BUILDING ONE STRONG ‘OHANA:
PROMOTING DATA-INFORMED POLICY ADVOCACY IN A STATEWIDE
COALITION DEDICATED TO THE PREVENTION OF
CHILD ABUSE AND NEGLECT

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Abstract

Child abuse and neglect is a pervasive problem that can have long-term consequences on mental and physical health. Preventive interventions can be successful in preventing child abuse and neglect, particularly when they take into account individual, family, and community level factors. Policies aimed at strengthening families can also help to prevent child abuse and neglect and promote well-being. There is an abundance of research on the prevalence of child maltreatment, the benefits of prevention, and the effectiveness of specific interventions. Policy change efforts are hampered, however, because much of this research is not available to practitioners and policymakers in easily readable formats.

This study takes an action research approach to examine the effects of knowledge translation activities on policy change efforts, in collaboration with the Hawai‘i Children’s Trust Fund (HCTF) Coalition. The study included four steps: (1) conduct a preliminary assessment of policy goals and data needs of HCTF coalition members, (2) meet with Coalition members to determine visions and associated policy goals, and obtain further feedback on information needs, (3) engage in knowledge translation activities including the development of data products and an online data repository, and (4) meet again with Coalition members to refine policy goals and identify assets that can aid in the achievement of these goals.

The results of these activities indicated that most Coalition members believe that data and research is important in practice and policy decisions, but do not have access to all of the data they wish to use, and that specific knowledge translation activities may help to close the gap between actual and desired use of data in
program planning and policy change efforts. This study addresses a gap in the literature regarding the implementation and efficacy of knowledge translation interventions, and provides one model for how such an intervention can be integrated with policy advocacy activities in a coalition setting.
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Introduction

Community programs aimed at preventing child abuse and neglect (CAN) recognize that individual and family behavior are best understood in their community and cultural contexts (Daro & Dodge, 2009). Child and adult behavior can be considered in terms of the ecological-transactional framework, which posits that development is a dynamic process in which individuals influence each other and engage in a mutually influential relationship with their environments (Belsky, 1980; Coulton, Crampton, Irwin, Spilsbury, & Korbin, 2007). Therefore, child maltreatment and its consequences are best considered in light of this framework, taking into account influences at multiple ecological levels.

Prevention programs may be directed at preventing recidivism among those who have already engaged in maltreatment (tertiary prevention), targeted toward high-risk groups (secondary prevention), or universally applied to the general public (primary prevention). Though tertiary prevention programs are necessary, primary and secondary prevention programs are preferable because of the difficulty of identifying abuse and neglect, the stigma associated with it, and the high propensity of those who have committed maltreatment to continue doing so (Appleyard, Berlin, Rosanbalm, & Dodge, 2011; Valentino, Nuttall, Comas, Borkowski, & Akai, 2012).

Prevention programs with multiple components, many of which operate at multiple ecological levels including community levels, are among those that have demonstrated success in reducing child maltreatment (Daro & Dodge, 2009; Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009; Reynolds, Mathieson, & Topitzes, 2009). For example, the Triple-P program includes both a universal media-based
component and more intensive components for work with higher-risk families (Prinz et al., 2009; Reynolds et al., 2009).

Increasingly, prevention programs have adopted strengths-based approaches, which focus on protective factors that can help to prevent CAN, as well as widening the scope of efforts to go beyond prevention in emphasizing the overall well-being of children. The Strengthening Families Initiative outlines several protective factors, such as social support and knowledge of child development that can reduce the likelihood of CAN occurring (Center for Study of Social Policy [CSSP], 2004; Counts et al, 2010; Daro & Dodge, 2009).

 Adoption of the protective factors framework for preventing CAN has occurred throughout the mainland U.S. (Counts et al., 2010; Ross & Vandivere, 2009), and is now being promoted in Hawai‘i by the Hawai‘i Children’s Trust Fund (HCTF). Recently, HCTF embarked on a public awareness campaign, called One Strong ‘Ohana, whose aim is to increase awareness that child abuse and neglect can be prevented, and that there are specific protective factors that can help to decrease the likelihood that child abuse and neglect will occur. Launched in 2012, the One Strong ‘Ohana campaign has been well received by many members of the HCTF Coalition, which includes nonprofit organizations, government agencies, other entities, and concerned citizens throughout the state of Hawai‘i. In the initial envisioning of the One Strong ‘Ohana campaign, the public awareness activities would be supplemented in later years with a coalition focus on promoting policies that could help to strengthen families and prevent CAN.

 Policies devised to support the strengthening of families can help to promote healthy development and improve child well-being (Nelson & Mann, 2011).
However, policy advocacy and implementation of evidence-based practices are hampered because research related to child maltreatment prevention is not available in easily readable formats to policy advocates and service providers (Toth & Manly, 2011). The importance of knowledge translation is being increasingly recognized, and there are many existing models for how research knowledge can be translated into practice and policy (Mitton, Adair, McKenzie, Patten, & Perry, 2007). The CDC’s Knowledge-to-Action Framework is a dynamic model of knowledge translation that includes research, translation, and institutionalization (Wilson et al., 2011). 

Adopting the Knowledge-to-Action Framework, this project includes both research and translation phases, with an emphasis on dissemination of information that has been identified by HCTF Coalition members as being crucial in accomplishing policy advocacy goals related to the prevention of CAN in Hawai‘i.

This study seeks to answer the question of how the dissemination of information can influence policy planning and advocacy by a statewide coalition. In particular this project aims to directly assist the HCTF Coalition in identifying and advocating for policies that can help in the prevention of CAN. This aim will be achieved through the following steps:

- Step 1: Conduct a preliminary assessment of information needs and policy goals of HCTF Coalition members;
- Step 2: Lead individual and group activities dedicated to helping HCTF Coalition members envision and generate policy goals, and gathering additional information on research and data needs;
- Step 3: Design and disseminate data products that will help to close the gap between desired and actual use of data;
• Step 4: Lead group activities in which HCTF Coalition members clearly define their policy goals, plan their next policy action steps, and identify assets that can help them to achieve their policy goals.
Chapter 1: Background and Literature Review

The problematic nature of child abuse and neglect (CAN), also referred to as child maltreatment\(^1\), and the importance of its prevention are self-evident; yet the scope of the problem and the extent of its consequences can still be astonishing. In 2012, over 1500 children in the U.S. died due to maltreatment (U.S. Department of Health and Human Services [USDHHS], 2013a). Each year, approximately 3.3 million reports of child abuse affecting over 6 million children are made, and approximately one quarter of these cases are substantiated. The actual number of children experiencing CAN is assumed to be far higher, with most cases going unreported (Heim, Shugart, Craighead, & Nemeroff, 2010). Given the magnitude of CAN it is helpful to understand the following: 1) what is considered CAN, 2) the consequences associated with CAN, 3) the different factors that contribute to CAN, and 4) the programs and policies that have been most helpful in reducing CAN.

Definitions and Types of Child Maltreatment

Child maltreatment does not have a uniform definition. The Child Abuse Prevention and Treatment Act (CAPTA) of 2010 defined child maltreatment as:

- Any recent act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, sexual abuse, or exploitation;

\(^1\) The terms “child abuse and neglect” and “child maltreatment” will be used interchangeably throughout this paper.
• An act or failure to act that presents an imminent risk of serious harm.

