List of Questions
Based on Responses to Mark Chaffin's Commentary:
"Is it time to Rethink Healthy Families/Healthy Start?

Instructions to SLAC: While this document is simply an FYI, it is also intended to encourage you to think about the recent dialog on the scientific evidence for home visitation and what it means for you in advancing your efforts to prevent child abuse and neglect. Each of the questions below is based on ***responses*** to Mark Chaffin's commentary: *Is it time to rethink Healthy Families/Healthy Start?* Response letters were published in the March 2005 issue (Vol. 29, #3) of Child Abuse & Neglect: The International Journal. The original commentary by Chaffin was published in the same journal in Volume 28, Issue 6, pages 589-595 (June 2004). Each question includes a brief annotation to provide you with a convenient summary of the point made by Mark Chaffin in his commentary[i].

The first three questions were adapted from the editorial by John Leventhal[ii], Editor-in-Chief of Child Abuse & Neglect: The International Journal. In his editorial, Dr. Leventhal takes stock of prevention efforts, and suggests that it is important to go beyond maintaining the status quo and focus on at least three issues: (1) strengthening current practices, (2) identifying and testing new approaches, and (3) increasing the involvement of the federal government.

1. **What can Healthy Families America (HFA) do to strengthen current practices?**

   Annotation: Dr. Leventhal suggests, for example, can paraprofessional models of home visiting be strengthened by increasing the level of mental health supervision? Or should programs rely on a team approach in which home visits are conducted by a paraprofessional paired with a social worker or nurse? On a related note, he brings to bear the issues of which families are being served and the family's duration of involvement in the program. He asks, should a program not attempt to serve the very highest risk families? For example, should services be offered to "mentally retarded" mothers? And would it be helpful to provide more home visits or incentives for families at critical times?

2. **What are some innovative approaches to prevention within HFA but also beyond?**

   Annotation: Dr. Leventhal provides brief descriptions of two innovative approaches to prevention, specifically, Project Safe Care (a home-based parent training program funded by the CDC in Oklahoma) and Gary Melton and colleagues' community-based approach, "Strong Communities," in South Carolina.

3. **What can HFA do to influence the federal government to support prevention?**

   Annotation: Dr. Leventhal's question is: "When will the federal government in the United States support prevention? And when will it develop a national policy regarding the funding of child abuse prevention and provide substantial long-term funding to support both research on prevention and the widespread implementation of prevention programs?"[iii] Dr. Leventhal notes that most funding of ongoing programs comes from state or local governments or foundations. He thinks it is unlikely that the prevention of abuse and neglect will become part of every community without substantial federal funding. He emphasizes this point by providing the example of how polio has been prevented: "The prevention of poliomyelitis and other childhood infectious illnesses did not come about because local researchers and local programs did good work in their regions, received funding from local sources, and published their findings in reputable journals. Rather prevention came about because of research programs funded by the federal government, the development of national policies, and federal funding of immunization programs. It is now time for the federal government to join the local programs and do its part."[iv]

4. **How do we conduct randomized control trials on HFA's efforts when core funding decisions are linked to the production of positive evaluation results rather than serious self-criticism in the service of continuous improvement?[v] Should programs consider downsizing if necessary in order to provide adequate resources for innovation combined with rigorous testing?[vi]**

   Annotation: The first question here is actually one that we at Prevent Child Abuse America raised in our response to Mark Chaffin's original commentary about rethinking Healthy Families. The second question is one that Mark Chaffin raises (I suspect as an answer to us) in his response to all the letters that followed on the heel of his original commentary.

5. **Will the prevention field "invest in explaining away unwelcome findings, blaming the messenger, disseminating talking points and engaging in damage control, or will it follow the data and use prevention organizations and implementation systems to fix the problems"[vii]? What is the road map to this end?**

   Annotation: The first question is Chaffin's, which he thinks is the most important question asked in his commentary. The second question is mine.

