

Child Abuse Prevention Implementation Report

**The Duke Endowment Child
Abuse Prevention Initiative:
Durham Family Initiative
Implementation Report**

Deborah Daro
Lee Ann Huang
Brianna English

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Chapin Hall
at the University of Chicago
1313 East 60th Street
Chicago, IL 60637

773-753-5900 (phone)
773-753-5940 (fax)

www.chapinhall.org

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Overview

The Durham Family Initiative (DFI) is one of two community-based child abuse prevention efforts that comprise The Duke Endowment's Child Abuse Prevention Initiative. Beginning in 2002, the Endowment provided support to the Durham Family Initiative (DFI) in North Carolina and Strong Communities in South Carolina to develop a comprehensive approach to address four core outcomes: a reduction in child abuse rates; an improvement in parenting practices and behavior; strengthening community service systems; and an improvement in a community's capacity to protect children and support parents.¹ Both sites were given considerable latitude in defining how to achieve these objectives and were encouraged to develop strategies with the potential for replication throughout the Carolinas.

Although sharing a set of common objectives with Strong Communities, DFI theorizes that child abuse can be prevented by addressing the risk factors and barriers that affect the healthy development of parent-child relationships. Adopting an ecological perspective, DFI staff formulated a work plan to strengthen and expand the pool of available evidence-based direct services, to identify and secure meaningful public policy reforms, and to build local community capacity. Analysis of the annual reports and discussions with DFI staff and stakeholders suggests that the initiative has evolved through three phases:

- Phase 1: Circulation of ideas, resulting in the implementation of a number of activities that were assessed in relation to specific outcomes.
- Phase 2: Clinical trials implemented to understand key risk and protective factors among the at-risk population and to test intervention outcomes.

¹ Strong Communities was developed by Dr. Gary Melton and his colleagues at Clemson University. A discussion of this project and its implementation trajectory is presented in a companion report to this document, *The Duke Endowment Child Abuse Prevention Initiative: Strong Communities Implementation Report*, available at www.chapinhall.org.

- Phase 3: Launching Durham Connects, a strategy designed to achieve universal reach to new parents and to efficiently connect those requiring assistance with needed resources.

In transitioning through these phases, DFI has demonstrated a willingness to examine data and use it to make decisions about program implementation and direction. In the first phase of the initiative, DFI worked heavily in selected Durham city neighborhoods with high reported rates of child maltreatment, expanded direct clinical services via the Center for Child and Family Health (CCFH), and initiated its efforts to establish a community-wide preventive System of Care. In the second phase, DFI launched several clinical trials to test the efficacy of interventions targeting high-risk or new parents and focused on filling the gaps in scientific knowledge regarding risk factors related to child maltreatment. When the project's internal survey data did not indicate a shift in the quality of resident interactions, use of community services, or reported rates of maltreatment within its targeted service neighborhoods, DFI altered its community development activities and moved toward a more focused attempt to develop population-level strategies. Drawing on the information gathered and staff experiences during DFI's initial operating years, the project team solidified its efforts around designing, implementing, and evaluating Durham Connects, a strategy focused on providing every newborn in Durham County with a home visit. The purpose of these visits is to conduct a systematic assessment of a family's needs and provide linkages to appropriate resources that the family can draw upon in building a healthy parent-child relationship. Although DFI is still wrapping up the last of its clinical trials, most of its current focus is on the implementation and planned evaluation of Durham Connects.

A critical strength of the Durham Family Initiative has been the staff's ability to step away, analyze data, and use information to make key decisions about the initiative's overall direction. DFI is shifting toward adopting universal home visitation, a course of action that, according to many respondents, would not have been reached without the information gathered from the initiative's initial two phases.

DFI Evaluation

A rigorous and multi-faceted evaluation is a critical component to any large-scale initiative that is testing innovative ways of preventing child abuse and neglect. As part of its portfolio, DFI embedded several evaluation strategies into its work plan. The Duke Endowment provided DFI generous funding to plan and implement its internal evaluation. Because of the program's desire to achieve population-level outcomes, DFI focused on documenting changes in various county-wide statistics, including the rate of reported and substantiated child maltreatment and the rate of hospitalizations involving conditions suggestive of maltreatment. Changes in these rates over time were compared to similar data collected from one or more comparison counties within North Carolina. In addition, anonymous sentinel surveys were completed with 1,741 family-serving

professionals in Durham and one comparison county (Guilford) in 2004 and 2006 to assess changes in parental practices and overall levels of child safety. Finally, DFI staff surveyed residents within its six targeted Durham city neighborhoods regarding changes in service use, service satisfaction, levels of community interaction, and perception of child safety. Comparisons were made between the three neighborhoods that were provided general education and assistance and those that were staffed with DFI outreach workers.

These local efforts were augmented by Chapin Hall's role as an external, third-party evaluator of The Duke Endowment's overall initiative. As the cross-site evaluator, Chapin Hall was asked to document the extent to which DFI and Strong Communities made progress toward accomplishing the initiative's core objectives and to provide a comparative analysis of each project's implementation trajectory and replication potential. This assessment was guided by the trends observed in repeated surveys of a random sample of households in the intervention and matched comparison communities and by administrative and survey data collected by the individual sites. In interpreting these data, Chapin Hall placed particular emphasis on drawing out key lessons with respect to each site's respective theory of change, the relative efficacy of each site's various strategies, and the most promising areas for replication.

In addition to collecting and analyzing the household survey data, Chapin Hall staff conducted annual visits to each site to discuss implementation accomplishments and challenges. Chapin Hall was also actively engaged in ongoing conversations with The Duke Endowment staff regarding implementation issues, promising strategies, data-collection methods, and operational challenges facing the two sites.

Evaluation Results ²

On balance, the DFI evaluation documented several positive findings. Among children from birth to age 17, the rate of substantiated child maltreatment in Durham County fell 49 percent between 2001 and 2002, the year before DFI began, and 2007. In contrast, the rate for the mean of five demographically matched comparison counties in North Carolina over the same period fell just 21 percent. Of particular interest is the recidivism rate—that is, the rate at which children who have been assessed for possible maltreatment by the Division of Social Services must be reassessed within 6 months. A high rate would indicate a failure of the professional system to respond adequately. Among children from birth to age 17, the reassessment rate in Durham

² For a full discussion of evaluation results as of June 2008, refer to the following Chapin Hall report: Daro, Deborah, Lee Ann Huang, Brianna English. (2008). *The Duke Endowment Child Abuse Prevention Initiative: Mid-Point Assessment*. Chicago: Chapin Hall at the University of Chicago.

dropped 27 percent between 2001 and 2002 and 2007. In contrast, the rate for the mean of five demographically matched comparison counties over the same period dropped 15 percent.

Responses for the project's two sentinel surveys also suggest measurable improvements in child safety within the project's service area. Professionals' estimates of the proportion of children who had been abused decreased 11 percent in Durham but increased 2 percent in Guilford (the comparison county) over this period. Estimates of the proportion of children who had been neglected decreased 18 percent in Durham but only 3 percent in Guilford. Estimates of the proportion of children who had been spanked fell 11 percent in Durham but rose 4 percent in Guilford. For positive parenting behaviors, professional estimates of the proportion of children shown love, affection, or hugs by parents increased 5 percent in Durham but decreased 2 percent in Guilford.

Emergency department and in-patient hospital records from local hospitals also supported findings of positive program impacts. The rate of possible maltreatment-related injury among all children from birth to age 9 in Durham fell 17 percent between 2001 and 2002 and 2005 and 2006, whereas in Guilford it fell 10 percent. Pediatric hospitalizations for any reason represent a reverse measure of child well-being. Between 2001-02 and 2005-06, the overall hospital visit rate for children from birth to age 17 in Durham decreased 12 percent, whereas in Guilford County it increased 5 percent.

Finally, the repeated household survey conducted by Chapin Hall found significant reductions in parental stress and improvements in parental efficacy over time among randomly selected parents of young children in the Durham city neighborhoods as compared with residents in the project's matched comparison areas. These data, however, did not reveal any significant changes in parental self-reports of positive or potentially abusive interactions with their children, changes in observed acts of potential abuse in other families in the community, or any changes in resident interactions, collective efficacy, or neighborhood satisfaction. Trends were particularly unfavorable on these measures in the high-risk communities in which DFI provided outreach workers. It is not clear why anecdotal reports of favorable impact by outreach workers were not reflected in population surveys. It is possible that the workers' impact was limited to a small number of families and did not reach enough families to yield population change on the more direct measures of parent-child interactions.

