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How can society best support parents, beginning early in their children's lives?

That's the most basic question we ask in this issue of *Future of Children*. The articles that follow describe several ways that local communities have tried to provide such support, by implementing new interventions, reforming existing systems of care, and improving the coordination and planning of services. The primary assumption underlying these efforts is that unless we can develop programs and strategies with universal reach to help parents at all levels of need, we will fight a never-ending battle to deal with families and children exhibiting individual problems that affect child development and child safety. Perhaps even more important, the efforts we highlight in this issue are showing scholars and policymakers how programs that help all or nearly all families in a community might be developed, tested and used as a platform to employ existing resources more efficiently. The most important point of all is the growing realization that parents rarely succeed entirely on their own, and that providing support from community resources to families in need is a worthy goal of public policy.

Before we turn to briefly summarizing the content of each article, it's useful to consider why the program innovations described in these articles are widely seen as the next step in evidence-based policymaking. Those concerned with children's welfare and safety can no longer be content to support individual families deemed to need assistance only after they have demonstrated serious problems or substantial risk. Our approach must be organized around offering assistance to all or nearly all families in a given community early in children's lives, and trying to bring supports and services at the moment family problems and vulnerabilities are identified or shortly thereafter. We contrast this broader preventive approach with strategies that confront family issues only after serious problems such as abuse or neglect have arisen and seem to pose an immediate or potential risk of harm to children.

If we saw children in a canoe heading for a waterfall, we wouldn't be content to wait at the bottom and mend their wounds

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after they crash; instead, we would climb to the top of the falls and try to stop them from going over the edge in the first place. Similarly, we must begin earlier in children's lives and come equipped to identify family needs and offer assistance in a timely fashion before problems surface. Yet this issue of the journal is not merely about prevention versus treatment—it's about universal approaches that can reduce the population rate of adverse outcomes.

Many questions remain about the appropriate design, implementation and funding of universal strategies. Still, the programs described in this issue suggest that building the infrastructure to support a universal approach involves three important steps. The first is a mechanism that allows all families in a community to be assessed and to receive advice from qualified professionals about how to ensure the healthy development of their children. Second, when giving advice, these professionals must recommend specific prevention or treatment services that are available and accessible in the local community—and, often, help parents gain access to and pay for the services. Third, programs need a way to track families' developmental and other issues, the services they seek and receive, and the results of those services. The various strategies reviewed here illustrate not just how all three steps can be accomplished, but also the advantages of this approach to serving families.

A few words are in order about how child protection currently operates in the United States. Over the past few decades, child protection has been governed largely by the accepted belief that parents should make most of the decisions regarding their children's care and wellbeing. Laws overriding parental preferences are generally limited to cases in which a child has experienced physical harm or neglect, or is at imminent risk. And usually, public concern is triggered only after a parent fails. Unfortunately for parents who have limited access to family support services or who can't navigate a complex social service delivery system, this public concern involves a formal report to child protective services, which can be threatening to parents and may deter them from seeking support.

Overview of the Issue

This issue of *Future of Children* is about changing the point at which public concern comes into play, on multiple levels. It's about moving away from a singular emphasis on "fixing" flawed parents and toward enhancing the context in which parents raise their children. It's about shifting the focus from stopping or preventing the negative to promoting the positive. It's about measuring success in terms of changes, not just among individual participants of a program but also among population-level indicators. It's about creating a framework in which universal strategies contribute to a more equitable and efficient allocation of costly targeted prevention and clinical services. It's about redefining the balance among competing goals: child safety, enhanced child development, and parental autonomy. And it's about expanding the way we learn what works best to promote healthy development, going beyond clinical trials to broader questions of implementation and continuous improvement.

Admittedly, the tension between responses that focus on individual change and those

that adopt a community-wide or population-level perspective is nothing new. Take, for example, the struggle between clinical medicine and public health. Historically, investment in medical research and treatment has heavily favored clinical medicine—which focuses on detecting and curing disease at the level of the individual. But this approach often occurs at the expense of promoting community or contextual change. Efforts to improve clinical interventions, for instance, concentrate on identifying the best match between specific therapies and a patient's socioeconomic and biological characteristics. The hope is that such "precision medicine" will improve population-level rates of illness and death. But, in reality, this strategy offers little insight into the underlying structural conditions that fuel persistent health problems and disparities.