6. **Should HFA continue to market itself as a child abuse and neglect prevention program even if there is an absence of sufficient experimental evidence to validate the effort? Is this a mistake? Is it more accurate to market the program as one that enhances maternal and child health?**

   Annotation: Chaffin responds to a major conceptual point raised in the response letters he received, specifically, that child maltreatment is the wrong outcome for judging program effectiveness. He refutes this point by bringing to bear that the selection of child maltreatment outcomes as the benchmark for judging the effectiveness of perinatal home visiting was not his choice, nor that of evaluation researchers. Rather he points out that it was the choice made by the programs themselves. "Programs such as Healthy Families have self-identified and marketed themselves to policy makers, legislators, communities, and professionals primarily as child maltreatment prevention programs, even if they have not presented themselves that way to consumers."[viii] Chaffin states, "I have advocated for years that this is a mistake and that the programs are more accurately characterized as maternal and child health enhancement programs, and should market and fund themselves accordingly."[ix] Finalizing his point, he adds, "Nonetheless, if the programs advertise themselves as child abuse prevention, and are funded with child abuse prevention monies, then that is how they should be evaluated."[x]

7. **If HFA had performed well (i.e., prevented child abuse and neglect) in randomized trials but poorly in other designs, would prevention advocates still be objecting to the primacy of RCTs?[xi]**

   Annotation: In his commentary, Chaffin counters objections raised against randomized trials. He points out that the problem in the child abuse and neglect prevention field is that we have not relied on randomized controlled trials (RCTs) enough or that we have ignored their findings. He explains that we have "pursued research questions about quality control, retention, client satisfaction, program nuance, implementation, possible mechanisms of effect, program theory and so forth, despite 25 years of RCT findings suggesting that the majority of perinatal home visiting prevention programs do not prevent child abuse."[xii] He reminds readers that "if you want to know whether or not a program achieves its intended bottom-line outcome, the fact remains that randomized trials are the fairest and most accurate way of doing so."[xiii] He supports his statement by citing the US Office of Management and Budget's recommendations for program evaluation, which state that "well-designed and implemented RCTs (randomized controlled trials) are considered the gold standard for evaluating an intervention's effectiveness across many diverse fields of human inquiry…"[xiv] He adds that of all the respondents to his original commentary, it is only Dr. Olds that endorses the primacy of randomized trials and that he is the only developer whose model has randomized trial support, "while prevention advocates without randomized trial support are unanimous in their advocacy for other types of

evidence."[xv] Thus, he asks if circumstances were reversed, and Healthy Families had performed well in RCTs, would we still be objecting to the primacy of RCTs?[xvi]

8. **If child abuse and neglect prevention effects are indirect and are mediated by things that take time to develop, then what does the promise of possible 4-15 year indirect benefits offer to a family that is on the verge of being reported to child welfare next week or to a family that is experiencing domestic violence or struggling with a drug addiction?[xvii]**

   Annotation: Chaffin addresses the appeal and limitations of developmentally accruing benefits. Specifically, he comments that "One of the most intriguing aspects of the Elmira trial (NFP study), was the finding that maltreatment prevention effects, which were small or absent during children's early lives, did emerge later on."[xviii] He concludes that such maltreatment prevention effects are indirect and are mediated by things that take time to develop (e.g., fewer and more spaced pregnancies, better jobs, etc.). However, he thinks the length of time involved in the emergence of these developmentally accruing effects, and their indirect nature should give us some pause because program elements that may be sufficient in one domain (e.g., indirect, mediated, long-term, life-course developmental effects), may not be sufficient in others (e.g., prevention of more imminent maltreatment or management of very high-risk situations). A second reason he thinks we should be careful about the appeal of developmentally accruing benefits is captured in question #9 below.

9. **From a cost-benefits standpoint, how much are we willing to spend on prevention today for the promise of a return several years in the future?[xix]**
   Annotation: The annotation for question #8 applies here as well.

10. **If the issue of quality control and implementation is no longer plausible, then is it a mistake to continue to assume that child abuse and neglect can be reliably prevented by providing home visitation services?[xx]**

    Annotation: Chaffin notes that the total effectiveness of any program is a function of both the intervention model, and the quality with which it is implemented. When null findings occur, he thinks that it is reasonable and important to ask if it was the model or the implementation. He adds that this is particularly important in field trials where service quality is not tightly controlled. He suggests that one way the implementation question can be answered is to examine trials where implementation quality was very high. He then notes that Duggan's Hawaii trial and Landsverk's Sand Diego trials, respectively, were exemplary implementations of the Healthy Families model but still yielded null findings. Thus, he suggests that at some point, "emphasizing quality control and implementation as the issue is no longer plausible, and we must raise questions about the assumption that child abuse can be reliably prevented by providing home health services and social support to pregnant women."[xxi] He believes this point has been reached.