Because the overall evaluation design was not a randomized trial, alternate explanations for the findings are possible. Unknown corresponding changes in community economics, demographics, or politics, rather than DFI, could be responsible for changes in child maltreatment over time. To further test the efficacy of its efforts, DFI will conduct a rigorous evaluation of Durham Connects, paying particular attention to the impacts of this program on subsequent child abuse reports among participants and on the degree of service integration, capacity, and quality within

the target community. As discussed later in this report, this effort will involve a randomized trial within Durham, with new mothers being assigned to the intervention or control group based on the baby's birth date. This trial will begin in 2009 and last several years.

Purpose of the Report

In order to understand the project's evolution and the decision-making process that led to Durham Connects, Chapin Hall staff conducted a comprehensive review of the initiative's annual reports, written summaries of various site visits and Advisory Board meetings, and completed a series of interviews with DFI staff and stakeholders. A list of these resources and those interviewed as part of this process is provided in Appendix A. In addition to these resources, Chapin Hall staff conducted additional analyses of the household survey data to help clarify when possible the potential impacts of a specific program strategy or operating hypothesis. The three goals for this report are:

- to critically assess the implementation levels achieved within DFI, including how data were used to make program decisions;
- to examine the current status of Durham Connects and note implementation challenges that require careful monitoring; and
- to identify any ways in which the DFI experience at its midpoint can inform the future efforts of funders and program planners.

The report begins by presenting the DFI theory of change. It then discusses the activities that have been central to DFI efforts over the life of the grant, including those activities DFI decided to suspend. The report ends with a summary of key implementation accomplishments and challenges.

DFI Theory of Change

DFI is based on the belief that child maltreatment occurs as a consequence of inadequate parenting, and that the parent-child relationship exists at the center of a set of concentric circles, each influencing the other (see Figure 1).³

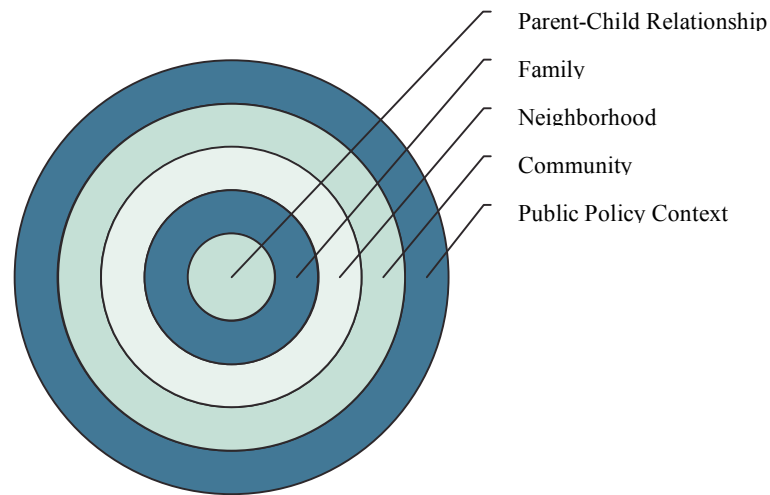
In its 2001 proposal to The Duke Endowment, DFI articulated its conceptualization of how child maltreatment occurs:

The theory holds that child abuse is a breakdown of the child-parent relationship that occurs in a context of risk in which (a) the family is not functioning in a healthy manner; (b) the local community does not provide sufficient support for families; and (c) the broader health care and legal systems similarly do not provide adequate support for families or community institutions serving families.⁴

³ “The Challenge of Community-Level Change in Preventing Child Maltreatment.” Presentation by Ken Dodge at the 21st Annual San Diego International Conference on Child and Family Maltreatment, January 25, 2007.

⁴ DFI Proposal to The Duke Endowment, 2001, p. 2.

Figure 1. DFI Ecological Framework



Based on this logic, DFI planned interventions that address these four risk domains: 1) the individual child and family, which has the most direct influence on maltreatment; 2) neighborhoods; 3) the community; and 4) government and legal policies, regulations, and systems.⁵ As the initiative matured, it articulated its logic model in slightly different ways, but remained consistent in its focus primarily on the community and policy contexts that influence the primary child-parent relationship. The initiative continues to address all four of these contexts through a “continuum of care” that intervenes at an individual child level all the way through state policy advocacy.⁶ In its 2007 Annual Report, DFI explained that maltreatment rates could be reduced if:

...1) community leaders could collaborate to enhance community resources for families at risk for maltreatment; 2) universal screening could identify factors in families that place them at risk for maltreatment; and 3) evidence-based professional services and informal

⁵ DFI Annual Report, 2002.

⁶ DFI Annual Report, 2004, p. 5.

paraprofessional and volunteer support could be delivered to families according to their identified needs.

One key theme in the DFI rationale is the identification of risk. As discussed below, clinical protocols were developed to learn more about which risk factors best predict maltreatment and to establish reliable methods for identifying families with those risk factors so that services could be efficiently allocated. However, DFI staff members recognized that even if they could identify every family that needed assistance, the program did not have the service capacity to meet the needs of a sufficient number of residents to affect population-level child abuse and neglect rates. This realization required the project to shift from offering individual services to facilitating greater efficiencies in how existing systems identify and meet the needs of all residents. As one respondent reported, DFI adopted a singular focus on an attempt to “identify families early, preventatively, and match them with community resources.” The move to Durham Connects embodies this revised philosophy and service-delivery approach.

Implementation of Core Activities

Over time, DFI has evolved from an initiative encompassing a wide range of activities, including direct clinical services to high-need families and diffuse community activities, to more structured research trials, and finally to universal screening of new parents. In this section, we highlight the strategies that were or continue to be central to DFI. Our assessment of these strategies is based on a review of the project's written material as well as our interviews with key stakeholders. This information was used to assess the degree to which each strategy was fully implemented, the range of decisions made regarding its ongoing scope and role within the initiative, and the specific challenges that emerged in implementing them.

Clinical Service Provision

During DFI's initial years, direct provision of clinical services through CCFH was a key component. DFI funding was used to expand clinical services to children and families already being served by CCFH and to create new services when a gap was identified. Numerous efforts were undertaken, including the following examples:

- Offering services to children with behavioral and family relationship problems identified through school-based clinics, preschools, childcare providers, the Children's Advocacy Center, and the Multiple Response System model (MRS) being implemented by the Department of Social Services to respond to a broader array of child maltreatment reports
- Expanding home-based Healthy Families services to increase capacity to reach new parents and to facilitate enrollment of families with older children
- Providing community based services through Part C of the Individuals with Disabilities Education Act (Infant-Toddler services)

- Implementing respite care services

Respondents explained that during those early years, there was minimal systematic planning or evaluation of how best to direct service resources; one respondent called it the “cast a wide net and see what sticks” phase. During that phase, CCFH was heavily involved. As the project evolved, CCFH’s involvement shifted away from direct service provision toward leadership and strategic guidance. Some respondents noted that CCFH’s involvement became more collaborative over the years, even while funding for service provision decreased.

Neighborhood Development

DFI developed neighborhood programming to address the relationship between neighborhood characteristics and population-level child abuse and neglect rates. It did so with three goals in mind: 1) to engage communities in assuming responsibility for child safety; 2) to develop neighborhood teams and strengthen community capacity to support families; and 3) to sustain reforms and services resulting in reduced child abuse and neglect.⁷ This strategy was phased out in 2006 in part because evaluation data showed no substantial improvement in child maltreatment reporting in the intervention communities.