As a recent commentary in the *New England Journal of Medicine* puts it, improving collective health calls for "the vision and willingness to address certain persistent social realities, and it requires an unstinting focus on the factors that matter most to the production of population health."[1] Wealth inequality and racial prejudice—including the legacies of past inequality and discrimination in American society—create conditions in which some individuals are at higher risk for poor health and less likely to have access to a full array of services. Precision medicine has little to say about these structural forces. In contrast, a precision public health framework has much to say about how underlying social conditions govern our policies, our service delivery systems, and the external narratives that contribute to poor outcomes—particularly among our most disadvantaged populations.

The articles in this issue apply the public health perspective to child protection and to the health, nurturing, and growth of parent-child relationships, particularly those established during a child's first few years. We're not the first to suggest this approach. In its 1990 and 1991 reports, the US Advisory Board on Child Abuse and Neglect issued a series of recommendations that centered on creating a public health response to what it termed "a national emergency" in the child protection system.[2]

This issue applies the public health perspective to child protection and to the health, nurturing, and growth of parent-child relationships, particularly those established during a child's first few years.

But our approach differs from earlier efforts in three important ways. First, the precision public health perspective we envision extends beyond current child welfare practice and examines how policymakers could coordinate a broader array of family supports and institutional efforts to reach *all* new parents with offers of help that match their level of need. Of course, changing the way public child welfare systems allocate resources is part of the story. More importantly, the strategies presented in this issue situate child protection in a broader continuum of parent support. Second, we are guided by growing evidence that well-crafted and carefully implemented prevention strategies

can significantly improve parental capacity and child safety while also enhancing child development. Others have doubted the utility of a prevention strategy. But now the evidence—including the rapidly expanding research on universal strategies reviewed in this volume, along with other recently published research on the implementation and efficacy of intensive home visiting programs—allows us to point to several promising pathways worthy of serious consideration and possible replication.[3] Third, we're not suggesting that a universal perspective is a policy panacea that will eliminate poor parenting, ensure optimal development for all children, and render obsolete any mandated interventions, including foster care. Rather, each article proposes a framework or strategy to better align both public and private agencies and move us toward significant change in our collective efforts, with public policies to support all parents, beginning with new parents and young children.

Using these frameworks, communities may be able to build a platform that reaches nearly all new parents, create a unifying normative profile around parenting demands, generate greater integration and service coordination at the local and state agency levels, and distribute information on the pressing needs of today's new parents. We don't know how far this change will go—that will depend on the efforts of public and private agencies at the state and community level, as well as on financial support. And additional research will be key to assessing this new perspective's eventual success. But we do know that current efforts have fallen short, and that a precision public health framework offers a promising evidence-based option for creating collective responsibility for all children while maintaining the privacy of responsible parents.

Summary of Articles

The issue begins with historical context. In "A Shift in Perspective: A Universal Approach to Child Protection," Deborah Daro reviews a Progressive Era policy that offered support to all new parents. Daro then traces the shift toward more targeted interventions over the next 50 years, as child welfare and child maltreatment prevention systems evolved. In contrast to early Progressive policies, which emphasized universal or common needs among all pregnant women and newborns, later treatment and prevention systems to support parents operated independently. Policymakers have paid little attention to the continuum of risk and variability among families with respect to adequate support and early intervention. Disparities in access to services, often shaped by race and class, mean that a disproportionate number of minority and poor families receive far fewer and often more punitive service options.

The divide between mandated and voluntary parental assistance stands in sharp contrast to the way other systems, particularly health care and education, carry out their mission. Daro notes that when a patient is diagnosed with precancerous cells, she isn't immediately offered chemotherapy or told to go away until the disease becomes Stage IV cancer. Rather, she's offered an intervention appropriate to her condition. Early medical treatment isn't viewed as intrusive; it's seen as an important first step in protecting health and avoiding more complex and costly therapy. Unfortunately, Daro argues, the policy response to parental shortcomings isn't comparable. There's no adequate early assessment when people become parents,

and child welfare agencies typically offer assistance only after a parent fails to meet expectations or a child is harmed.

