, family transitions, adult aging) knowledge.	Stages of family development, related to ages/stages of children, transitions families experience, and the adult aging process are sometimes reflected in materials and approaches.	Stages of family development, related to ages of children, transitions families experience, and the adult aging process are consistently reflected in materials and approaches.
<b>8. Long term and adequate intensity</b>  <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: 20px;">Score:</div>	Frequency, intensity, and length of service needed to demonstrate desired outcomes have not yet been established or current services are provided at less than recommended levels.	Frequency, intensity, and length of service are being provided as recommended, but data are not collected to ensure efficacy with the current setting and population.	Frequency, intensity, and length of service have been and continue to demonstrate adequacy to meet and maintain desired outcomes as evidenced by qualitative research or retrospective self-report only.	Frequency, intensity, and length of service have been and continue to demonstrate adequacy to meet and maintain desired outcomes as evidenced by quantitative outcomes research.
<b>9. Culturally responsiveness/reciprocity</b>  <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: 20px;">Score:</div>	Materials are written only in one language and have a singular race/ethnic orientation.	Program components acknowledge and respect cultural identity and background. Workers demonstrate cultural competency/reciprocity and their capacity to engage with a diverse range of families.	Materials are written in multiple languages and bilingual workers are utilized. Workers demonstrate cultural competency/reciprocity and their capacity to engage with a diverse range of families.	Staff demonstrates awareness, knowledge, attitudes, and skills related to impact of culture - theirs' and that of the family - on the working relationship, engagement of families in services and assumptions about the process/goals of

				<p>services. Organizations tailor services, materials, and staffing to facilitate this and promote cultural exchanges.</p>
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**Please discuss any indicators rated with a “1”. Specifically, is there a rationale for this practice that is in keeping with your program, organization, or community? If so, please describe. If not, what factors have influenced this and what can be done to overcome those factors and progress in Standards adoption?**

**Our top 3 priority improvements within the Families domain for this year:**

Rank	Specific Area of Concern	Strategies for Improvement	Assistance Needed
1.			
2.			
3.			

**Practice with Communities**

	Foundation 1	Emerging 2	Established 3	Best Practice 4
<p><b>1. Participatory Development Planning</b></p> <div style="border: 1px solid black; width: 60px; height: 20px; margin-left: 20px; display: flex; align-items: center; justify-content: center;">                     Score:                 </div>	<p>Program is designed with little or no input from participants.</p>	<p>Program is designed with minimal input from participants, such as through a survey or focus group.</p>	<p>Program is designed with the active input of intended participants, such as through an advisory group.</p>	<p>Program is designed collaboratively with the intended participants.</p>

<p><b>2. Community Integration</b></p> <p>Score:</p>	<p>Program is focused exclusively on the families enrolled in services and may advocate for families with other providers when necessary.</p>	<p>Program networks and may have collaboration agreements with other services in the community to improve access and coordination of services.</p>	<p>Program actively participates with community-wide efforts to study, plan, and implement strategies to address aspects of the community (i.e. structural and parenting norms) that promote or undermine family functioning.</p>	<p>Program takes a leadership role in organizing efforts to study, plan, and implement strategies to address aspects of the community (i.e. structural and parenting norms) that promote or undermine family functioning.</p>
<p><b>3. Early start at all developmental stages</b></p> <p>Score:</p>	<p>Program is provided only to CPS involved families.</p>	<p>Program is provided to families referred to CPS and deferred to community-based intervention that is only accessible with CPS referral.</p>	<p>Program is provided to targeted families on the basis of at-risk characteristics.</p>	<p>Program is aimed at the general population for the purpose of keeping child maltreatment from happening before it has occurred, at every developmental stage (i.e. prenatally, positive youth development, etc.).</p>

**Please discuss any indicators rated with a “1”. Specifically, is there a rationale for this practice that is in keeping with your program, organization, or community? If so, please describe. If not, what factors have influenced this and what can be done to overcome those factors and progress in Standards adoption?**

**Our top 3 priority improvements within the Communities domain for this year:**

Rank	Specific Area of Concern	Strategies for Improvement	Assistance Needed
1.			
2.			
3.			

**Administrative Standards**

	Foundation 1	Emerging 2	Established 3	Best Practice 4
<b>1. Long-range and on-going planning</b>  <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: 20px;">Score:</div>	Strategic planning and other systematic organizational assessments have not been conducted in at least 10 years, if at all.	Assessments and planning are conducted on an ad-hoc basis.	Strategic planning and other systematic organization assessments are conducted at least every 5 years. Staff and community/family partners have limited involvement.	The organization engages in a comprehensive, on-going cycle of assessment, planning, intentional decision-making, implementation, and evaluation of the organization in all its aspects. This is shared with staff and community/family partners.