In 2003, when the strategy became fully operational, DFI assigned two types of neighborhood development staff: Community Partners (CP) as direct community organizers and facilitators (i.e., Outreach Workers), and Family Partners (FP), who provided mental health and social services through CCFH. Six high-risk Durham neighborhoods were selected and then randomly assigned to either receiving community development staff or serving as a control group. One of the Community Partners’ first tasks was to develop Neighborhood Teams consisting of local residents and community stakeholders who were charged with responsibility for identifying community needs and working to find solutions in the three designated neighborhoods.⁸ Identified needs included improving safety, increasing employment opportunities, developing programming for children, and creating English as a Second Language classes. The Family Partners (CCFH mental health workers) met with individual families in their homes to identify needs and help families access resources. The Community Partners continued to build relationships with community residents throughout 2004, and increased the sustainability of their work by building partnerships with the Durham Housing Authority, Parks and Recreation

⁷ DFI Annual Report, 2003, p. 29.

⁸ DFI Annual Report, 2003

Department, local churches, universities, the Durham Police Department, health care professionals, and local businesses.⁹

Family Partners were hired and trained by the CCFH. These mental health professionals provided “short-term, intensive, community-based therapeutic services to families by circumventing traditional barriers to high-quality services.”¹⁰ Initially, the three Family Partners assigned to the project were to limit their caseloads to residents from the target communities. However, due to the low number of local area referrals, this component was reevaluated in 2004 and a decision was made to allow Family Partners to accept referrals from all areas in Durham.¹¹ After this point, it is unclear whether the Family Partners continued to play a role in the neighborhood-development strategy.

To assess the impacts of the community development workers, DFI conducted a Neighborhood Assessment survey in 2003 to gather information about the efforts of the development workers as well as to detect change over time in residents’ perception of neighborhood cohesion, utilization of resources, childcare support, safety, and parenting practices. In the 2004 Annual Report, DFI reported:

The survey revealed that child abuse is still a very low priority for most of the community, whereas issues of drugs, crime, economics, physical safety and dirty surroundings are more important. In order to get residents who are not perpetrating abuse or neglect involved in the effort to reduce abuse and neglect, we need to be somewhat responsive to issues of greatest concern to them.¹²

In 2005, the neighborhood staff decreased the time spent on neighborhood development activities by half and increased their focus on developing community spaces, promoting effective parenting, providing access to services, and increasing social networks for parents.¹³ As of 2006, the main role for Community Partners had shifted further to include a primary focus on providing information about accessing community resources to caregivers.¹⁴ Respondents during our site visit explained that Community Partners also worked to provide many opportunities for residents to take ownership of activities and build leadership skills. Residents were encouraged to develop

⁹ DFI Annual Report, 2004

¹⁰ DFI Annual Report, 2004

¹¹ DFI Annual Report, 2004

¹² DFI Annual Report, 2004

¹³ DFI Annual Report, 2005

¹⁴ DFI Annual Report, 2006

and implement strategies to improve their neighborhood, control resources coming into their neighborhood, and expand their social network.¹⁵

DFI analysis of the 2005 Neighborhood Assessment survey results revealed that...

... the only statistically significant change was that in 2005 respondents across both intervention and control neighborhoods reported seeing a smaller percent of neighbors disciplining their child in a negative way, by screaming and spanking (62 percent in 2003 vs. 47 percent in 2005). This finding is an indication of positive change in the whole of Durham County but does not support the efficacy of the neighborhood level intervention.¹⁶

The survey also measured the social cohesion of neighborhoods (i.e., whether residents felt close to one another, shared values, and helped each other), with results showing that social cohesion declined between 2003 and 2005 across both the intervention and control areas. Additionally, the DFI survey measured social control (i.e., whether residents would act to promote positive goals in their neighborhoods), and again there was a decrease for both intervention and comparison groups.¹⁷ At this point the decision was made to move away from the emphasis on neighborhood development.

Building on these findings, we conducted additional analyses using the cross-site household survey data to explore whether our data suggested similar trends. We found that social control and social cohesion, among other outcomes, showed declines in the three neighborhoods that received the most intense neighborhood development work. In fact, we found only a few positive trends in the intervention neighborhoods, including the following:

- In McDougald Terrace, respondents reported an increase from 2004 to 2007 in positive physical activities with their children (mean 3.68 to 4.05, $p=.09$), a sharp reduction in self-reported acts of physical or verbal assault (mean .65 to .37, $p=.01$), and a reduction in reports of observed acts of physical or verbal assault (mean 1.19 to .53, $p=.00$).
- In East End South, survey respondents reported that parental stress had decreased significantly from 2004 to 2007 (mean 2.14 to 1.75, $p=.01$).

In 2007, DFI's community work transitioned to *neighborhood social capital development*. The DFI 2007 report states, "...the DFI Neighborhood Social Capital Development intervention was designed to reduce maltreatment by partnering with communities to promote community

¹⁵ DFI Annual Report, 2006

¹⁷ DFI Annual Report, 2006

¹⁷ DFI Annual Report, 2006

cohesion and build sustainable community capacity.” Community Partners developed a Leadership Training Program, in partnership with the Durham Housing Authority, to train community members to act as informal leaders. The program consisted of weekly training sessions on how to start a Neighborhood Team, develop relationships with community members, access formal and informal support resources for others and support other leaders.

The Grandparent Network was also developed at this time to support the new Durham Connects initiative (discussed later in this report). The goal of the Grandparent Network is to pair volunteers aged 55 and older with mothers whose children are 0-6 years of age. Each mentor and mentee meet for 6 hours per month; additionally, each mentee also meets regularly with DFI staff for support, stress reduction, and information sharing. The 8-hour training consists of four classes covering child abuse and neglect, the Grandparent Network’s policy and procedures manual, safety issues, and principles of mentoring. Aside from the 8 hours of training, mentors are required to undergo a background check and to complete a pre- and post-program survey. During our most recent site visit (February 2009), respondents indicated the program has 28 mentors and 18 mentor-mentee matches that developed over the course of 1 year. Respondents explained that the primary challenge is maintaining mentees; there is a high mobility rate, often phones are disconnected, and sometimes mentees are simply unable to make the commitment to regular meetings with the mentors. Durham Connects is the sole referral source for the program.

During our site visit, one respondent noted that the neighborhood work established a new face in how the university interacts with local residents, countering some of the prevailing negative perceptions of Duke University. As a result, the decision to end the neighborhood work was somewhat controversial and viewed negatively by the public, particularly by those directly involved with the neighborhood development activities. Others noted, however, that an effort was made to transition the most involved community residents into other DFI components, particularly and most recently, Durham Connects. These individuals now help identify new mothers, assist nurses with visits when the family or nurse requests it, and locate referrals to the program so that visits can be provided in a timely manner.

Preventive System of Care

In its proposal to The Duke Endowment, DFI staff identified the failure of the overarching health care and legal systems to support families as a major barrier to enhancing outcomes: “Existing systems are unlikely to address problematic child-parent relationships and harmful parenting practices which do not meet the legal definition of child abuse.”¹⁸ DFI wanted to develop a

¹⁸ DFI proposal to The Duke Endowment, 2001, p. 5.

Preventive System of Care that built on the ideas framing the mental health System of Care approach in creating a system to prevent abuse and neglect. Such a system would be based on three core values: services would be child-centered and family-focused, neighborhood- and community-based, and culturally competent. DFI asserts that a Prevention System of Care would include three key components:

1. A broad and flexible array of services and supports (services should go beyond traditional interventions and include crisis outreach, home-based services, therapeutic family/foster care, family support and education, and respite)
2. Child and family teams (these teams, individualized to each family, are the “heart” of the preventive system of care)
3. Collaborative management, support, and accountability (including a Community Collaborative that promotes and sustains necessary collaboration at the practice, program, and system or policy levels).¹⁹

DFI brought together the directors of Durham County agencies, the Chief Court Counselor, the District Court judge, county government leaders, and the Superintendent of Schools for a meeting in July 2002; this was the first meeting of the Durham Directors Group. The group began meeting monthly and continues to meet to this day. Its mission is to develop policies and procedures that support the well-being of all children and families. In 2002, the group identified numerous long-term goals, including a shared data system, centralized intake process, unified needs assessment, setting priorities for local resources, and cross training of staff.²⁰ In 2004, the Durham Directors Group revised its goal to “coordinate human service delivery to help families help their children succeed in home, school, and community.” It also tasked the System of Care (SOC) group (previously called the High Flyer group), consisting of the operational managers at the various county agencies, with addressing the systemic issues identified by the Directors Group. By 2005, the Directors Group had accomplished several tasks, including signing a formal Memorandum of Agreement to use a system of care approach to delivering services to children and families and obtaining ongoing financial support for infrastructure (e.g., staff training and information technology).