Highlighting inefficiencies found in both the parent support and intervention systems, Daro suggests the time is right to align both systems through a universal approach that reaches out to all new parents, offering each family a level of assistance commensurate with their needs. State child welfare agencies that adopt the Family First, Welcome Baby, or First Born frameworks, for example—all discussed in this issue—can work with those implementing evidence-based prevention services, and with state public health and welfare agencies, to create a broad network of services. Such a partnership can minimize the longstanding gap between mandated and voluntary parental assistance, and can build an integrated, more effective child protection system. For this partnership to be truly innovative, Daro argues, it will need to move toward a community-owned universal assessment strategy that's offered to all new parents.

This universal platform wouldn't replace a community's mandated reporting system, nor would it be managed by the child welfare agency. Daro suggests that a delivery system to accomplish this objective should include promoting public recognition that raising children presents challenges for all parents. It should also strengthen cross-system staff and agency collaboration, and build a database categorizing the types and levels of support sought by families.

"Universal Reach at Birth: Family Connects," by Kenneth A. Dodge and W. Benjamin Goodman, offers a compelling example of what could be accomplished by following Daro's recommendations for a universal system of prevention services. Dodge and his team at Duke University developed a program now called Family Connects. In this article, Dodge and Goodman report the results of three studies using the Family Connects model that illustrate its feasibility and show the strengths it could bring to broader implementation. The first trial encompassed nearly 5,000 children born in two hospitals in Durham, NC, between July 1, 2009, and December 31, 2010. Half the babies and their families were randomly assigned to an experimental group, the other half to a control group. To contain costs, a random sample of 664 experimental and control families was selected for data collection; 80 percent of these families agreed to participate.

The Family Connects program consists of three pillars: home visiting, community services, and data and monitoring. During the home visiting portion, a discussion took place between a parent, usually the mother, and a program nurse. The interview was conducted in the family home during the first few weeks of the child's life and lasted from 90 to 120 minutes. The visiting nurse assessed family risk in 12 domains, and then the mother and nurse developed a plan to promote the child's development and wellbeing. Where necessary, and when agreed to by the mother, the nurse arranged visits to community agencies. Birth records were used to record family needs and services received.

The results of the intervention are encouraging. First, while 94 percent of the families had at least one need that merited intervention, most were minor or moderate. Only 1 percent of the families required immediate intervention because of serious need; about half had serious to moderate

needs that could be resolved by home visits, brief counseling, or other nonemergency services; and 44 percent had serious needs that required connection with community resources, such as treatment for substance abuse or depression, or intensive home visiting programs and other social services. Because Family Connects reaches the full population of birthing families in a community, it can reinforce targeted home-visiting programs by becoming a primary source of referral to them. In Durham, for example, Family Connects is the single most frequent source of referrals to Early Head Start and to Healthy Families Durham (an affiliate of Healthy Families America, the national model that offers intensive home visiting to new parents who have multiple sources of stress). One important finding was that a month after the nurse's involvement ended, 79 percent of families said they'd followed through to make a community connection. Even more impressive, 99 percent of the families involved with Family Connects said they would recommend the program to other new mothers.

A longer-term follow-up was conducted when the children were six months old. In this study, when compared with control group mothers, those in the experimental group reported 16 percent more community connections; reported more positive parenting behaviors and higher-quality father-infant relationships; were nearly 30 percent less likely to show signs of clinical anxiety; and reported 35 percent fewer serious injuries or illnesses among their infants that required hospitalization. Throughout their first year of life, infants of experimental families had many fewer emergency medical episodes than did control babies.

In addition to these positive findings, the Dodge team examined records of Child Protective Services over the children's first five years. Their review showed that children in the program group received 39 percent fewer protective services investigations than children in the control group.

Family Connects conforms to what the editors of this issue assume will characterize nearly all intervention programs with universal potential: namely, a mechanism for examining large (even universal) populations to detect problems in child development and parent-child relations, another mechanism to treat those with moderate and serious problems, and a data system to follow the families over time, keeping track of the results as well as the need for additional intervention.