This is the legal minimum definition of CAN necessitating government intervention. Each state then further defines how they will assess child maltreatment, and child protective service agencies determine their responses in light of these state definitions. Since these definitions require government intervention, they may be narrower than definitions of CAN that are adopted by others engaged in prevention efforts.

Public health agencies and other organizations seeking to prevent CAN often adopt broader definitions, which allow them to identify and prevent maltreatment that may not present an imminent threat, but may still have long-term negative consequences. The Centers for Disease Control and Prevention (CDC) defines child maltreatment as “Any act or series of acts of commission or omission by a parent or other caregiver (e.g., clergy, coach, teacher) that results in harm, potential for harm, or threat of harm to a child” (Leeb, Paulozzi, Melanson, Simon & Arias, 2008, p. 11). An act of commission, or child abuse, is further defined as any act that causes harm, potential harm, or threat of harm. There are three main types of child abuse: physical abuse, psychological abuse, and sexual abuse. An act of omission, or child neglect, is a failure to provide for a child’s basic needs, or to protect them from harm or potential harm. According to the CDC, child neglect can be divided into two types: failure to provide and failure to supervise. Though acts of commission (and specifically, physical abuse) may be the most common paragon of child maltreatment, there are many other forms of abuse and neglect (Table 1).
Table 1: Types and sub-types of child abuse and neglect

<table>
<thead>
<tr>
<th>Type</th>
<th>Sub-types /examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse</td>
<td>Physical acts - Hitting, kicking, punching, beating, throwing, pulling, stabbing, shaking, burning, poisoning</td>
</tr>
<tr>
<td>Psychological abuse</td>
<td>Terrorizing – making a child feel unsafe</td>
</tr>
<tr>
<td></td>
<td>Isolating – preventing or minimizing contact with others</td>
</tr>
<tr>
<td></td>
<td>Spurning – belittling or degrading, singling out, public humiliation</td>
</tr>
<tr>
<td></td>
<td>Exploitation – parentification, encouraging criminality or alcohol abuse</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>Sexual act – genital on genital, mouth on genital</td>
</tr>
<tr>
<td></td>
<td>Abusive sexual contact – touching genitalia, anus, buttocks, breast, inner thigh, groin, without penetration</td>
</tr>
<tr>
<td></td>
<td>Non-contact sexual abuse – exposure, filming, sexual harassment, sex trafficking</td>
</tr>
<tr>
<td>Failure to provide</td>
<td>Physical neglect – inadequate nutrition, hygiene, shelter, or clothing</td>
</tr>
<tr>
<td></td>
<td>Emotional neglect – denying emotional responsiveness or access to necessary mental health care</td>
</tr>
<tr>
<td></td>
<td>Medical/dental neglect – failure to seek needed medical attention or provide medications</td>
</tr>
<tr>
<td></td>
<td>Educational neglect – failure to enroll child in school, allowing child to miss more than 25 days of school in a year without excuse</td>
</tr>
<tr>
<td>Failure to supervise</td>
<td>Inadequate supervision – failure to use safety devices, to protect child from unnecessary hazards, to provide substitute caregiving, or to protect child from abuse from others</td>
</tr>
<tr>
<td></td>
<td>Exposure to violent environments – selling drugs out of the home, allowing a student to be victimized by others</td>
</tr>
</tbody>
</table>

Adapted from Leeb et al. (2008) “Child maltreatment surveillance: Uniform definitions for public health and recommended data elements” and Baker et al. (2011) “Psychological maltreatment”
Consequences of Child Maltreatment

Different types of CAN frequently co-occur, and all types of maltreatment are associated with both short-term and long-term negative consequences. These include short-term health problems that directly result from abuse or neglect, such as injuries from physical abuse or diseases stemming from neglect (Lanier, Johnson-Reid, Stalschmidt, Drake, & Constantino, 2010; O’Donnell et al., 2010). Also included are a variety of long-term emotional and physical health problems that have been found to be more prevalent in adolescents and adults with a history of childhood maltreatment, such as substance abuse, depression, and heart disease (Heim et al., 2010; Norman et al., 2012; Shonkoff & Bales, 2011). Experiences of child abuse and neglect have both indirect and direct consequences. For example, child abuse and neglect can affect physical functioning indirectly, by influencing health behaviors, and directly through impacts on brain development and immune system functioning (Doom, Cicchetti, Rogosch, & Dackis, 2013; Heim et al., 2010).

In terms of short-term health consequences, child abuse and neglect can result in physical injury, illness, and even early death. Physical abuse can cause direct injury to children, while physical or medical neglect can leave children at higher risk for unintentional injury and preventable disease. In a population-level study of child maltreatment in Western Australia, maltreatment was associated with head or abdominal injuries, as well as infectious and parasitic diseases (O’Donnell et al., 2010). In a longitudinal study in the Midwest, low-income children with maltreatment reports were found to have 74-100% higher risk of hospitalization prior to age 18 for asthma, cardio-respiratory issues, and non-sexually transmitted diseases, even after controlling for other individual and community-level factors.
(Lanier et al., 2010). Further, repeated reports were associated with recurrent hospitalizations.

In addition to short-term physical health consequences, child maltreatment can affect emotional functioning, which can then have consequences for interpersonal relationships and later behavior. For instance, children who have experienced physical abuse may exhibit greater levels of emotional dysregulation than similar peers who have not experienced abuse (Maughan & Cicchetti, 2002). In a series of experiments, it was found that those who had experienced physical abuse more readily recognized anger in facial expressions than other emotions, an ability which may be adaptive in the context of abuse, but which could lead to interpersonal difficulties later in life (Pollak, 2008).

Moreover, adolescents and adults who experienced childhood abuse are more likely to experience depression, anxiety and PTSD; more likely to abuse alcohol or drugs; and more likely to engage in suicidal behavior or self-harm (Gilbert et al., 2009; Krug, Mercy, Dahlberg, & Zwi, 2002; Shonkoff, Boyce, & McEwen, 2009). For example, in one study of mothers in Japan, childhood abuse history, particularly psychological maltreatment, was found to have a strong impact on adult mental health problems such as dissociated, depressed, and traumatic symptoms (Fujiwara, Okuyama, Izumi, & Osada, 2010).

Childhood maltreatment has also been identified as a non-specific risk factor for psychiatric disorders, especially mood and anxiety disorders (Heim et al., 2010). Meta-analytic studies of the long-term mental health consequences of CAN have found that all forms of maltreatment were associated with an increased likelihood of experiencing depression (Chen et al., 2010; Norman et al., 2012). Additional
associations have been found between different types of maltreatment and lifetime mental health issues, such as associations between physical and emotional abuse with anxiety disorders (Norman et al., 2012), associations between sexual abuse and PTSD, (Chen et al., 2010), and associations between neglect and substance abuse (Norman et al., 2012).

