Child Abuse & Neglect 35 (2011) 633–636

Contents lists available at ScienceDirect

Child Abuse & Neglect

Practical Strategies

Bridging research and practice: Challenges and successes in implementing evidence-based preventive intervention strategies for child maltreatment☆

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ARTICLE INFO

Article history:
Received 28 April 2011
Received in revised form 3 May 2011
Accepted 3 May 2011
Available online 19 August 2011

Keywords:
Child maltreatment
Evidence-based interventions
Policy implications

ABSTRACT

Child maltreatment has been associated with a wide range of negative developmental outcomes for children and families as well as significant economic consequences. While efficacious intervention strategies have been demonstrated to reduce symptoms of trauma and to improve behavioral and emotional functioning, these models have not been widely adopted by clinicians. The challenges associated with exporting evidence-based interventions into community settings are discussed, along with an example of a preventive intervention program for young mothers, successfully implemented through a partnership of community agencies and funders.

> "Science is focused on *what we do not know*. Social policy and the delivery of health and human services are focused on *what we should do*." (p. 182, Shonkoff, 2000).
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> "The gap between what we know and what we do is lethal." (Jamison, 1999).

Child maltreatment represents one of the most potent examples of the failure of the caregiving environment to provide opportunities for promoting healthy child development (Cicchetti & Toth, 2005; Widom, Kahn, Kaplow, Sepulveda-Kozakowski, & Wilson, 2007). In 2007, the estimated annual cost of child abuse and neglect in the United States was 103.8 billion, including both expenditures associated with the immediate needs of children, and those related to the long-term or secondary effects of abuse and neglect (Wang & Holton, 2007). Child maltreatment affects not only socioemotional development, but also research on the adverse consequences to psychophysiological and neurobiological development is mounting (Watts-English, Fortson, Gibler, Hooper, & DeBellis, 2006), highlighting the long-term health consequences and increased morbidity associated with child abuse and neglect (Brown et al., 2009). Despite these mental and physical health burdens for maltreated victims, too few empirically supported interventions are readily available for these traumatized children and their caregivers.

A myriad of reasons may be contributing to limited effective and accessible prevention and treatment models. It is only relatively recently that basic research and clinical practice have begun to be more consistently integrated (Renninger & Sigel, 2006). As crystallized in the opening quotation, Shonkoff (2000) highlighted a formidable challenge to the translation of research into clinical and social policy arenas: fundamental differences in where prevention research and service delivery are located on the action cycle of service innovation. It is not surprising that, when confronted with an immediate and life-altering decision, research that is not easily accessible (i.e., not readily available, not presented succinctly and in plain

☆ Funding from the Administration on Children and Families Children's Bureau also supported this work. We are grateful for the funding by the National Institutes of Health for several of our RCTs.

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doi:10.1016/j.chiabu.2011.05.003

language, implications and practical strategies under-articulated) is not maximized in its usefulness to the clinician or policy advocate.

Design issues that typically accompany randomized control trials (RCTs) of intervention also may be contributing to the impediments of incorporating evidence-based models into our services for preventing and treating child abuse and neglect. Historically, RCTs have had very clear, and often quite narrow, inclusion criteria for individuals enrolled in studies. So, for example, a treatment for depression might exclude a child who had a co-morbid anxiety disorder. Extrapolating from these studies into the child maltreatment world immediately poses an array of research-based decisions that could eventuate in therapists finding an empirically supported treatment of questionable value for their practice. For example, limiting inclusion in a clinical trial to a single subtype of maltreatment is potentially problematic as we know that the majority of maltreated children experience multiple forms of maltreatment (Manly, Kim, Rogosch, & Cicchetti, 2001). Moreover, children who have been maltreated are more likely to reside in homes with domestic violence and in high crime and violent communities. Thus, unless RCTs are sufficiently broad in their recruitment of participants to allow for the inclusion of individuals who are likely to be the norm of patients referred for treatment, clinicians are likely to remain wary of utilizing evidence-based models. To engage the "real world" maltreatment client effectively, sufficient resources need to be available to the research to support the challenges in recruiting and retaining a population that is routinely confronted with multiple problems. In short, there is a need for increased research investment in studies that represent the complexities in the lives of maltreated children and their families.