A major challenge for a universal approach is the expense required to provide treatment programs to every family in a population. We assume that in most cases, this challenge can be reduced or solved by employing the approach taken by Dodge and Goodman: *providing infrastructure to better use and link targeted programs with the most appropriate recipients*. This is an example of the precision public health approach we discussed earlier—to achieve population impact, it individualizes interventions but reaches the entire population. In Family Connects, nearly every family with a new birth in a community is interviewed, and those who appear to need services get help finding them. This approach offers both the prevention advantages of universal coverage (or at least coverage among families who don't refuse the initial interview) and the financial advantages of limiting the most

costly services to the families in greatest need. Illustrating the potential of Family Connects for broad implementation, the program is now in place at 16 US sites, and negotiations are in progress with several more.[4]

Turning to another home visiting program with broad reach in a community, Christina Altmayer and Barbara Andrade DuBransky—in "Strengthening Home Visiting: Partnership and Innovation in Los Angeles County"—outline how Los Angeles County is developing an integrated prevention system for parents with babies. The authors discuss how a universal offer of assistance establishes a foundation on which public and private agencies can plan meaningful systemic reform—and spark incentives for greater investments in services directed to vulnerable families.

The vision builds on Welcome Baby, the county's universal home visiting program funded by First 5 LA, which provides as many as nine contacts to pregnant women and new parents until a child's ninth month. Three contacts occur before birth, one at bedside in the birthing hospital, and five afterward in the home.

Piloted in one hospital in 2009, the program is now available to new parents delivering in 14 hospitals throughout the county. These facilities deliver more than a third of all births in the county, and almost 60 percent of births occurring in the county's highest-risk communities. As of June 2018, the program had reached more than 59,000 families.

Since initiating Welcome Baby, First 5 LA has supported a range of evaluation studies to track early impacts of the pilot project and to document the quality of the program's expansion. The authors report on how the results of these studies have been used to refine the program's structure and content and to facilitate its replication. One evaluation of the pilot program compared Welcome Baby participants to new parents in the same communities who didn't access the program; it found favorable impacts on parental capacity, child development, and service utilization up to three years following program enrollment. A randomized trial of the program is currently being conducted to provide a more rigorous account of its effects.

Welcome Baby and other related investments in home visiting are part of a broader story unfolding in LA County. The authors describe an important policy shift underway, moving both public and private providers toward an integrated universal and targeted home visiting system. In December 2016, the county's Board of Supervisors adopted a unanimous motion instructing the Department of Public Health—in collaboration with First 5 LA and other programs and departments—to "develop a plan to coordinate, enhance, expand, and advocate for high-quality home visiting programs to serve more expectant and parenting families so that children are healthy, safe and ready to learn." Though Welcome Baby remains an important first step for addressing needs common to all new parents, the county's action plan calls for significant investments in new parent support and responsiveness from multiple county-level agencies, as well as the development and expansion of multiple home visiting models to meet the needs of the county's diverse population.

Altmayer and DuBransky summarize the responses of county agencies and private providers. Recommendations include streamlining referral pathways to ensure

maximum participation, especially in the county's highest-risk communities; filling service gaps for high-risk populations; increasing access to voluntary home visiting for families at high risk for involvement in the child welfare system; creating a common data collection system to improve outcome reporting; and maximizing the use of current resources while generating new revenue.

The authors aren't naive. They cite the many challenges faced by county leaders in developing this more integrated service system. These include the fact that Welcome Baby is available only in certain communities, the eligibility restrictions that decide who can access intensive home visiting services, LA's multitude of cultures and ethnic groups, the shortage of therapeutic and other resources required by families at high risk for maltreatment, and the critical need for workforce development. To help with funding shortfalls, the county has partnered with state leaders to expand the use of dollars from Medi-Cal (California's version of Medicaid) to support home visiting services. Leaders have also secured substantial new investments in intensive home visiting programs through the state's Temporary Assistance for Needy Families program and the county's Department of Mental Health. A newly created Collaborative Leadership Council is overseeing this expansion, focusing on integrating services, training and retaining qualified home visitors and supervisors, and building a sustained commitment to long-term system change.