In addition to short-term physical consequences and potentially long-term mental health consequences, there are long-term physical health consequences of child maltreatment. Adults who experienced maltreatment as children are more likely to face issues such as obesity, reproductive health problems, and certain chronic illnesses (Gilbert et al., 2009; Krug et al., 2002; Shonkoff et al., 2009). Childhood nutritional or medical neglect may have direct effects on adult physical health. For instance, childhood malnutrition may lead to stunted growth (Alderman, Hoddinott, & Kinsey, 2004), or to later rapid weight gain. Growth curve modeling using data from the National Longitudinal Study of Adolescent Health found that children who experienced neglect had a faster average rate of body-mass index (BMI) growth (Shin & Miller, 2012). In the same study, combined childhood neglect and physical abuse was related to a higher BMI at baseline even when accounting for other variables. In the U.S., the obesity epidemic has led to new controversies as to when and whether it is appropriate to remove morbidly obese children from their homes, as insufficient attention to obesity and comorbid conditions such as Type II diabetes can lead to irreversible harm (Varness, Allen, Carrel, & Fost, 2009).

There are multiple pathways by which child maltreatment may affect later physical health. Child maltreatment can influence adult physical health indirectly, through its effect on emotional health and consequent adult health behaviors (e.g.,
drug abuse). A retrospective study of adult women found a connection between childhood physical and psychological abuse and self-reports of poor physical health, which was mediated by perceived stress and emotion-focused coping (Hager & Runtz, 2012). Psychological and interpersonal problems can also lead to maladaptive coping behaviors such as substance abuse or overeating, which can then directly influence physical health issues such as obesity and cardiovascular disease risk (Felitti et al., 1998).

An illustrative example of the ways in which child maltreatment can affect adult health was found in a study of the effects of childhood sexual abuse on myocardial infarction (Fuller-Thomson, Bejan, Hunter, Grundland, & Brennenstuhl, 2012). In this study, men over the age of 50 who had been a victim of childhood sexual abuse were four times more likely to report having had a heart attack. Factors such as psychological diagnoses and health behaviors were partially responsible for this association. However, even when accounting for these factors and others such as differences in SES, these men were still three times more likely to experience myocardial infarction than men who did not report experiences of abuse. The association continued throughout the lifespan, and was actually strongest in men over the age of 80. The authors postulate that this association may be due to psychological distress, as well as potential physiological consequences of abuse. For instance, neuroendocrine changes resulting from childhood sexual abuse may result in an increase in the ratio of cortisol to testosterone, which has been linked with heart disease in males (Fuller-Thomson et al., 2012).

Increasingly, research has focused on the potential neurobiological consequences of child abuse and neglect, which can hamper cognitive development
(Shonkoff et al., 2009), and have the potential for far reaching negative impacts on mental and physical health. Early stressors, such as maltreatment, may alter the development of the brain, causing maladaptive stress responses in the hypothalamo-pituitary-adrenal (HPA) axis that can persist throughout adulthood, affecting not only psychological well-being and health-related behaviors, but also brain development and immune system functioning (Doom et al., 2013; Heim et al., 2010). For instance, some studies have found that sexual abuse and PTSD are related to smaller hippocampal volume, which may be due to overactivation of the HPA axis and hyperfunction of the amygdala, and which can have long-term effects on memory (Nunes, Watanabe, Morimoto, Moriya, & Reiche, 2010).

Focusing on the neurobiological consequences of child maltreatment has been a successful strategy in convincing policy makers of the importance of investment in early preventive efforts (Shonkoff & Bales, 2011). The Center on the Developing Child (2007) has focused its messaging on concepts such as brain architecture and what they term ‘toxic stress.’ They make a distinction between three types of stress: positive stress, which happens in the course of everyday living and is adaptive; tolerable stress, which is marked by unusually stressful circumstances such as the death of a parent, but which does not have long-term negative consequences due to the presence of buffering supports; and toxic stress, which refers to extreme stress in the absence of such buffers, and which can increase the risk of lifelong mental and physical health problems.

Although the litany of potential short and long-term consequences paints a bleak picture for those who have been victims of child maltreatment, these consequences are not inevitable. There are also many factors that influence the
resilience of children who have experienced abuse or neglect, including children’s self-esteem and the presence of stable caregivers (Afifi & MacMillan, 2011). Still, with such a wide range of consequences, the importance of preventive interventions and policies to ensure that children do not experience any form of maltreatment is clearly reinforced.

**Multilevel Influences on Child Abuse and Neglect**

Development can be best understood by using an ecological transactional framework that takes into account influences at multiple ecological levels, as well as the mutual influence between a child and his or her environment (Belsky, 1980; Bronfenbrenner 1979; Coulton, et al., 2007; Dodge & Pettit, 2003). The causes and consequences of child maltreatment are likewise best conceptualized in terms of multiple levels of influence, including the influence of individual-level characteristics of children and parents, family dynamics and structures, and community contexts (Figure 1).
Figure 1: Examples of multilevel influences on child maltreatment

Individual-level characteristics of both children and their parents can affect the likelihood of maltreatment. Beyond these individual-level effects, family-level characteristics, such as family structure and living conditions, can increase risk of
abuse or neglect. Community-level characteristics, such as community violence or neighborhood poverty, can also influence child maltreatment rates, and may interact with individual-level characteristics. Furthermore, children of parents who were victims of maltreatment are at increased risk of experiencing abuse or neglect (Appleyard et al., 2011; Valentino et al., 2012). However, it should be noted that the likelihood of intergenerational perpetuation of abuse can also be impacted by other characteristics at the individual, family, and community levels.

**Individual-Level Influences.** There are many factors that can increase the risk of child abuse and neglect, including individual characteristics of children and of parents. Though abuse is never a child’s fault, there are characteristics of children that put them at greater risk of experiencing maltreatment. Age is an important factor, as children under the age of 4 are the most likely to experience severe injury or death due to maltreatment (USDHHS, 2010), and adolescents are most at risk for sexual abuse (World Health Organization [WHO], 2002). Globally, boys are more likely to be physically abused, while girls are at greater risk for sexual abuse, infanticide, and various forms of neglect (WHO, 2002). Children with physical or developmental disabilities may be especially at risk for child abuse and neglect, particularly in cases where their families have few resources (Dubowitz et al, 2011).

Parental characteristics that are associated with child maltreatment include mental health problems, substance abuse, knowledge of child development, and a history of family violence (Appleyard et al., 2011; Bugental et al., 2010; Kim, Pears, Fisher, Connelly, & Landsverk, 2010; Onigu-Otite & Belcher, 2012; Valentino et al., 2012). Among mental health problems, depression has been frequently cited in association with child maltreatment (Eamon & Zeul, 2001). Both maternal and
paternal depression have been associated with risk for child neglect, even when accounting for economic hardship (Lee, Taylor, & Bellamy, 2012).

Parental substance abuse is also a risk factor for child maltreatment. In a study conducted with a clinical sample of children receiving services at an urban community-based mental health center, maternal drug abuse history was associated with risk for child neglect and abandonment (Onigu-Otite & Belcher, 2012). In this same study, child maltreatment mediated the relationship between maternal drug abuse history and children’s functional impairment. Another longitudinal study of children in their first three years found that maternal alcohol abuse history predicted harsh parenting at age three (Kim et al., 2010).