The Directors Group and SOC Council continue to meet, although DFI staff are less directly involved since the departure of the key staff person responsible for this effort, Adele Spitz-Roth. There was consensus among respondents interviewed during our most recent site visit that the

¹⁹ DFI Annual Report, 2002, p. 4.

²⁰ DFI Annual Report, 2002, p. 25.

SOC work DFI started does continue, and that it has changed the way in which public agencies work together and serve families. Respondents universally agreed that DFI staff directly involved in this effort made an important difference to its success; as one respondent asserted, “[they] helped us all come together, roll up our sleeves, and break down the silos and work together.” Given that this effort is one of the few DFI activities that targeted the entire county service system, as opposed to specific neighborhoods or individuals enrolled in specific interventions, the strategy might well account for the dramatic drop in child abuse reporting rates, the degree to which abused children were revictimized, and the drop in hospitalizations related to conditions suggestive of maltreatment. Indeed, at least one respondent mentioned the SOC work being done in Durham as one potential contributor to these reductions.

Clinical Trials

The key component of DFI’s second phase was the initiation of several clinical research trials, designed to improve knowledge regarding the use of screening measures to detect risk; the efficacy of home visitation services; strategies to prevent re-reports of child maltreatment; expanding social support for high-risk families; and testing new prevention activities within the Latina community.

Screening for High Risk of Child Maltreatment

DFI asserts that identifying parents at risk for abusing or neglecting their children is an important component of any community prevention strategy. DFI staff believed that there are gaps in scientific knowledge about specific risk and protective factors. To address these gaps, the team designed and implemented a specific protocol (the Prenatal Psychosocial Screening Study) with pregnant women served at two prenatal clinics in Durham: the Duke University Medical Center Maternal Fetal Medicine (High Risk) Obstetrics clinic, and the Durham County Public Health Department’s Lincoln Community Health Center (Baby Love). The idea was to gather basic epidemiological data on risk factors during pregnancy for all women who were screened, as well as link screening data with birth records and subsequent maltreatment reports for women who consented to that portion of the study. The study began in November 2005 and recruitment began in February 2006. At the Duke University clinic, 67 percent of women screened agreed to participate in the research component (linking screening data to birth and child welfare data); at the Baby Love clinic, 26 percent of women consented.²¹ When asked about the reasons for such a low recruitment rate, respondents did not have any concrete hypotheses. DFI hoped to work with

²¹ Final Prenatal Screen Report, May 2008, provided by DFI staff to Chapin Hall staff.

all OB providers in the county to implement the screening instrument, but it is not clear that any other settings adopted the methodology.

Another screening project that DFI was initially involved in was Project MOM, led by Dr. Lisa Berlin. This protocol involved a one-hour psychosocial screen administered to 499 pregnant women. A follow-up phone interview was conducted when the child was 15–18 months old and data were linked with birth records and child abuse and neglect reports. The goal was to conduct a community study of risk factors leading to maltreatment, and respondents explained that it helped inform subsequent screening efforts developed as part of Durham Connects.

Respondents explained that both of these efforts involved collaborative work with the health department, which was seen as helpful as DFI shifted toward Durham Connects. Additionally, respondents noted that the results of both screening trials will be used to inform the field about how best to identify pregnant women who are at higher risk for maltreatment.

Healthy Families Durham

In 2005, DFI decided to implement a clinical trial to test three different models of delivering home visitation services to see whether some families might benefit from something other than the traditional, 3-year model being offered through the Healthy Families Durham program. As one respondent explained, "...we wanted to do primary prevention but with a high-risk sample, we wanted to test the optimal duration of Healthy Families, and we wanted to test modifications to the Healthy Families content and procedures." DFI began a randomization trial that assigned high-risk parents recruited to one of four groups: 1) 36-month version of Healthy Families, 2) 18-month version of Healthy Families, 3) standard maternity care coordination (representing existing local services), or 4) a yearly visit. Families are followed until the target child turns 3 years old and assessments are completed at the child's birth, 6 months, 2 years, and 3 years of age. The randomization process is now complete and 343 women were recruited into the study.

Respondents expect data collection to be completed in 2012.

Recruitment for this study took much longer than anticipated. Respondents gave two reasons for the slow recruitment. They cited reluctance on the part of referral sources because of the random-assignment process (e.g., providers fear that families might not get anything other than a yearly check-in). Additionally, the primary referral source was the Baby Love program at the health department where nurses were already recruiting women into numerous other studies and programs. Some respondents believe that recruitment for Healthy Families got "put on the back-burner" as a result. Respondents hope that results from this trial will add to the evidence-based options for home visitation programs, with particular focus on the shorter duration of services (18 months instead of 36 months).

Parent-Child Support Program (Family Interventions to Prevent Re-Reports of Maltreatment)

In response to the high level of re-reports among Durham County's child welfare caseload, DFI created a research protocol to examine three different interventions for child welfare cases where the child either remained in the home or had been temporarily placed with a relative. The goal of the intervention was to prevent re-reports to DSS. Families with children from birth to 6 years old were targeted and assigned to one of the following three interventions:

1. Promoting Early Relationships intervention, created by DFI, a 16-week intervention that focuses on parents' emotional regulation and responding to children's behavioral cues, modified from the Circle of Security intervention.
2. Parent-Child Interaction Therapy (PCIT), a 16-session intervention with live-coached sessions with parent/child dyads that focuses on coaching in specific parenting skills as the parent interacts with the child
3. Child Health and Safety program, a 16-week intervention focusing on treating physical illness, maximizing healthcare skills, home safety, and improving the child-parent relationship²²

Families were assessed at enrollment, right after the intervention ended, and at 4 months post-intervention. The goal was to recruit 48 families with children aged birth to 2 ½ years and 192 families with children aged 2 ½ to 6 years. A total of 124 families were recruited to participate; 53 in the young age group and 71 in the older group.

This trial suffered from two primary obstacles: recruitment and program completion. Respondents explain that Department of Social Services (DSS) workers, who were responsible for referring families, simply did not refer many families. One respondent said that she thought there was great collaboration with DSS administrators but less direct partnership with front-line workers who were being asked to refer families. The second barrier was parent completion of the program. In the 2006 Annual Report, DSS case closure was cited as a key contributor to parents leaving the intervention. DFI speculated that if DSS had continued with a case until the parent completed the intervention, program adherence rates would increase.²³ DFI revised its recruitment goals and ended enrollment in December 2007.

²² DFI Annual Report, 2005, p. 15.

²³ DFI Annual Reports, 2006 and 2007.

Social Support Intervention

According to the 2004 Annual Report, DFI planned to implement the Social Support Building Intervention research project to measure the impact on maltreatment rates of encouraging social networks among neighborhood residents, an activity engaged in by DFI staff working directly in selected communities. The Social Support Intervention (SSI) had two components:

1. Universal component: “brief conversation to expand participants’ use of additional sources of support and to provide reinforcement and normalize help giving and receiving”
2. Targeted component: “up to three discussions with an interviewer about specific ways to develop and enhance participants’ social support networks”²⁴

Families with a child 1 to 3 years old were identified in nine neighborhoods that had high maltreatment rates. Identification was to occur via birth record data and door-to-door canvassing.²⁵ There were three research groups: one receiving neighborhood development activities and the full SSI research assessments, one receiving no neighborhood development activities but receiving the SSI research assessments,²⁶ and one that received only the Social Support Assessment (SSA) designed to measure the support families gave and received. The goal was to assess 810 families using the SSA, implement the universal component with 540 families, and deliver the targeted intervention with 180 families. The pilot test occurred in early 2005 and the intervention and trial research began in July 2005.

DFI planned, from the start, to use initial data results to make decisions about continuing the SSI. In the 2006 report, DFI states that “a significant problem was encountered in finding families,” and therefore stopped implementation. The SSI protocol engaged 162 families, with most expressing a need for more tangible support (money, food) rather than social support.²⁷

CoMadres

Project CoMadres was a research program designed to provide an alternative to home visitation for low-income English and Spanish speaking Latina expectant mothers. The intervention was an

²⁴ DFI Annual Report, 2005, p. 11 (no page numbers in document)

²⁵ DFI Annual Report, 2004, p. 23.