For many specific populations, such as homeless or suicidal youth, there may be few or no well-established evidence-based approaches available. Moreover, far too few evidence-based models of treatment have been developed with racially and ethnically diverse groups (Huey & Polo, 2008). In a recent editorial in the *Journal of Consulting and Clinical Psychology*, Art Nezu, the then incoming editor, noted that between 2006 and 2008 only 4% (13 of 328) of articles published in the journal focused on diverse populations (Nezu, 2011). Diversity was broadly defined not only to include race, so these statistics are particularly startling. Consequently, clinicians may feel ill equipped to evaluate existing research evidence to determine which approaches are appropriate for the children in their practice. Given that many clinicians are expected to address a wide range of child and family needs, they may not be able to learn numerous evidence-based intervention approaches for treating the multiple and complex diagnostic presentations of their clientele. Research direction, then, on narrowing the "learning list" and the provision of support that is sensitive to client demographics is imperative if the exportation of evidence-based treatments is to be facilitated.

Finally, even when policy advocates and service providers want to embrace evidence-based models, logistical obstacles may be at best, daunting, and at worst, prohibitive. Unless funding is available to support training, and unless staff members are provided with time to master a new evidence-based model, the adoption of such interventions is very difficult. Simply completing an on-line course or attending a workshop does not provide sufficient expertise for implementation of an evidence-based model. Moreover, once training has been provided, the provision of ongoing supervision is necessary. Within the context of maltreatment, issues are typically complex (e.g., with multiple and sometimes competing needs among family members for developmental or psychological assessments, substance abuse and mental health treatment, training in parenting, anger management, and social skills, and out-of-home placement decisions). Productivity demands for clinicians often result in high caseloads and expectations for reduced frequency of client contact that are incompatible with the parameters of evidence-based models. Weekly hour-long sessions that are utilized in many evidence-based approaches may be unattainable for clinicians with caseloads above 30 or 40. Unless reasonable caseloads and adequate support are present, staff turnover also threatens the capacity of systems to continue the provision of evidence-based models.

Given impediments such as these, one might conclude that the challenges associated with the translation of evidence-based models for child maltreatment into real world settings are nearly insurmountable. However, dissemination is possible when mutual respect and a spirit of collaboration are nurtured, and the investment in partnership is made for the long-term. In conjunction with the Monroe County Department of Human Services and the United Way of Greater Rochester, a program directed toward the prevention of child abuse and neglect was launched in 2007. This initiative, Building Healthy Children (BHC), reflects a culmination of decades of discussions and the development of trust among Mt. Hope Family Center (MHFC), a university-based organization, community service providers (University of Rochester, Departments of Pediatrics and Social Work; Society for the Protection and Care of Children), and government and private funding sources. A number of components of this collaborative endeavor are noteworthy. First, child welfare administrators and county and private funders had a clear commitment to the utilization of evidence-based models of treatment. Second, there was recognition that a period of time was necessary for the provision of adequate training and for the importance of supporting ongoing clinical supervision and monitoring of treatment fidelity. Finally, there was a willingness of funders and community partners to support random assignment to BHC or treatment as usual, and to fund the research evaluation component.

BHC is directed toward impoverished mothers who had their first child prior to age 21, and who had not yet been reported for maltreating their child. Despite these rather broad recruitment criteria, this population has emerged as a very high risk group of mothers, with 35% having indicated Child Protective Service reports for maltreatment as a child. BHC consists of a tiered-model of services that range from outreach and educational/employment training, to the provision of evidence-based models such as Child-Parent Psychotherapy (Cicchetti, Rogosch, & Toth, 2006; Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002; Lieberman, Van Horn, & Ghosh Ippen, 2005, 2006; Toth, Rogosch, Manly, & Cicchetti, 2006), Interpersonal Psychotherapy for Depression for the Mothers (Mufson, Dorta, Moreau, & Weissman, 2004; Weissman, Markowitz, & Klerman, 2000), Incredible Years Parenting Skills training (Reid, Webster-Stratton, & Baydar, 2004; Webster-Stratton & Reid, 2010), and Par-