Cognitive factors, such as beliefs and attributions, can also play a role in parents’ risk for abusing or neglecting their children. Lack of information and education on child development can lead to inappropriate expectations of children and harmful attributions of their behavior. A mother of a crying infant, for instance, may believe that the child is purposely crying to aggravate her, even though this kind of intentional behavior is not possible at such an early stage of development. Parents who are quick to assign blame or to attribute their child’s inattention or unwanted behavior to purposeful defiance are more likely to be physically abusive (Bugental, & Happaney, 2004; Bugental, 2010). Parents who view parenting as an ongoing power struggle may also be more likely to abuse their children, particularly if they perceive a power imbalance in which they are at a disadvantage (Bugental, 2010). Guterman and colleagues (Guterman, Lee, Taylor, & Rathouz, 2009), found a mother’s sense of personal control to be directly linked to neglect, as well as indirectly linked to psychological and physical abuse via its effect on parental stress.
Characteristics of the child can interact with parental attributions to influence child maltreatment. In a study of low-income mothers who were judged to be of mild to moderate risk of CAN, both the child's health risk and maternal perception of having low power increased self-reports of harsh parenting, and there was an interaction between these factors that was mediated by maternal depression (Bugental & Happaney, 2004). Mothers with low perceived power were also less likely to take safety precautions to protect their children, and more likely to report injuries; this effect was stronger in families with infants who had multiple risk factors.

Although most survivors of childhood maltreatment do not go on to perpetuate that abuse, a family history of maltreatment increases the likelihood that a parent will subject his or her child to abuse or neglect (Appleyard et al., 2011; Valentino et al., 2012). Intergenerational perpetuation of abuse and neglect can be considered in terms of transmission or continuity. Transmission of maltreatment refers to cases in which a parent with a family history of maltreatment goes on to inflict maltreatment on their children. Continuity refers to a broader set of circumstances in which parents who have experienced childhood maltreatment go on to have children who are maltreated, whether or not the parents themselves are continuing that abuse. For instance, a father who experienced physical abuse as a child may not abuse his own children, but may provide them with inadequate supervision (Appleyard et al., 2011).

Parent behaviors may affect the likelihood of intergenerational transmission or continuity of abuse. Appleyard and colleagues found that substance abuse mediated the relationship between a mother's history of childhood physical or sexual
violence and the chances that her own children would be victimized (Appleyard et al., 2011). This finding indicates that there may be a need and opportunity for mothers with substance abuse problems and histories of abuse to be specifically targeted for interventions that can prevent the likelihood that their children will experience abuse.

**Family-Level Influences.** Characteristics of the family as a whole can also influence child abuse and neglect, including the presence of social support, family structure, and family socioeconomic status. The broader social network in which the family is embedded influences child maltreatment. An absence of social support increases the likelihood that child maltreatment will occur (Dubowitz et al., 2011; Martin, Gardner, & Brooks-Gunn, 2012). In fact, social support is listed as a protective factor that can help prevent CAN (CSSP, 2004). Family and friends may provide instrumental support such as offering to watch children, and emotional support that reduces parental stress.

Family structure may also influence maltreatment. Berger (2004) found poorer caregiving environments in single mother households and households in which a non-biological father was present. One population-level study found that children living in households with at least 1 non-related male were at significantly increased risk of death due to maltreatment (Stiffman, Schnitzer, Adam, Kruse, & Ewigman, 2002). Additional studies have corroborated the increased risk of maltreatment in single parent households, particularly among young, low income women (Berger, 2005; Brown, Cohen, Johnson, & Salzinger, 1998; Sykes, 2011). It is likely that these findings are simply a function of women not having the resources or support that has been shown to be so important for parents of young children rather
than women’s marital status. Additional research is needed to understand the nature of these findings.

Also related to family structure, the presence of more children has been associated with higher risk for child maltreatment reports (Dubowitz et al., 2011), and the length of time between pregnancies may also influence child maltreatment risk. Thompson and colleagues (2012) found an effect of inter-pregnancy-interval on CAN. Shorter time periods between pregnancies were associated with child maltreatment, particularly when the mother indicated that she would have preferred a longer period between pregnancies. Other research suggests that shorter inter-pregnancy intervals are linked with self-reports of child neglect, as well as children’s behavior problems (Crowne, Gonsalves, Burrell, McFarlane, & Duggan, 2012). However, it is important to note that causal pathways cannot be inferred from these analyses.

Family socioeconomic status (SES) is one factor that often figures prominently in discussions of CAN. There are increased reports of CAN in families of low SES (Berger, 2005). Poverty is a stressor in itself and a predictor of violence, and can also lead to other stressors such as overcrowding and lack of resources. Interestingly, in a model that examined socio-demographic influences on paternal violence toward children, paternal income and employment were not associated with higher incidence of psychological or physical aggression; as an explanation for the null finding, the author suggested that psychosocial factors such as stress may be responsible for the link between SES and child maltreatment (Lee, Guterman, & Lee, 2008). As further evidence of this interpretation, an SEM study of the influence of poverty on children’s socio-emotional problems found that maternal depression
partially mediated the link between poverty and use of physical punishment (Eamon & Zuel, 2001).

Although parental stress and depression may be significant mediators between SES and physical and psychological abuse, the relationship between SES and neglect may be more direct. Certain forms of neglect, such as medical neglect, are far more likely in low SES households, as families may not have sufficient resources or time to bring their children to routine medical and dental visits (Berger, 2004), or to obtain necessary care for children with disabilities or chronic diseases (Algood, Hong, Gourdine, & Williams, 2011).

Though the effects of low SES on child maltreatment have been broadly supported, social factors and increased stigma associated with child maltreatment may lead to under-reporting of child maltreatment in high SES families. One study supporting this idea found that high- and low- income parents completing an anonymous phone survey had more congruent self-reports of abusive or harsh parenting practices (Theodore, 2005). This is in sharp contrast to the usual findings that show a clear discrepancy in the prevalence of child maltreatment based on SES.

In addition to social support, family structure, and socioeconomic status, both intimate partner violence and the presence of substance abuse in the household are strongly connected to child maltreatment, (Dong et al., 2004; Zolotor, Theodore, Coyne-Beasley, & Runyan, 2007), with some citing figures that both IPV and CAN are present in 60% of households where either is found (CAPTA, 2010). One study of a high risk clinical sample of Dutch children who had been exposed to IPV and had severe emotional and behavioral problems found that they had experienced an average of 5 adverse childhood experiences, such as abuse, household dysfunction,
and neglect (Lamers-Winkelman, Willemen, & Visser, 2012). Exposure to intimate partner violence has increasingly been considered a form of child maltreatment in itself, which frequently co-occurs with other forms of victimization, and may have long-lasting consequences on child development and health outcomes (Cross, Mathews, Tonmyr, Scott, & Ouimet, 2012).

**Community-Level Influences.** There is evidence for geographic clustering of negative health outcomes including low birth weight, infant mortality, homicide, accidental injury, and child maltreatment (Sampson, 2003). Community-level characteristics are often treated as if they are individual traits. However, neighborhood effects can sometimes be found even when individual characteristics are taken into account. Therefore, neighborhoods and communities should be treated as units of analysis in their own right, rather than as properties of the individual.

In a systematic international review of multilevel studies that took into account both individual and neighborhood attributes, neighborhood characteristics such as socioeconomic status and crime rates were found to explain up to 10% of the variance in child and adolescent health outcomes, such as low birth weight, teenage pregnancy and criminal behavior, and child injury and abuse (Sellström & Bremberg, 2006). In another review of 25 studies of neighborhood level effects on child maltreatment, support was found for a relationship between neighborhood structural characteristics and child maltreatment rates (Coulton, et al., 2007). Most commonly, maltreatment was associated with socioeconomic characteristics of neighborhoods, such as income level, median housing costs, poverty rates, and unemployment rates. There was some evidence that neighborhood-level effects
differed among types of maltreatment, with neglect in particular being associated with socioeconomic factors.