²⁶ The SSA was used to measure the amount of support families both gave and received. The SSI Tracking Log (SSI-TL) was used to monitor while new social support resources families used as a result of the targeted component discussion sessions. From the 2006 DFI Annual Report, p. 9.

²⁷ DFI Annual Report, 2006, p.3.

educational support group for women, beginning in their third trimester of pregnancy until their infants reached 3 months of age.²⁸ The project was pilot tested in 2005 and 2006 and received positive feedback, but was found to be more effective with Latina mothers than African American mothers. Ninety-one Latina mothers were recruited and divided into six groups, with three groups receiving the intervention and the other three serving as controls. These trials ran from 2006 to 2007. According to respondents, the program objectives were to increase social supports, increase knowledge about baby development and community resources, and reinforce the healthy attachment between a mother and her child, thereby reducing negative attributions toward the child.

The project was designed with a universal approach, to reach mothers at risk regardless of age, Medicaid status, or number of pregnancies. The intention was for the program to provide less-expensive and more culturally responsive programming that would not only help reduce the incidence of child abuse, but also provide the opportunity for making connections with other mothers. Pre- and post-natal tests were administered to assess the effectiveness of the intervention at modifying correlates to child abuse prevention.²⁹ Results indicate that the intervention group improved parenting cognitions and knowledge and use of community resources, but showed no improvement in social support.³⁰

The CoMadres program was suspended after the research trial concluded. However, during our site visit, respondents noted that there was a possibility of providing an adapted version of the program as part of Durham Connects. The main challenge with this idea is that the CoMadres curriculum was primarily prenatal, and Durham Connects is a postnatal program. Respondents also noted that there are logistical challenges related to transportation and childcare that would affect implementation. It is unclear whether these issues affected initial implementation or if so, how they might be resolved as the program goes forward.

State Policy Development

DFI was committed to affecting public policy from the beginning of its implementation. As stated in the 2003 Annual Report, “DFI’s success will stem not only from the ability to decrease the number of reports of abuse and neglect but also from the capacity to recognize, develop, and

²⁸ DFI Annual Report, 2006, p.9

²⁹ DFI Annual Report, September 2007

³⁰ Flint, Roxanne C. “Immediate Impacts of the CoMADRES Child Maltreatment Prevention Trial.” Unpublished empirical paper, Duke University, November 30, 2007.

document policy changes at the local, state, and national level that affect the lives of Durham’s children.” DFI outlined goals for the policy component in the 2005 Annual Report, which were:

- Improve and increase the number of customer-service guidelines at federal, state, local, and private levels that support families’ access to services
- Increase funding for prevention and early intervention services
- Increase collaboration among child-serving agencies
- Increase use of policies at federal, state, local, and private levels that improve parenting³¹

Throughout the initiative, DFI engaged in numerous activities to achieve these goals. Beginning in 2003, DFI worked with the North Carolina Child Advocacy Institute, Prevent Child Abuse North Carolina (PCA-NC), and several child abuse prevention organizations to develop alternate measures of child abuse and neglect. These partnerships led to several statewide initiatives, including the following examples:

- North Carolina Institute of Medicine Task Force on Child Abuse Prevention, to examine better ways to prevent child abuse and neglect
- Meetings with the Maternal and Child Health Branch of the North Carolina Division of Public Health, to identify strategies to improve the detection of risk factors and the provision of direct prevention services in order to prevent child maltreatment in children 0–3 years
- PCA-NC’s Gaining Ground Initiative to develop a document that outlined funds available and expended for child abuse prevention in North Carolina

DFI has also been involved in drafting three pieces of legislation. The first piece, SB 622/HB 719 Section 6.24, requires the use of Child and Family Teams and the principles of System of Care in schools to address children at risk for academic failure. The second, SB 622/HB 719 Section 10.25, continues the requirement that System of Care principles, values, and practices are used in public agencies serving children at risk for out-of-home placement. The last, SB 216/HB222, establishes a Study Commission to eliminate barriers to collaboration between and among child-serving agencies.³² In addition to the above accomplishments, the North Carolina Division of Social Services requested that DFI evaluate their Multiple Response System (MRS) and the federal Children’s Bureau grant to implement the System of Care in the child welfare system. These evaluations resulted in a change in reporting classifications to more directly reflect the

³¹ DFI Annual Report, 2005, p. 17.

³² DFI Annual Report, 2005, 2006

practice and outcomes associated with the child welfare staff's involvement with families and additional funding to support the hiring of additional child welfare workers in MRS counties.³³

Durham Connects

Durham Connects was initiated in 2008 with the goal of delivering a home visit to every family with a new birth for purposes of screening the family for risks and linking them with needed community resources. The name was chosen because of the emphasis on connections; as explained in the 2007 Annual Report, "Nurses will connect with every family so that families can connect with community resources with the goal of helping parents connect with their babies."³⁴ A key decision made early in the planning phase was to contract with the Durham County Public Health Department to provide nurses, supervisory staff, and some computer support. Home visits began in July 2008 and program modifications are ongoing based on negotiations between DFI and health department staff as well as feedback from nurses, evaluators, and the DFI Advisory Board. A randomized trial to gauge the impact of the program on population-level maltreatment rates began in July 2009.

Program Structure

Approximately 90 percent of all new births in Durham occur at Duke University Hospital or Durham Regional Hospital.³⁵ The process for scheduling home visits was modified as of July 1, 2009. Previously, the 10 nurses, whose assignments were divided by geographic area, were given a list of new births each week. The nurse then called the family to set up an appointment for the home visit. As of July 1, DFI staff members are going to the hospitals and attempting to engage families there by explaining the program and scheduling the home visit. The family is then sent a postcard reminder about the visit, and the nurse assigned to the case calls the family a few days prior to the visit. During the visit, the nurse examines the baby and interviews the mother. The interview focuses on 12 risk factors across four domains and uses a matrix developed collaboratively between the health department, DFI researchers, and CCFH clinicians. Topics include physical health issues, parenting, domestic violence, social support, material needs (food, clothing, etc.), substance use, depression, family planning, and breastfeeding. A copy of the risk assessment tool is included in Appendix B. If the nurse discovers any service needs, referrals are

³³ DFI Annual Report 2005

³⁴ DFI Annual Report, 2007, p. 1.

³⁵ The other 10 percent of births occur primarily at University of North Carolina Medical Center or Wake Medical Center.

made to appropriate community resources. DFI expects that in about 20 percent of cases, the nurse will need to make a follow-up visit with the family due to concerns about domestic violence, depression, or other issues.

Another recent change to the program's structure is how information is entered into the database. Nurses have now been given "tablet" laptops and will use these during the visit to enter the risk factor information and complete the information necessary to make referrals. After the visit, the nurse finishes entering any remaining data and sends a letter to the baby's pediatrician summarizing the visit noting any issues that arose as well as those requiring follow-up.

If nurses are unable to locate a family, they turn to the Office of Community Resources, directed by Jeanine Sato and staffed by three outreach workers (former neighborhood development workers), a part-time interpreter, and the Durham Connects data manager. The outreach workers attempt to locate the families in the community or determine why there is no response. As of February 2009, out of 56 families that the nurses could not find, 32 were found by OCR staff, 4 were determined to have aged out of the program (baby was already too old by the time the family was located), 5 had moved out of the county, 5 refused, and 10 could not be located.³⁶ Respondents agree that OCR staff do an excellent job finding families that the nurses are unable to locate.