11. **Do we want home visitation programs not so much for what they produce, but mostly just for what they are?[xxii]**

    Annotation: In her response to Chaffin's original commentary, Dr. Deborah Daro had pointed out that home visitation programs are good because they reflect and encourage broad social and cultural commitment to caring for and valuing our families and children, and are important for their intangible cultural benefits regardless of any specific measurable client outcomes they produce. Chaffin thinks this is a valid point but questions whether it is sufficient to want the programs not for what they produce but for what they are.

12. **If measuring surveillance related reports directly is not difficult to do, then why aren't they a consistent measured variable in evaluations?[xxiii]**
    Annotation: Chaffin counters the objection made in the response letters he received that surveillance bias masks true program effects. He thinks this is an "almost reflexive objection offered whenever child maltreatment programs fail to yield their intended outcome."[xxiv] He

thinks that this is an empirical question that can be tested scientifically and he demonstrates this by describing how he and his colleagues have routinely measured surveillance reports in their evaluations and consistently have found the unique influence of program surveillance reports on overall child welfare report outcomes to be small. Thus, he argues that there is little direct evidence that null findings on child welfare report outcomes can be attributed to surveillance. He suggests that if researchers are concerned that surveillance bias may produce erroneous results in evaluation, then the researchers should adopt "the fairly simple and straight forward practice of measuring surveillance related reports directly."[xxv] He adds that it is not difficult to do and thus, "surveillance reports should be a measured variable in evaluations, not held as a caveat or an all-purpose excuse against the possibility of null findings." [xxvi]

13. **If "the solution to the maltreatment measurement problem is not turning to questionable inferential or proxy measures, but rather to collect multi-method data on the direct outcome of interest, such as collecting a combination of child welfare report data, out-of-home placement data, and self report data on maltreating behavior,"[xxvii] then why is this not being done more often in evaluations? What needs to happen to make the collection of multi-method data on the direct outcome of interest common practice?**

    Annotation: Chaffin notes that one of the points made in the response letters he received was that child welfare reports are imperfect outcome measures. Yet, he counters that some of the "proxy" alternatives to child welfare report data suggested in the response letters, are far worse when it comes to under-estimating maltreatment rates. For example, he argues that hospital admissions, emergency room visits, or injuries may underestimate maltreatment as much as or more than child welfare reports and that these proxies are an incomplete and misleading measure of maltreatment. He argues they are just the wrong measure. He's skeptical of "proxy" or inferential measures, especially when "programs fail on the hard bottom-line measure and succeed only on the proxy, inferential, or indirect measure."[xxviii] He suggests that the solution to the maltreatment measurement problem is to collect multi-method data on the direct outcome of interest, such as collecting a combination of child welfare report data, out-of-home placement data, and self-report data on maltreating behavior.

---

[i] See Chaffin, M. (2005). Response to letters. *Child Abuse & Neglect, 29*, 241-249.
[ii] See Leventhal, J. (2005). Editorial: Getting prevention right: maintaining the status quo is not an option. *Child Abuse & Neglect, 29*, 209-213.
[iii] Leventhal, 2005, p. 212.
[iv] Leventhal, 2005, p. 212.
[v] See Oshana, D. et al. (2005, p. 226). Rethinking healthy families: A continuous responsibility. *Child Abuse & Neglect, 29*, 219-228.
[vi] Chaffin, 2005, p. 247.
[vii] Chaffin, 2005, p. 248.
[viii] Chaffin, 2005, p. 244.
[ix] Chaffin, 2005, p. 244.
[x] Chaffin, 2005, p. 244.
[xi] Based on Chaffin, 2005, p. 242.
[xii] Chaffin, 2005, p. 241.
[xiii] Chaffin, 2005, p. 241.
[xiv] US Office of Management and Budget, 2004, p. 4, as cited in Chaffin, 2005, p. 241.
[xv] Chaffin, 2005, p. 242.
[xvi] See Chaffin, 2005, p. 242.
[xvii] Based on Chaffin, 2005, p. 247.
[xviii] Chaffin, 2005, p. 247.
[xix] Chaffin, 2005, p. 247.
[xx] Based on Chaffin, 2005, p. 244.
[xxi] Chaffin, 2005, p. 244.
[xxii] Based on Chaffin, 2005, p. 244.
[xxiii] Based on Chaffin, 2005, p. 245.
[xxiv] Chaffin, 2005, p. 245.
[xxv] Chaffin, 2005, p. 245.
[xxvi] Chaffin, 2005, p. 245.
[xxvii] Chaffin, 2005, p. 245.
[xxviii] Chaffin, 2005, p. 245.