Though the connection between low SES neighborhoods and child maltreatment has been substantiated, there is insufficient information to explain the nature of this relationship (Coulton et al., 2007). Neighborhood SES may affect parental behaviors, e.g., by increasing stress or promoting social norms that foster maltreatment. Utilizing data from the Fragile Families and Child Well-Being Study, Guterman and colleagues (2009) found that parental perceptions of neighborhood processes can indirectly influence the risk of three forms of CAN – psychological abuse, physical abuse, and neglect. Although there were no clear direct pathways between perceptions of neighborhood processes, SEM analysis indicated an indirect pathway via personal control. Negative perceptions of neighborhood processes, including social disorder, informal social control, and social cohesion, were linked with a decreased sense of personal control. In addition to having a direct influence on neglect, decreased sense of personal control was found to have a strong relationship with parental stress, which was in turn linked to self-reports of all three forms of child maltreatment.

Selection may play an important role, as there may be individual and family characteristics that lead to families living in low SES neighborhoods (e.g. lack of economic resources, location of public housing), and which also correlate independently to child maltreatment. Multilevel studies that take both family-level and neighborhood-level influences into account tend to find less variation on the neighborhood level, supporting this idea (Coulton et al., 2007).
Other neighborhood structural characteristics, such as the concentration of businesses selling or serving alcohol, can also influence child maltreatment rates (Freisthler, 2004; Freisthler, Bruce, & Needell, 2007). Spatial regression analysis was performed using data from three counties in California to examine neighborhood effects on child maltreatment reports. Maltreatment was more commonly found in neighborhoods with higher percentages of poverty, and with greater densities of bars (Freisthler, 2004). Another study using similar methodologies found that the density of stores selling alcohol was associated with higher rates of child maltreatment reports in African-American families (Freisthler, et al., 2007).

Community violence has also been associated with child maltreatment in numerous studies (Coulton et al, 2007, Cichetti & Lynch, 1993, Molnar et al, 2003). In one study, community violence was operationalized in terms of the homicide rates, and was found to predict child maltreatment rates (Molnar et al, 2003). However, this connection was no longer significant when accounting for family composition and SES. Community violence may interact with individual and family-level factors to influence the risk for CAN. For instance, among children whose mothers had a history of childhood maltreatment, exposure to community violence was associated with increased risk of maltreatment (Valentino et al., 2012).

**Child Maltreatment Prevention Programs**

Healthy early development provides the basis for lifelong health and productivity. Since childhood maltreatment has the potential for long-lasting negative effects, it is essential to invest in prevention efforts. Research on the
effectiveness of child maltreatment prevention programs continues and more work is needed. However, there have been several types of programs that, when implemented faithfully, have shown success in preventing CAN. Though preventive interventions are necessary, promoting healthy development extends beyond simply avoiding negative outcomes. The promotion of children’s physical health and social and emotional well-being should be a shared societal goal. With the many different influences on CAN at the individual, family, and community levels, strategies that center on strengthening families and communities in order to promote child health and well-being and encourage healthy development are needed.

**Preventive Interventions.** Prevention of child maltreatment is of paramount importance. From an ethical, practical, and financial standpoint, it is far better to prevent child maltreatment from ever occurring than it is to act only once maltreatment has been substantiated. Prevention programs may be targeted toward tertiary, secondary, or primary prevention, depending on whether their target audience has already committed maltreatment, is at high risk for maltreatment, or is part of the general population. Some examples of these programs are described below. There are also multi-component programs that use multiple strategies (e.g., both primary and secondary prevention approaches), with different populations.

Tertiary prevention programs, which work to reduce recidivism among those who have already mistreated their children, are important, but insufficient. First, it has been shown that recidivism is quite high among this population, indicating that it is difficult to stop maltreatment once it has become the norm (Dakil, 2011). Second, the negative effects of child abuse on development can have life-long consequences. Once it has occurred, there are factors that can increase resilience and
improve the chances that a child will be able to escape some of the negative sequelae of maltreatment. However, there still may be psychological and neurobiological vulnerabilities, particularly if the child experiences abuse at a very young age.

Secondary prevention programs, which aim to work with populations that are deemed to be at-risk for child maltreatment, are among the most popular approaches, and have shown some successes. The Chicago Child-Parent Center (CPC) preschool program, a federally funded preschool program available to residents of low-income communities in Chicago, has demonstrated success in reducing child maltreatment (Mersky, Topitzes, & Reynolds, 2011; Reynolds & Ou, 2004). Chicago CPCs are focused on enhancing language, literacy, and numeracy, and have a strong emphasis on family involvement. An SEM study found that CPCs affected child maltreatment risk via mediators including maternal educational attainment and reduced family problems (Mersky et al., 2011).

One of the most common approaches for secondary prevention of child abuse and neglect is through home visiting programs. In a review of research on early childhood prevention programs, the majority of which were home visiting programs, Reynolds and colleagues (Reynolds, et al., 2009) found a weighted average effect size of 2.9%, with a 31% decrease in the rate of child maltreatment among families who participated in the program (from 9.5% to 6.6%). Another review, which centered exclusively on home visitation programs, found that while none of these studies directly measured child maltreatment rates, several were found to improve parenting practices, which could be expected to lead to reduced rates of CAN (Howard & Brooks-Gunn, 2009). Though there was some overlap between these two reviews, which could account for similarities, it should be noted that both studies
found that professional staff and high dose intensity were important elements of successful programs (Howard & Brooks-Gunn, 2009; MacLeod & Nelson, 2000; Reynolds et al., 2009).

A randomized controlled trial of the Healthy Families New York (HFNY) home visiting program found it was effective in promoting positive parenting. It was effective in reducing negative parenting only in a group of young, first time mothers, indicating that it may be more useful for preventing the initiation rather than the recurrence of harsh parenting (Rodriguez, Dumont, Mitchell-Herzfeld, Walden, & Greene, 2010).

The Hawai‘i Healthy Start Program (HSP) was designed to prevent CAN, and has been used as a model for home visiting programs nationally and internationally (Duggan et al., 1999). An early evaluation of HSP found that it did not directly impact child maltreatment reports; however, it was found to affect factors associated with child maltreatment, such as maternal stress and the presence of intimate partner violence. In a randomized controlled trial of the Hawai‘i Healthy Start program, home visiting was associated with lower rates of physical assault victimization and perpetration among mothers during program implementation (Bair-Merritt, et al., 2010).

In a comprehensive review of the literature on the effectiveness of home visiting programs, 14 out of 35 programs were found to have strong evidence of effectiveness in promoting a variety of positive outcomes (Avellar, Paulsell, Sama-Miller, & Del Grosso (2013).). The review defined primary outcome measures as those collected through direct observation, direct assessment, administrative data, or self-reported data collected with a standardized instrument, and classified all other
data as secondary outcome measures. Of the 14 home visiting programs identified as effective, 6 included primary outcome measures related to child maltreatment, such as hospital visits due to injuries. The 6 programs, all of which showed changes in at least one of these child maltreatment measures, were: Child FIRST, Early Start (New Zealand), Healthy Families America (which includes Hawai‘i Healthy Start), Nurse Family Partnership, Parents as Teachers, and SafeCare Augmented. In addition to reductions in child maltreatment, programs also showed benefits in other areas such as child health, positive parenting practices, and school readiness.