Several modifications to the program have occurred since the planning phases and the program continues to evolve as issues are raised and resolved. A few issues related to the structure of the program are still being addressed, including the following:

- **Evening and weekend visits:** The health department has been reluctant to allow nurses to conduct home visits after regular business hours. Respondents cite various reasons for this, including concerns about overtime pay, nurse safety, nurse burnout, and the more rigid regulations of the health department, which generally does not require (or allow) its nursing staff to work beyond the traditional work day. Respondents note, however, that the Durham Connect nurses need greater flexibility in order to accommodate the schedule of families who are not available during the regular work day.
- **Tension between the conversational nature of the interview and the need for accurate data collection:** Respondents explained that the nurses felt strongly about not using a laptop during the interview and conducting the assessment as a conversation rather than a structured questionnaire. Although several respondents said they appreciate this concern, they noted that the strategy presents potential challenges in accurate recall of the appropriate questions to ask

³⁶ "OCR Referrals" spreadsheet, provided to Chapin Hall by DFI staff, February 2009.

as well as documenting answers. According to the revised Durham Connects plan, nurses will now conduct the clinical interview, covering all 12 factors in the four domains, as well as the physical exam of the baby, then stop and enter the risk data into a laptop. The nurse also will use this break to generate a plan for any referrals. The nurse will then talk again with the mother, going over any referrals and scheduling any future visits as necessary.³⁷

- **Number of attempts to locate and engage families:** Respondents assert that there is a cultural divide between the health department and DFI researchers regarding how many attempts should be made to locate and engage a family in order to complete a visit. Researchers are motivated to obtain a very high completion rate in order to maximize the statistical power of their analyses and insure the representativeness of their data. On the other hand, health department staff, though highly motivated to help families, are very conscious of typical health department protocols regarding attempts (e.g., three letters sent to encourage compliance with a requirement after which benefits and services are terminated) as well as practical time constraints.
- **Adherence to the interview protocol:** There is some anxiety over the consistency of the home visit interviews. Some respondents worry that because a nurse's education and experience focus primarily on medical and health issues, she may be less willing or able to explore issues of family relationships, mental health, and parenting. A new quality assurance plan has been devised that includes three components: audiotaping interviews for review by a CCFH staff person, independent rater agreement checks conducted on a random sample of interviews, and a 1-month post-visit follow-up phone call with each family to explore service referrals.³⁸
- **Visit timing:** Originally, DFI planned for the home visit to occur at 4 weeks postpartum to coincide with the highest-risk timeframe for postpartum depression. This has been extended to 12 weeks postpartum primarily because of the difficulty in collecting birth data from the hospitals and the length of time it takes nurses to schedule and conduct the visits. Several respondents expressed concern about the impact of conducting an interview so long after a baby's birth. It will be difficult to ascertain whether the timing has any effect on the outcomes of the program, but this shift will need to be considered when interpreting results.

³⁷ "Updates for Advisory Board-DC Plan" document, May 1, 2009.

³⁸ "Updates for Advisory Board-DC Plan" document, May 1, 2009.

Administrative Structure

The decision to contract with the health department for the nurses was a key early step in designing Durham Connects. It creates a unique partnership between DFI researchers, who designed the program and its evaluation—and also control the funding—and health department personnel, who staff the program. The key overlap is in program design and decision making, and nurse supervision.

To address these issues in an integrated manner, the Durham Connects leadership team meets weekly on Monday mornings and makes all of the program’s strategic decisions. This group includes Ken Dodge, Christina Christopoulos, Karen Appleyard, Jeanine Sato, Robert Murphy, and Karen O’Donnell.³⁹ Another leadership team meets on Thursdays and includes the above members, minus Ken Dodge, as well as the nurses, Helen Wright (nurse supervisor at the health department), Sue Guptill (Durham Health Department Director of Nursing), and Jan Williams from CCFH. One respondent explained, “Most of the high-level decisions with respect to program content and operating procedures are made at these Thursday meetings.” Respondents agree that these meetings are critical to the program. As one respondent said, “The meetings are useful because a good deal of training happens, it is an open forum for discussing issues (including data issues), and the nurses get continuing education credit for attending.” During our site visit, respondents explained that Ken Dodge plans to begin attending the Thursday meetings once a month to ensure decisions are made in a timely manner and to be more involved in the frontline operation of Durham Connects.

The Office of Community Resources (OCR) was created specifically to support Durham Connects, and all respondents agree it has been an extremely critical contributor to the program’s development and acceptance by the community. OCR creates marketing materials for the program; networks in the community to increase awareness and support; develops partnerships with hospitals and obstetric and pediatric practices; develops and updates the database of community resources that nurses use to make referrals; assists nurses with finding families or identifying resources for unique needs; manages the Cribs-for-Kids program; facilitates a Community Advisory Board and a Leadership Council; and utilizes numerous social marketing strategies to increase awareness (e.g., visible public launch of Durham Connects, monthly column in local newspaper, blog contributions, attending various community events and classes). Respondents believe the OCR is a crucial piece of Durham Connects and expect it to continue

³⁹ An additional monthly meeting has been added that includes the Interim Director of the Durham County Health Department, Gail Harris, and Due Guptill, Ken Dodge, Robert Murphy, and Karen O’Donnell to ensure timely communication with health department leadership.

throughout the life of the program. One respondent noted that the OCR is “doing everything to make the program work and is work that the health department would not be very good at doing.”

The administrative structure of Durham Connects has faced some challenges, including the following:

- **Cultural differences between DFI and the health department:** This issue was raised by virtually every respondent interviewed during our recent site visit, and is one that needs close monitoring as the program evolves. DFI and CCFH staff are primarily researchers and therefore have scientific research tenets at the forefront when making programmatic decisions. Additionally, DFI and CCFH staff have strong backgrounds in family dynamics, child-parent relationships, and mental health. On the other hand, the health department personnel have a strong focus on medical and health practice, as well as experience working within the constraints of government-funded programs with their accompanying rules and policies. As a result, the team involved with Durham Connects has differing viewpoints and priorities, and it has been a challenge to find common ground on some issues. We propose conducting a focus group with nurses and interviews with key program supervisors (e.g., Helen Wright, Karen O’Donnell, Karen Appleyard) to monitor how these conflicts are being resolved during our site visit in the fall of 2009.
- **Nurse supervision:** This component has been challenging, but new ideas to address it continuously emerge. Two CCFH staff members, Jan Williams and Karen O’Donnell, provide clinical supervision to nurses. Helen Wright at the health department is the nurses’ employment supervisor. In the early months of the initiative, respondents explained that there was confusion among nurses regarding who to ask for assistance or guidance, as there is some overlap between CCFH and health department supervisors. Additionally, because Durham Connects is designed to address numerous domains affecting families, and the education and backgrounds of the various supervisors differ (medical/public health versus psychological/family and child development), there is some concern among respondents that nurses may not receive appropriate supervision if supervision is left to only CCFH personnel or only to health department personnel.
- **Individuals involved are important to program success:** Respondents agree that it has been critical to have Sue Guptill from the health department involved in designing Durham Connects, and agree that without her vision and drive to make the program a success within the health department, it would not have been viable. Concern was expressed about a new health department director and the effect on the program in the long run. As personnel shifts occur, the effects on program implementation should be monitored.

Community Engagement and Service Provision

Durham Connects aims to connect families with necessary services and supports to ensure that needs are being met, and consequently, risk for maltreatment is reduced. Respondents agree that the community at large has been supportive of the program, as have county agency directors and government leaders. OCR staff, in addition to other Durham Connects personnel, have spent significant time publicizing the program to the general public as well as to specific stakeholders. A few respondents asserted that the previous System of Care work DFI engaged in was crucial in creating an environment where county decision makers were open to the idea of Durham Connects.⁴⁰ Additionally, DFI staff have developed programs to fill in some of the gaps in community resources identified by the nurses, including the Cribs-for-Kids program (to provide cribs to families who cannot afford one) and the Grandparent Network (discussed in a prior section).

However, concerns were expressed by some respondents about the collaborative spirit of Durham Connects and the ability of service providers to meet the needs of families referred. These issues are highlighted below.

- **Engagement with middle- and upper-income families:** The primary refusals for Durham Connects have come from middle- and upper-income mothers who say they do not need the service, that they have enough support, or are turned off by the idea of a visit from a public health nurse. OCR is working to identify marketing strategies for this population. Recent changes to Durham Connects include DFI staff members visiting new parents while they are still in the hospital after the birth and scheduling the home visit; one respondent expressed the hope that this strategy will be more effective with middle- and upper-income women.
- **Lack of collaboration:** Some respondents expressed a concern that although DFI must necessarily collaborate with the health department for Durham Connects, minimal work was done to make Durham Connects a program that fits into the broader array of services already available to Durham residents. Numerous other organizations and agencies serve families with young children, and some respondents questioned whether DFI personnel were interested in making Durham Connects a part of this continuum of care for families. The medical community was mentioned in particular as one sector that should naturally be more engaged but is not meaningfully involved in the program. Respondents suggest this is an area that needs to be addressed for Durham Connects to successfully engage both the highest- and lowest-risk ends of the new parent continuum.