As the authors note, systems don't change overnight. The service expansion underway in LA County is the result of long-standing, thoughtfully designed investments in home visiting, as well as community and county partnerships. These efforts are creating a political and policy context that's spurring elected officials to accelerate the system-building process.

In "Home Visiting for First-Time Parents: Community Innovation," M. Rebecca Kilburn and Jill S. Cannon report on the development, implementation, and outcomes of First Born, a targeted universal home visiting program that serves all first-time parents in several New Mexico communities. Created by local service providers in response to a lack of support for pregnant women and new parents in small towns and rural communities, First Born is a hybrid model that draws on several evidence-based programs in responding to conditions common to high-need, low-resource communities, including a shortage of nurses and other health professionals.

To promote early childhood health and development, First Born educates parents and helps them access community resources. It builds on a three-pronged approach to promoting child and family wellbeing, with teams of parent educators, registered nurses, and other health professionals visiting families in their homes during a child's first three years. The aim is to enhance life and social skills and to identify those who need more specialized services for issues like substance dependency, family violence, and developmental delays. Home visitors also help lead community service networks, which aids coordination and data sharing.

In contrast to other universal efforts discussed in this issue, First Born focuses on enrolling women pregnant with their

first child, drawing on formal and informal referral sources. The program also works with hospital maternity ward staff to identify eligible participants who were missed during pregnancy. It offers at least 40 weekly home visits during the child's first year; the frequency of visits diminishes during the child's second and third year.

A registered nurse or other licensed health care professional visits the home both before and after the child's birth, but most of the visits are made by paraprofessional parent educators who have at least a high school degree and some human services experience. All staff members receive extensive training in the First Born curriculum, as well as in child development, culturally competent practice, and more. Supervisors who observe the work of home visitors provide them with ongoing coaching and information on such topics as new health insurance eligibility standards and new aspects of the First Born curriculum.

First Born has used several types of evaluation to assess implementation and outcomes. According to Kilburn and Cannon, the first evaluations focused on clarifying core program components, defining common implementation indicators, and articulating early outcomes. Those studies have been used to guide program replication and enhance implementation quality.

The authors also report on a recent randomized clinical trial in which the study design took advantage of a natural experiment in Santa Fe, where service needs significantly outpaced service capacity. Using a lottery system, the team randomly assigned participants to intervention and control conditions, ultimately enrolling 244 families between June 2011 and October 2013.

The evaluation produced mixed results. On the positive side, children in the treatment group were a third less likely than control group children to visit a hospital emergency department, and 41 percent less likely to have visited a primary care provider nine or more times. These health outcomes, which occurred for families at all levels of risk, suggest that the parents were using well-baby care appropriately. But no significant differences were found for hospitalizations or for injuries requiring medical attention.

The First Born experience offers a cautionary tale for those who would adopt a universal approach. In Grant County—where the program was first implemented, 20 years ago—average outcomes for newborns have improved, but only modestly. Many factors account for this outcome of the program. Home visiting programs are typically voluntary, and not all families use the services effectively. Beyond program-specific issues, community levels of risk are sensitive to changes in the local economy, reductions in public services, and migration in or out of the area. As Kilburn and Cannon note, it's easy to explain why a universal program might not improve population-level indicators, but advocates of universal services commonly expect that such programs will lead to upticks in these indicators.

First Born also illustrates the challenge in getting a new idea to market. Although funders strongly prefer to support evidence-based programs, programs can only achieve evidence-based status after they've been tried. Kilburn and Cannon argue that in the current evidence-based investment climate, the cost of achieving evidence-based status and supporting quality replication is daunting, and beyond the reach of many communities. Fostering innovation and

continuous quality improvement in home visiting programs may require a more diverse approach to funding, one that rewards the ongoing evaluation and refinement of a program's innovations and adaptations.