A prior review conducted by Mikton and Butchart (2009) also found that home visiting programs were one of four types of programs that have been shown to be successful in reducing CAN. In addition to home visiting, there was sufficient evidence to support the effectiveness of parent education programs, abusive head trauma prevention programs, and multi-component interventions, in reducing actual child maltreatment (Mikton & Butchart, 2009). As with home visiting programs, parental education programs include direct work with parents, often those who are deemed to be high risk. Abusive head trauma prevention programs are in some ways more comparable to other public health efforts (e.g. smoking cessation) in that they can target a single specific behavior and work to transform social norms surrounding it (Daro & Dodge, 2009). Multi-component interventions use several strategies to address CAN, sometimes targeting both parent and child, or both individual and community-level factors.

In addition to secondary prevention programs, primary prevention efforts, sometimes referred to as universal prevention, may be especially crucial in preventing CAN, due to the stigma around child abuse (Sykes, 2011). While there are
risk factors associated with CAN (as described above), an exclusive focus on high-risk populations ensures that those who do not fit the typical profile for abuse will be overlooked. Primary prevention programs may provide an added benefit because they can also help prevent maltreatment through education efforts that are aimed outside the family at friends or neighbors who may be able to provide social support, which has been identified as an important protective factor against CAN (CSSP, 2004).

As discussed above there is evidence to support the utility of focusing prevention efforts to high risk and to universal populations; however, it may be that interventions that target multiple groups will have more of an impact in reducing overall rates of child maltreatment. Such interventions could target different audiences (universal and high risk) or operate at multiple levels (MacLeod & Nelson, 2000; Reynolds et al., 2009). These different programmatic features may work in concert and be more effective than each one would be individually. For instance, a combined primary and secondary intervention program may include child care, parent education, and community building components. With this range, interventions with more than one focus may be more successful in addressing the many factors that contribute to CAN.

The Triple-P Project is an example of a multi-component and multilevel intervention that has demonstrated substantial success (Prinz et al., 2009; Reynolds et al., 2009). The crux of the Triple-P Project is that it includes both primary and secondary prevention components. One component takes a universal prevention approach including media-based efforts to increase awareness. Additional components include more intensive services, aimed at families deemed to be at risk.
for child maltreatment. Originally devised in Australia, the Triple-P Program has since spread to many other locations, including many parts of the U.S., and has been rigorously studied. In a recent population-level study of the Triple-P Program, where 18 counties were randomly assigned to the program, large effect sizes were found in three core measures: child maltreatment injuries, substantiated reports of child maltreatment, and child out-of-home placements (Prinz et al., 2009).

Coalition-Based Approaches to Prevention. When addressing widespread persistent issues that defy easy solutions, such as the prevention of child abuse and neglect, collaborative efforts may be superior to fragmented individual efforts. Collaborative efforts include partnerships between one or more organizations, as well as networks of organizations, such as community coalitions. Collaborative or network-based approaches have been used in the prevention of substance abuse (Collins et al, 2007; Dzierzawski et al., 2004) intimate partner and sexual violence (Cox et al., 2010), youth violence (Hernandes Cortero et al., 2011), and teen pregnancy (Cassell et al., 2005). Funding agencies such as the Centers for Disease Control and Prevention (CDC) have been particularly supportive of collaborative efforts (Cassell et al, 2005; Cox et al, 2010) as they seek holistic community-based preventive solutions to pervasive threats to health and well-being.

Though collaborative and network-based approaches, including coalitions, are often promoted, it can be difficult to define coalition success, and even more difficult to measure it (Provan et al., 2005). In a mixed-methods study on coalition building, Mizrahi & Rosenthal (2001) found that leaders of social change coalitions held multiple definitions of success. The most commonly cited reason for forming a coalition was to bring together organizations to achieve a common goal. Accordingly,
the most commonly cited definition of success was achieving the goals. However, since goals were often very broad and ambitious, e.g., ending hunger or domestic violence, assessing goal achievement was not a simple matter. Intermediate goals were often defined and additional aspects of coalition success were considered. Among these were recognition from the target of social change efforts, garnering community support, gaining awareness of new issues, building lasting networks, achieving longevity, and learning new skills (Mizrahi & Rosenthal, 2001, p. 68).

Given the difficulty of ascertaining community-level outcomes of collaborative efforts to effect social change, Nowell and Foster-Fishman (2011) joined a growing body of researchers who focus instead on intermediate outcomes, including the ways in which collaboratives increase organizational capacity of their members. In a mixed-methods study of collaboratives in the Midwest dedicated to combating domestic violence, the authors first interviewed key informants regarding the ways in which participation in a collaborative were perceived to contribute to organizational capacity, and then used their findings to create a survey which was then completed by 614 organizational members of 51 collaboratives.

In the initial phase of research, qualitative analysis of key informant interviews yielded descriptions of major types of positive outcomes, each of which reinforced the others: increased knowledge and awareness, increased opportunity and impact, and improved social capital (Nowell & Foster Fishman, 2011, p. 196). The first, increased knowledge and awareness, itself included three elements: access to information, including community data and information about community events; heightened awareness of issues; and increased system awareness, including understanding who does what in the community, and the strengths and limitations
of other organizations. Increased opportunity and impact included increased access to resources, improved problem solving, and enhanced ability to serve clients. Improved social capital included elements such as improved reputation and increased influence with other organizations. In the second phase of the study, confirmatory factor analysis led the authors to transform these outcomes to a four-factor model, with acquisition of resources being added as distinct from other aspects of opportunity and impact. These factors were then related to member characteristics such as tenure and depth of involvement. For instance, both representatives who were newer to their organizations and representatives who held leadership positions in collaboratives reported increases in social capital resulting from their participation in the collaborative.

As a way to connect intermediate and longer-term outcomes related to coalitions, the literature makes a distinction between “internal” outcomes that describe strengths of the coalition itself or benefits to member organizations, and “external” outcomes, which are described in terms of impact on the community, though in truth these two sets of outcomes are intertwined (Mizrahi & Rosenthal, 2001). Different factors may contribute to internal and external success. For example, a study of 48 collaboratives, including many coalitions, found that interorganizational coordination (an “internal” outcome) was associated with leadership and decision making, while external systems change outcomes such as policy change or alterations in population-level health outcomes were associated with the presence of cooperative relationships among stakeholders (Nowell, 2009).

Although there are differences depending on whether internal or external outcomes are the focus, factors that are consistently associated with coalition success
more generally include: community readiness; broad, diverse coalition membership; participatory decision making; strong, inspired leadership; and ongoing, planned evaluation (Barile, Darnell, Erickson, & Weaver, 2012; Butterfoss, 2007; Wolff, 2001, Zakocs & Edwards, 2006). Community readiness is frequently described as a precondition to coalition effectiveness, and an assessment of community readiness at the outset might decrease the likelihood that coalition strategies would fail due to a lack of receptivity on the part of targeted individuals and institutions. Broad, diverse coalition membership is likewise widely considered to be necessary in order for coalitions to be effective, and a commitment to broad inclusion and full participation by member organizations of different types may help reduce the chances that a few politically powerful players exert an undue influence on less powerful organizations. Strong leadership and participatory decision making are interconnected goals, as a strong leader will help to reduce conflict among members and ensure that everyone has a voice. Finally, early and ongoing evaluation can help coalition leaders and members assess whether programs are being implemented appropriately and guide members toward adopting strategies that have demonstrated effectiveness.