⁴⁰ We propose exploring the importance of the SOC work in creating favorable conditions for Durham Connects during 2009–2010.

- **Service capacity and uptake:** There is some concern that organizations and agencies will not be able to absorb the increased demand from families, and respondents believe that DFI leadership is unwilling to plan for this possibility. This worry is countered by those who note that nurses are not making many referrals to community services other than those directly related to health concerns. An additional concern is that when referrals are made and providers have the capacity to serve families, families may not always take advantage of these resources without more consistent efforts of the Durham Connects staff to educate them on the benefits of ongoing support. Another recent change in the Durham Connects program is the addition of a “post-visit connection,” which is a phone call made by DFI staff to each family approximately 1 month after the home visit. During this call, families are asked about how the visit went, whether referrals were made by the nurse and if those have been completed, and any new needs that might have arisen. DFI staff members then encourage families to follow through with referrals and attempt to problem solve if new issues have arisen.

Evaluation Design

DFI has structured Durham Connects as a randomized trial in order to understand its impacts. Originally, random assignment was to be done by geographic unit—Durham was divided into 12 units, with 6 receiving Durham Connects and 6 acting as control communities until July 2010. DFI recently restructured the random assignment process and is now assigning new mothers based on the baby’s birth date.⁴¹ The plan was to start this randomization on July 1, 2009, and continue through December 31, 2010, resulting in 3,000 intervention and 3,000 control births. DFI staff hopes this new plan addresses many of the concerns expressed by Advisory Board members but remain palatable to the health department. A few respondents expressed frustration with the random assignment process because they believed it may limit medical providers’ willingness to discuss the program with their patients, but this is a concern faced in most random assignment studies. The primary outcome indicator for the full sample will be subsequent reports for child maltreatment.

A second component of the evaluation will be the follow-up assessment with a sample of 200 intervention families and 200 comparison families. These families will be interviewed at 6 months after the baby’s birth, and interviewers will explore the 12 domains of risk, the parent-infant relationship, child development, and community services received.

The Advisory Board and DFI staff have been engaged in fine-tuning the proposed evaluation plans for the project. Additionally, Chapin Hall has proposed conducting research work around

⁴¹ Full discussion of these changes is in the “Updates for Advisory Board-DC Plan” document, May 1, 2009.

issues not currently covered in the DFI evaluation plan or ones that would more appropriately be conducted by a third party. These include:

- **Referral process, service capacity, and family uptake:** A critical component of whether Durham Connects will have an impact on child maltreatment rates will be the actual provision of needed services. Several factors affect this, including family needs, whether nurses are making appropriate referrals, providers' capacity to meet demand, and family follow-through with the referral and subsequent intervention plan. One way we propose evaluating these issues is to conduct interviews with service providers and focus groups with families to better understand how the program is actually working in the field and fitting in with the existing continuum of preventive services.
- **Relationship with the System of Care:** Respondents assert that the work DFI engaged in to foster a System of Care in Durham County laid the foundation for the community's willingness to embrace Durham Connects. We propose exploring this relationship as one way to understand the successes and challenges in implementing Durham Connects.

Sustainability

A key question for Durham Connects is its sustainability in the Durham community once The Duke Endowment funding is discontinued. One respondent said that housing the program in the health department will hopefully improve the odds that continuation funding will be secured. We asked almost every individual we interviewed about plans for sustaining the program, and no one had any concrete ideas about how to find funding to continue Durham Connects. A few respondents said that they hoped the county would "find the money" to continue it and a few respondents commented that it would be much easier to find funding if the evaluation shows positive results. Additionally, at least one person commented that if you stripped away the money spent on administration and research, Durham Connects would be much less expensive and it might be more realistic to find that amount of money from public or private sources. One respondent noted that if DFI is successful in making the program "universally desired" by all Durham County residents, then it will naturally become sustainable.

Summary of Implementation Accomplishments and Challenges

Examining the evolutionary process the initiative has traveled provides a learning opportunity for DFI staff and stakeholders, as well as the broader field of program planners, funders, and researchers. DFI has modified activities and strategies over time while remaining consistent in its goal to reduce the population rates of child abuse and neglect by half over the 10-year period covered by The Duke Endowment funding. It began with direct services to high-risk children and families and diffuse efforts to improve social capital in various neighborhoods. It then shifted to more rigorous clinical trials in order to better understand how to identify and serve families considered high risk. At this point, DFI is focusing on a universal effort to identify families with risk factors and connect them with appropriate community resources. Throughout this process of change, the DFI leadership team has used evaluation data, as well as careful reflection, to make programmatic decisions. DFI has been willing to recognize when a strategy is not making an impact and alter its implementation plan accordingly, in part because of the unique flexibility and long-term commitment of The Duke Endowment. Several themes have emerged regarding DFI's implementation that may be useful to others attempting to implement, fund, or evaluate comprehensive community prevention programs, as summarized below.

- The Duke Endowment allowed DFI great latitude in designing and modifying its program components over the years. This flexibility provided DFI staff the time to explore different ideas, collect and analyze quantitative and qualitative data on various strategies, and collaboratively make decisions about beginning and ending interventions. Large initiatives are not normally given such flexibility in making program modifications midstream, and it appears that DFI used this flexibility to make thoughtful and data-driven decisions about program components. Several respondents cited this flexibility as a key component to DFI's

ability to make evidence-informed decisions and to craft the type of comprehensive and innovative strategy represented by Durham Connects.

- The Center for Children and Family Policy (CCFP) and Center for Child and Family Health (CCFH) brought scientific rigor to the evaluation of DFI, and continue to be guided by the desire to conduct interventions in ways that can be accurately measured and analyzed in order to understand impacts. The Duke Endowment's generosity in investing in both knowledge development and practice provided the resources necessary to insure that the effort would be informed by a consistent, high-quality research agenda.
- DFI has and will continue to contribute knowledge in the child abuse prevention field as a result of its clinical trials and careful documentation of efforts. The project's clinical trials addressed a number of critical issues facing the field such as better identifying those risk factors related to subsequent maltreatment of young children and clarifying the appropriate duration for home visitation programs. Unfortunately, recruitment and program completion in some of the trials proved problematic, a reality that in the end may limit the utility and generalizability of the findings. These types of implementation issues are not unique to DFI; they represent challenges for all those engaged in field research. As the Durham Connects research unfolds, however, it will be particularly important for the project to carefully monitor subject enrollment and retention if the results of this trial are to maximize the lessons for those seeking to implement comparable community-wide reform efforts.
- DFI successfully encouraged collaboration among Durham County's public agencies through development of its preventive System of Care. Virtually all of the stakeholders whom we interviewed offered consistent praise for this effort and for its ability to build a more integrated and responsive public service system. However, many stakeholders expressed concern that the development of Durham Connects has not reflected the same level of commitment to collaborative planning or recognized the existing efforts underway within the county's early intervention and prevention fields. Although the relationship with the county health department has improved, Durham Connects continues to face notable implementation challenges in integrating its program philosophy into the health department's operational culture. Durham Connects is still very early in its development and implementation, and respondents agree that modifications are occurring on a daily basis to address many of these challenges. Ensuring that Durham Connects unfolds in a manner consistent with and supportive of Durham County's preventive system of care will be important not only for children and families, but also for the program's sustainability.

References

Daro, D., Huang, L.A., English, B. (2008). The Duke Endowment Child Abuse Prevention Initiative: Mid-Point Assessment. Chicago: Chapin Hall at the University of Chicago.

Flint, R. (2007). Immediate impacts of the CoMADRES child maltreatment prevention trial. Unpublished manuscript. Duke University.