In "HealthySteps: Transforming the Promise of Pediatric Care," Trenna Valado and her colleagues Jennifer Tracey, Jonathan Goldfinger, and Rahil Briggs offer the promise of pediatric care as a way to deliver psychosocial parent and infant support. They argue that pediatric care is non-stigmatizing, nearly universally accessed, and prevention oriented. The American Academy of Pediatrics already urges pediatricians to screen for adverse childhood experiences, maternal depression, behavioral and developmental risk, and even the effects of poverty on children. The authors note that while most pediatricians would like to extend their narrow health care mandate to broader social-emotional and behavioral care and education, they're constrained by issues of time and reimbursement.

Valado and her colleagues offer a solution to those constraints: a program called HealthySteps, which inserts a skilled child development professional into the pediatric practice to deliver eight core components that include screening for child developmental risk and family needs, a child development support line, consultation with individual families, and care coordination. The HealthySteps program is universal in its potential reach to all families in a pediatric practice, though it targets services to the highest-risk subgroup.

The evidence supporting HealthySteps comes from several national studies conducted by a team at Johns Hopkins University.[5] The most important evaluation covered 15 sites. At six of these, families were randomly assigned to receive HealthySteps services or not. At the other nine, families in a HealthySteps practice were compared with families in other, nonrandomized practices. The studies found that staff members at HealthySteps sites developed more awareness of the families' needs, and that families receiving HealthySteps were more likely to receive screening and services. The authors report some positive impact on children and parents over time, though they characterize the impact as "modest." The HealthySteps team is continuing to evaluate implementation, training, impact, and cost as the program spreads across the nation.

The HealthySteps model has made an important contribution by opening up the idea of using pediatric care to bring a broader array of screening, prevention, and intervention services to a community's full population of children. How such a model should be financed, and whether health insurance could and should pay for it, are questions that still remain.

In "A Population Approach to Parenting Support and Prevention: The Triple P System," Ronald J. Prinz offers another important innovation in universal approaches to prevention. Triple P is a universal parenting support program that aims to impact the population by lowering community rates of child abuse and improving parenting behavior. It was developed decades ago by Matt Saunders at the University of Queensland in Australia, where it joined a cadre of interventions based on social-learning theory aimed at improving parenting skills in families with children who displayed behavior problems. These interventions were targeted either at individual families or at small groups

of families. The apparent success of such psychological skills training programs led Triple P developers to consider how to bring the philosophy of parent training to a population level, without trying to force every parent into a therapeutic program.

To reach all families in a community and increase the number of parents who have critical parenting skills and knowledge—as a way to reduce child abuse rates and improve overall child behavior and outcomes—the Triple P developers arrived at a tiered system. Each successive tier engages parents more intensively in response to perceived need, at greater cost but with fewer numbers than the tier below. The first tier is a media and communication strategy, intended to change norms and values at a population level with a "light touch" intervention. The second tier is a set of community seminars that educate large groups of interested parents, as well as one-time consultation sessions for parents. The third tier reaches individual parents with as many as four contacts through individual sessions or online. The fourth tier increases the number of individual parent training sessions for those who need more. The fifth tier involves intensive family intervention over several months.

The tiered system is a way to reach the entire population while allowing families to choose varying doses of intervention. The levels are connected by a similar philosophy, guiding theory, and messaging about parent skills.

Triple P's implementation and impact have been extensively evaluated for 20 years. Many rigorous studies of its individual components have shown that each adds positive value. Evaluating population impact is harder, because the unit of evaluation is effectively the entire community. A trial of Triple P in South Carolina started by randomly assigning 18 counties to receive Triple P or not.[6] Outcome measures were drawn from administrative records of substantiated child maltreatment cases, out-of-home placements into foster care, and hospital admissions for injuries. Prinz and colleagues found that Triple P had large positive impacts on all three measures. They conclude with insights about the issues facing population-level interventions, such as cost, maintaining quality of implementation while making local adaptations, conducting rigorous evaluation, and generating public support.

In "Every Child Deserves a Permanent Home: The Permanency Innovations Initiative," Mark Testa and his colleagues Kristen Woodruff, Roseana Bess, Jerry Milner, and Maria Woolverton describe a program that differs in several respects from the other projects covered in this issue. Most importantly, whereas the other projects begin with an intervention program that's then implemented and evaluated, the Permanency Innovations Initiative (PII) tests the results of an elaborate program with several stages. Implemented in six sites—in Arizona, Illinois, Kansas, Nevada, and two in California—the program aimed to follow a four-stage model for selecting and testing interventions that could be used in child protection programs. The stages include:

- *Exploration and installation:* choosing promising innovations to install in real-world settings, based on the best available research evidence of past success.