Conflict transformation has also been noted as an essential component of coalition success (Chavis, 2001). Coalitions are by nature paradoxical, as they may engender conflicting loyalties (toward one organization vs. toward the coalition), and promote unity while extolling diversity. A failure to acknowledge and address conflicts can limit coalition effectiveness, while the ability to successfully transform conflicts into opportunities to build capacity may be essential to their success.
Promoting Child Health and Well-Being through Policy Initiatives

Healthy child development can be encouraged not only by prevention programs and collaboratives but by policies that support the ability of caregivers and communities to foster children’s growth (Daro & Dodge, 2009). Policies in the U.S. concerning CAN have increasingly recognized the importance of taking comprehensive community-based approaches that can strengthen families and promote child health. This national acknowledgement must be supplemented by state and local public and private sector policies.

State and local policy efforts to protect children began in the U.S. in the late 19th century. Although parents are constitutionally guaranteed the freedom to raise their children without government interference, they also have the responsibility to care for their children. The government does have the right and the duty to protect children when they are not receiving adequate care, and the notion of parens patriae, or “parent of the nation,” provides the basis for government intervention when this is the case.

Federal action in regard to child protection began in 1912, when the Children’s Bureau was established to direct funds toward child welfare and to support states’ existing efforts. It continued in 1935 when the Social Security Act (SSA) was passed, which included a component concerned with federal support of state child welfare programs (Dyck, 2010). In 1974, the Child Abuse Prevention and Treatment Act (CAPTA) was passed, and since then it has been revised, reformulated, and reauthorized several times, most recently in December 2010.

The Child Abuse Prevention and Treatment Act (2010) is a comprehensive piece of legislation covering the establishment of a Child Welfare Office and a
clearinghouse for information on CAN. It also provides directions for funding programs administered or supervised by states and by community-based organizations. The 2010 CAPTA emphasizes the need for integrated approaches that include coordination between government entities, social services, community-based organizations, and others. It underscores the collective responsibility of Americans to respond to CAN, as well as the reality that failure to prevent CAN leads to incalculable intangible costs in addition to concrete expenditures that add up to billions of dollars.

Neighborhood-level and community-based approaches are recognized by CAPTA as essential to effective prevention and treatment of CAN. Community-based child abuse prevention programs and activities are defined as follows (Sec. 208. DEFINITIONS. [42 U.S.C. 5116h]):

The term "community-based and prevention-focused programs and activities to strengthen and support families to prevent child abuse and neglect" includes organizations such as family resource programs, family support programs, voluntary home visiting programs, respite care programs, parenting education, mutual support programs, and other community programs or networks of such programs that provide activities that are designed to prevent or respond to child abuse and neglect.

Cultural diversity and collaboration are also stated necessities in efforts to prevent and treat child maltreatment. CAPTA identifies the increased needs for resources in low-income communities, and prioritizes funding that goes to community-based programs and young families. It also emphasizes the need for additional research to understand how CAN affects specific communities, including Indian and Native Hawaiian communities.
Title II of the 1996 reauthorization of CAPTA established the Community-Based Child Abuse Prevention (CBCAP) program, in order to support community-based efforts to prevent CAN; this program was reauthorized in the most recent 2010 version of CAPTA. At the federal level, the CBCAP program is managed by the Office on Child Abuse and Neglect (OCAN), a division of the Children’s Bureau. At the state level, each CBCAP program is managed by a lead agency. In the majority of cases, state Children’s Trust Funds (CTFS) serve as the lead agencies managing CBCAP programs and funds.

**Children’s Trust Funds**

Children’s Trust Funds (CTFs) were established in response to growing awareness of the problem of CAN. The Children’s Trust Fund movement began with Dr. Ray E. Helfer, who in 1968 co-authored an influential book with Dr. Henry Kempe titled “The Battered Child Syndrome.” Inspired by wildlife and other conservation-oriented trust funds, Dr. Helfer helped start the Children’s Trust Fund in Kansas, which was then replicated through legislation in all 50 states, as well as Washington D.C. and Puerto Rico (National Alliance of Children’s Trust & Prevention Funds, 2009). The goal of all CTFs is to provide a channel for funding of CAN. In child protection as in other fields, prevention programs are often the first to be cut when funding is limited, as treatment for existing problems takes precedence. While this is understandable, it is also short-sighted, since prevention programs ideally will reduce future needs for treatment services. The CTFs were, therefore, created to be a separate mechanism to collect and maintain funding that would be used exclusively for the prevention of CAN.
CTF structures vary across different locales. Some CTFs are led by state government agencies, while others take the form of non-profit organizations or other structures. They are engaged in different types of activities, including collaborations with child maltreatment prevention organizations. The National Alliance for Children’s Trust & Prevention Funds serves to unite CTFs throughout the country, and to connect them to national institutions.

**Protective Factors Framework.** The National Alliance for Children’s Trust and Prevention Funds, along with several state CTFs and other organizations, collaborated with the Center for the Study of Social Policy (CSSP) on the Strengthening Families Framework. Strengthening Families uses a protective factors framework and is purposely framed as a positive approach that is intended not only to reduce CAN, but also to strengthen families and enrich child development. The messaging in Strengthening Families and its associated programs is in contrast to traditional child abuse and prevention messaging, which has often sensationalized maltreatment and villainized abusers (Aubrun & Grady, 2003). While such sensationalized portrayals may have been successful to some extent in helping to gain attention for the issue of child maltreatment and enable people to recognize and report abuse in its most egregious forms, it also may have had the unfortunate consequences of obscuring the reality of every day child maltreatment and decreasing the likelihood that families will seek preventive services or acknowledge the potential or actuality of maltreatment in their households.

The Strengthening Families Framework centers on six (originally five) protective factors that have intuitive appeal, and have also been demonstrated to
decrease the likelihood that maltreatment will occur. These six protective factors are (USDHHS, 2013b):

(1) Nurturing and attachment – a strong, warm relationship between parent and child is essential to the formation of secure attachments;

(2) Parental resilience – the ability of parents to effectively solve problems and cope with stressful circumstances has repercussions for children;

(3) Social connections – networks of support are essential to family strength, and isolated families are at greater risk and may need more support;

(4) Knowledge of parenting and child development – accurate information and reasonable expectations for child development can help parents promote their child’s healthy development, while information about effective parenting provided at relevant times in their child’s lives can be helpful, particularly for parents who were the victims of abuse or harsh parenting practices in their own childhood;

(5) Concrete support in times of need – families cannot thrive without adequate food, shelter, and other basic necessities, including support during times of crisis and in dealing with physical and mental health challenges;

(6) Social and emotional competence of children – early identification of social or developmental problems and assistance in dealing with these issues can help to prevent situations in which parents who are unable to cope with these issues resort to harmful practices that actually exacerbate their children’s problems.