Appendix A: Resources Used for this Report

Written Materials

- DFI Proposal and Annual Reports to The Duke Endowment, 2001 through 2007
- Various written materials including research reports, presentations, publicity materials, etc.
- Chapin Hall's written notes, reports, and correspondence about DFI
- Advisory Board summary notes

Site Visit Interview Respondents (February 2009 Visit)

- Jeannine Sato, Director, Office of Community Resources, CCFP
- Karen O'Donnell, Psychologist, CCFH
- Sue Guptill, Director of Nursing, Durham Public Health Department
- Katie Rosenbalm, Senior Researcher, CCFP
- Ellen Reckhow, Supervisor, Durham County Commissioners
- Karen Appleyard, Durham Connects Evaluation Director, CCFP
- Mary Nahm, Durham Connects Evaluation Project Manager, CCFP
- Robert Murphy, Director, CCFH
- Claudia Ruiz, Latino Outreach Worker, CCFP
- Lisa Berlin, Research Scientist, CCFP

- Jan Williams, Director, Healthy Families, CCFH
- Clarine Hyman, Outreach Worker, CCFP
- Nicole Lawrence, Research Coordinator, CCFP
- Annie Jones, Outreach Worker, CCFP
- Marsha Basloe, Executive Director, Durham Partnership for Children
- Helen Wright, Nursing Supervisor, Durham Connects, Public Health Department
- Adele Spitz-Roth, Former DFI Deputy Director
- Christina Christopoulos, Research Scientist, CCFP
- Ken Dodge, Director, CCFP and DFI

Appendix B: Risk Assessment Protocol

Mother's Initials: _____

Date: _____

	SUPPORT FOR HEALTH CARE			SUPPORT FOR CARING FOR INFANT		
	Maternal health	Infant health	Health care plans	Child care plans: 24/7, emergency, & respite	Parent-child relationship	Management of infant crying
GOAL	<i>Mother is recovering from delivery and is in good health, able to care for infant.</i>	<i>Infant born at or near term and is in good health.</i>	<i>Primary health care for infant is planned and scheduled.</i>	<i>Parent(s) has reliable child care plan, including emergencies and respite..</i>	<i>Parent and infant are growing into a sensitive and responsive relationship.</i>	<i>Parent describes infant crying as normal and has planned response. Copes with infant crying.</i>
Status good, no further intervention needed.	1- Mother is recovering as expected with few concerns.	1- Infant health good, as expected.	1- PCP identified, first visit completed, next visit scheduled.	1- Parent identifies care for each day, emergencies, and planned respite.	1-Parent seems to understand infant's needs and is responsive to infant signals. Talks to baby.	1- Parent sees infant crying as normal and responds. May find cry difficult but can cope.
Mild concerns that are resolved by discussion and/or resources.	2- Mother has minor health issues, but not expected to affect parenting. Advice and/or resources given, including family planning.	2- Minor infant health concerns (e.g., pre-term, postnatal condition). Advice given and/or plan developed during visit. CSC as needed.	2- Initial uncertainty about medical home or regular care. Plan developed and in place at conclusion.	2- Care plan for 3 areas not in place, but adequate plan developed during visit or resources suggested.	2- Parent sometimes not understanding infant cues and is perplexed or frustrated. Provide support and resources.	2- Parent is concerned about crying and needs reassurance and coping plan, provided in visit.
Concerns that require follow up visit and/or referral.	3- Mother's health presents a concern for infant and family. Follow up with visit and referral, if needed.	3- Infant health concerns. Requires follow up visit with link to PCP and CSC, if qualified.	3- Uncertainty about medical home, need, or plan. Follow up to ensure link is made.	3- Care plan for all three areas not in place, even following discussion. Follow up.	3- Parent not aware of need or unable to be responsive to infant signals. Follow up with visit or referral.	3- Parent is unable to cope with crying without external intervention. Follow up with visit or referral.
Serious concerns. Immediate intervention taken.	4- Mother's health presents immediate risk for infant. Help mother to health care or help change temporary custody.	4- Infant has serious health or developmental problems requiring immediate intervention.	4- Failure to provide for primary care. Need immediate intervention.	4- Emergency child care problem. Call DSS.	4- Parent at risk of neglect or harm. Call DSS.	4- Crying is out of control for parent. Call DSS and/or other emergency intervention.
	SUPPORT FOR A SAFE HOME			SUPPORT FOR PARENT(S)		
	Household/material supports	Safety	History with parenting difficulties	Parent emotional well being	Substance Abuse	Parent emotional support
GOAL	<i>Family has financial resources sufficient for basic needs.</i>	<i>Family experiences safety and security at home.</i>	<i>No risk factors for violence or neglect currently active.</i>	<i>Parent(s) mental health adequate for meeting parenting demands.</i>	<i>Parent and family show no drug using/ seeking in household.</i>	<i>Parent has emotional, practical, and social support for parenting.</i>
Status good, no further intervention needed.	1. Financial resources adequate for food, shelter, and transport. Medicaid, MCC, or public supports possible. Baby has crib.	1. No concerns about family violence. Parent and infant feel safe.	1. No known prior history of maltreatment as a child or parenting difficulties in family or with other children.	1. Parent mental health is sound. No anxiety or depression.	1. Parent denies use now or in past and interviewer has no reason for concern.	1. Parent names other person(s) who provide emotional, practical, and social support for parenting.
Mild concerns that are resolved by discussion and/or resources.	2. Financial resources limited or under-utilized. Plans and/or resources suggested during visit.	2. Mild concerns. Issues discussed and information about emergency services left in home.	2. Parent has history of maltreatment as a child and/or DSS involvement as adult, but reports good resolution and plans.	2. Parent mental health within normal limits but some concern is expressed and resolved during visit. Resources suggested.	2. Possible past history but current use is denied. Resolved through discussion and/or suggested resources.	2. Parent initially lacking in support from others but develops plan for seeking support during visit.
Concerns that require follow up visit and/or referral.	3. Financial resources inadequate and/or not utilized. Follow up and/or refer for support.	3. Concerns about safety in the home. Follow up and/or refer.	3. Recent DSS involvement and/or ongoing concerns. Follow up.	3. Parent screens positive for anxiety or depression. Follow up and/or refer.	3. Substance use is a concern. Follow up and/or bring to referral.	3. Parent lacking in support. Follow up and/or refer.
Serious concern. Immediate intervention taken.	4. Family's financial status is urgent. Immediately contact DSS field worker.	4. Serious immediate concerns about safety. Call police or DSS.	4. Ongoing DSS investigation is active. Contact DSS.	4. Urgent need for mental health intervention for parent. Contact DSS.	4. Substance abuse a major issue. Contact DSS.	4. Parent very isolated. Re-visit within 48 hours.

Family name _____ Date of home visit _____ This is home visit # _____

Mother's or father's name _____ Baby's name _____ Infant birthday _____

DRAFT: TO BE INTEGRATED INTO HEALTH FORMS ALREADY IN USE

Who was at home for the home visit? (check one)

Mother Father/partner

Other children Other family member(s) _____

How long did the HV last (approximately) (enter no. minutes) _____

General impressions of infant well being and family capacity (please circle one)

1- Family doing well, will send report to PCP, no further follow up.	2- Family doing well with mild concerns in 1 or 2 areas. Will follow up by report to PCP.	3- There are some concerns in some areas (scored or not). Follow up.	4. Major concerns. Follow up.	COMMENTS
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Summary and plan of action

<i>Domain and factor</i>	<i>Services currently received by family.</i>	<i>Follow up HV, time and dates scheduled</i>	<i>Referrals to (date contacts)</i>	<i>Transition plan (all HV have summary to PCP)</i>
Mother health				
Infant health				
Health care plan				
Parent-child relationship				
Child Care Plans				
Management of Infant crying				
Household and material supports				
Safety				
History with parenting difficulties				
Parent(s) emotional well being				
Parent emotional support				
Substance abuse				

Consent for copy to Medical Home _____ yes _____ no

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Deborah Daro
Lee Ann Huang
Brianna English

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Chapin Hall
at the University of Chicago
1313 East 60th Street
Chicago, IL 60637

773-753-5900 (phone)
773-753-5940 (fax)

www.chapinhall.org

1313 East 60th Street **T: 773.256.5100** **www.chapinhall.org**
Chicago, IL 60637 **F: 773.753.5940**