- *Initial implementation and formative evaluation:* confirming a program's usability and statistically testing whether its outputs and primary short-

term outcomes are trending in the desired direction.

- *Full implementation and summative evaluation:* supporting implementation as planned (with integrity) and rigorously evaluating whether the intervention creates practical improvements in primary long-term outcomes that can plausibly be attributed to causal effects of the intervention.

- *Replication and adaptation:* spreading evidence-supported interventions and assessing whether similar positive outcomes can be reproduced with diverse populations at different time frames and in different settings.

All six projects agreed that the primary outcome measure was stable placement, defined as children exiting foster care into reunification, adoption, or guardianship lasting for at least six months.

Four of the six projects selected intervention programs that had been reviewed by the California Evidence-Based Clearinghouse for Child Welfare (CEBC; see http://www.cebc4cw.org/, which includes references to the evaluations); two of these four selected two intervention programs. Only one of the six programs was judged by CEBC to be "well supported' by program evaluation data; three were judged "promising," a lower score; and two were scored "not able to be rated," meaning that the programs lacked enough evaluation data to yield a reliable indication of success. The two PII sites in California didn't use CEBC-rated programs. Instead, they developed new intervention programs and used those to guide their work with the young people and families in their projects. Though untested, these two programs may have been of high quality.

The results weren't encouraging. Due to implementation issues, the Arizona site and both California sites decided not to move to PII's full implementation phase. The Illinois, Kansas, and Nevada sites did move to full implementation and evaluation, but the level of participation was a problem at all three sites. In Illinois, about half the sample failed to participate in any session. About 25 percent participated in multiple sessions and completed the full course (10 to 12 sessions), 16 percent competed three to nine sessions, and 12 percent completed only one or two sessions. In Nevada, about one-third of families didn't even provide contact information, and the level of missing outcome data reached 70 to 80 percent, preventing investigators from assessing the intervention's impact on short-term outcomes.

In Kansas and Illinois, no significant differences in achieving stable and permanent homes for children were found between experimental and control groups. In Nevada, experimental-control differences were significant but favored the control group. Again, these results for the primary outcome variable aren't encouraging.

Their "principal finding," the authors conclude, is that "none of the promising innovations tested in this initiative yielded meaningful improvements in … stable permanence when rigorously evaluated." Discussing the implications of PII for child welfare programs in general, they raise a fundamental issue: should child welfare programs primarily aim to prevent abuse, or deal with it once it has occurred? Everyone understands that child welfare must do both,

but preventing abuse through universal programs could keep many children out of foster care in the first place. The failure of the PII programs suggests that once children have been removed from their families, it's hard to design programs that will help them return home or achieve another permanent placement.

Can the Results of These Studies Be Replicated?

Summarizing the current status of universal services, three lessons predominate. The first is that so far, the goal of seeking population impact and the means of achieving it are well received across communities. The programs described in this volume are being disseminated across the country because community leaders recognize the need and are searching for solutions.

Second, the development of these innovative programs with community-wide reach is still at an early stage. Many challenges lie ahead if we're to develop these programs in a way that maximizes their potential for serious impacts. Innovation and rigorous evaluation remain pressing needs, especially because most of the programs examined have demonstrated no more than a modest reduction of the problems children and families face in their communities—and some have shown no impacts. It's particularly important to replicate the findings from initial trials and to conduct more studies of the conditions under which these programs flourish or flounder. If they are to survive, these programs must evolve, and we hope the next generation of programs will have even greater impacts.

Third, paying for the programs will be an issue for the foreseeable future. Communities will likely work out many individual solutions, but most will involve combining funds from several sources, with both public and private dollars playing a role. Organizations like the ones that sponsor the interventions described in this issue can expect to spend much time and energy developing ways to help finance their programs.

Endnotes

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