<p><b>2. Supervision, organizational management, and professional development.</b></p> <p>Score:</p>	<p>Supervisors and senior management make unilateral decisions regarding individual service plans and organization direction, respectively. There are no opportunities for training and professional development.</p>	<p>Supervision occurs intermittently or as necessary. Organization policies may be minimal or infrequently updated. There are minimal resources for professional development.</p>	<p>Supervisors meet with staff regularly. Organization policies are established. There are minimal financial resources for professional development.</p>	<p>Supervisors and the organization engage in collaborative decision-making with staff, provide opportunities for professional growth and development. Management policies are documented and organizational finances are well managed.</p>
<p><b>3. Parent and community leadership</b></p> <p>Score:</p>	<p>There is little opportunity for program participants and community members to give feedback or take leadership roles.</p>	<p>Program conducts satisfaction surveys and involves participants/community as volunteers.</p>	<p>Participants and community volunteers are developed and given meaningful opportunities to engage in program activities.</p>	<p>Program participants and community leaders are on governing and/or advisory boards and are developed and given meaningful opportunities to engage in program activities.</p>

<b>Administrative Standards</b>				
	<b>Foundation 1</b>	<b>Emerging 2</b>	<b>Established 3</b>	<b>Best Practice 4</b>
<p><b>4. Fidelity to an established appropriate model</b></p> <p>Score:</p>	<p>Program has not yet developed a logic model or produced evaluation results.</p>	<p>Utilizing researched model, however some elements of the model are not being provided as designed and/or this program has not been utilized previously with this population.</p>	<p>Program is being provided with fidelity to an established model that has not been researched with the population being served or for the purpose intended, but data is being collected currently.</p>	<p>Program is being provided with fidelity to an established model that has been researched as effective with the population being served and for the purpose intended.</p>
<p><b>5. Highly qualified, competent, and caring staff</b></p>	<p>Some concerns regarding retention of families in services have been noted, but an</p>	<p>Some concerns regarding retention of families in services have been noted – through an</p>	<p>Staff demonstrates a moderate degree of success engaging families in services and demonstrating</p>	<p>Staff demonstrates excellence engaging families in services and demonstrating caring, empathy,</p>

<p>Score:</p>	<p>assessment to determine the cause has not yet been conducted.</p>	<p>assessment of retention, participant satisfaction, and/or observation – that have indicated concerns with staff capabilities.</p>	<p>caring, empathy, sensitivity, knowledge, and cultural competency/reciprocity, as evidenced by participant reports, retention in services, and supervisor observation.</p>	<p>sensitivity, knowledge, and cultural competency/reciprocity as evidenced by participant reports, retention in services, and supervisor observation.</p>
<p><b>6. Data collection and documentation</b></p> <p>Score:</p>	<p>Basic paper records are kept on activities. Sign-in sheet may be used at activities, but individual-level records are not kept.</p>	<p>Paper records on individual participants are maintained properly and accessible to workers as needed.</p>	<p>Records are maintained electronically on individual and program-level activities.</p>	<p>Records are maintained electronically on individual and program-level activities, as well as outcomes data.</p>

Administrative Standards				
	<b>Foundation</b> 1	<b>Emerging</b> 2	<b>Established</b> 3	<b>Best Practice</b> 4
<p><b>7. Measures outcomes and conducts evaluation</b></p> <p>Score:</p>	<p>Aggregate data are collected and reported on demographics of participants and outputs of programs (i.e. numbers served, types and numbers participating per activity).</p>	<p>Individual-level data are entered into a database and reports are generated on aggregate descriptive statistics. This might include average frequency and length of use, descriptive statistics on participants, and basic correlations.</p>	<p>Process data are collected on elements of the program and their implementation, such fidelity to the model, participant satisfaction, or needs assessments, in addition to individual-level data elements mentioned previously.</p>	<p>Scales are administered at baseline and completion of services. Data are analyzed to determine outcomes, which are <u>changes</u> in knowledge, skills, behavior, etc. related to promotion of protective factors and reduction of risk factors. Data might also be analyzed to determine who benefits and under what circumstances.</p>



<p><b>8. Adequate funding and long-term commitment to sustainability of the program</b></p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 10px auto;">Score:</div>	<p>Funds do not allow for full-implementation of the program and future funding is uncertain.</p>	<p>Funds do not allow for full-implementation of the program. Future funding is reasonable secure.</p>	<p>Program is fully funded with non-renewable funds. Future funding is uncertain.</p>	<p>Program is fully funded with renewable funds or there is a solid plan for continued public and private funding.</p>
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**Please discuss any indicators rated with a “1”. Specifically, is there a rationale for this practice that is in keeping with your program, organization, or community? If so, please describe. If not, what factors have influenced this and what can be done to overcome those factors and progress in Standards adoption?**

**Our top 3 priority improvements within the Administrative domain for this year:**

Rank	Specific Area of Concern	Strategies for Improvement	Assistance Needed
1.			
2.			
3.			

## **New Jersey Task Force on Child Abuse and Neglect - NJTFCAN**

### **PREVENTION COMMITTEE**

#### **CHAIR**

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#### **CO-CHAIR**

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