This framework has been extremely popular, spreading quickly throughout various CTFs and other institutions. Its popularity is fueled by its positive approach
and the fact that it can be built into existing programs and efforts at little or no additional cost. It also provides a shared perspective that can help to align the work of entities in different fields, including child welfare, health and social services, and early childhood education.

**Hawai‘i Children’s Trust Fund**

The Hawai‘i Children’s Trust Fund (HCTF) was formed in 1993 by Chapter 350B of the Hawai‘i Revised Statutes (HRS), as part of the larger nationwide movement to form CTFs in every state that would serve as conduits of funding specifically for the prevention of CAN. HCTF is defined by statute as a public-private partnership between the Hawai‘i State Department of Health and the private nonprofit Hawai‘i Community Foundation. An endowment was created and housed in HCF to allow donations from public and private sector donors to be accepted. According to the original statute, there are three main elements of HCTF: an Advisory Board (AB), an Advisory Committee (AC), and the HCTF Coalition.

The AB’s main role is to make recommendations to the HCF board for the expenditure of funds from the HCTF endowment. There are 7 members of the AB:

- 1 Hawai‘i state Senator
- 1 Hawai‘i state House Representative,
- 3 community representatives appointed by the governor,
- 1 member selected by HCF
- Director of Health or a designee

The AC is concerned with making recommendations to the AB about the allocation of funds, promoting statewide planning strategies for preventing CAN and
strengthening families, informing DOH child maltreatment prevention efforts, facilitating the exchange of related information among groups interested in strengthening families, spreading awareness of HCTF, and soliciting funds from public and private sector groups. Representatives from the HCTF Coalition are elected to the AC and make decisions collaboratively with public sector representatives from the following state agencies:

- Department of Health (DOH)
- Department of Human Services (DHS)
- Department of Education (DOE),
- Office of Youth Services (OYS)
- Judiciary

The HCTF Coalition is composed of community members, including representatives of government agencies, employees of community-based organizations, and concerned citizens. As with the AC, its major focus is on providing strategies for statewide CAN prevention efforts, as well as providing a forum where different stakeholders can discuss issues related to strengthening families. By statute, the Coalition is open to any agency representative or individual committed to strengthening families and preventing CAN.

The HCTF Coalition includes participants from across the state of Hawai‘i. Coalition meetings take place approximately four times per year, and typically last from 9am – 2pm. Coalition meetings typically included announcements, presentations and/or group activities, and a network lunch. Because Hawai‘i’s unique geography can make participation in coalition meetings difficult for residents of Oahu’s neighbor islands, travel scholarships are given for each coalition meeting.
Despite this, full participation in the coalition by representatives of organizations outside of Oahu remains a continual challenge.

The majority of HCTF Coalition members work with nonprofit organizations dedicated to improving child welfare, though the coalition also includes representatives from government institutions, universities, and nonprofit organizations dedicated to improving individual and community well-being. The Coalition is open to anyone, including individual members; however, most members are affiliated with an organization. Member organizations include Prevent Child Abuse Hawai‘i, the Sex Abuse Treatment Center, Neighborhood Place of Puna, and Good Beginnings Alliance. Organizational representatives are often Executive Directors or leaders in the organization, who may be attending on behalf of other employees. Since Coalition meetings last almost an entire weekday, it is impractical for a single organization to send several staff members. Organizational funding cuts may further hamper the ability of employees to attend staff meetings, and several Coalition members have informally noted a reduction in attendance over the last few years, which were attributed to such funding cuts.

The unique structure of HCTF has encouraged diversity and representation from many sectors, but has also been logistically problematic due to its complexity and the lack of paid staff. One major barrier to effective coordination has been the separation of the Advisory Committee and the Advisory Board. In Spring 2014, HCTF proposed legislation that would allow it to adopt a more simplified structure, combining the Advisory Committee and the Advisory Board and outlining the responsibilities of the new combined Advisory Board and the Coalition. This
legislation was ultimately postponed until the next legislative session, affording HCTF the opportunity to engage its stakeholders in the restructuring process.

**One Strong ‘Ohana Campaign.** Historically, HCTF has primarily acted through grants bestowed upon other organizations. Through this, HCTF has supported many different kinds of activities since its inception, such as training for professionals on child abuse and neglect, programs for parents that help them provide a positive environment for their children, and research and evaluation related to strengthening families and preventing child maltreatment. According to the HCTF website (http://www.hawaiichildrenstrustfund.org), HCTF distributed $6.6 million to 150 organizations from its inception in 1993 through 2012. Many organizations that received grants from HCTF became highly active in the HCTF Coalition and remained so even when not receiving funds. While HCTF has mostly refrained from planning and directly implementing activities, the recently launched One Strong ‘Ohana (OSO) public awareness campaign was a notable exception to this rule.

In 2011, HCTF partnered with the Joyful Heart Foundation, an organization dedicated to combating domestic violence, sexual assault, and child abuse, to embark on a major public awareness campaign. The campaign was named One Strong ‘Ohana based on community input, and was launched on January 17, 2012. The OSO campaign was designed to incorporate many aspects of multimedia information sharing, including televised PSAs, radio announcements, posters and other physical materials (Figure 2), a website, social media messaging, and sponsorship of local community events such as Children & Youth Day.
Several member organizations received grants as part of the OSO to develop these multimedia materials and to ensure that they were compatible with OSO’s mission of strengthening families and preventing CAN. As a strengths based initiative, the name One Strong ‘Ohana was chosen based on feedback from community partners, who worked with a public relations agency to develop materials that were culturally appropriate and would resonate with Hawai’i residents.

In addition to spreading awareness about CAN and protective factors that can help to prevent it, the campaign was designed to promote awareness of HCTF and foster growth of the HCTF Coalition. One of the long-term goals of the One Strong

Figure 2: Newspaper ad from the One Strong ‘Ohana campaign
‘Ohana campaign is to build the HCTF Coalition’s capacity to achieve policy changes that will support the prevention of child abuse and neglect.

The OSO campaign was planned and implemented by an ad hoc core team, which included members of Joyful Heart, the Department of Health, and Advisory Committee members. In 2012, HCTF hired a temporary contractor to coordinate duties related to the campaign. This contract was extended in January 2013 and duties were expanded to include coordination of Coalition meetings and communication with HCTF Coalition members.

In 2011, I was hired as a member of the evaluation team dedicated to assessing the effectiveness of the One Strong ‘Ohana campaign. The evaluation team collaborated with the OSO ad hoc core team to draft an evaluation plan. The resulting mixed-methods evaluation continued through 2013. In 2012, I became a member of the HCTF Coalition, and continued membership after the evaluation contract ended. The focus of this project was informed by consultations with many HCTF stakeholders, including staff members at the Department of Health and the Hawaii Community Foundation, members of the Advisory Committee, and HCTF Coalition members.

**Policy Advocacy and Knowledge Translation**

In order to achieve and sustain policy changes that can support the prevention of child abuse and neglect, coordinated action at multiple levels is required. Research can help to inform policy, but only if data are accessible to policy makers, community based organizations, and others who are needed to pass legislation or implement programs. Knowledge translation activities can help to equalize access to research
results, making it easier for stakeholders to make data-informed programmatic and policy decisions.

**Policy Advocacy and Prevention.** Policy advocacy is an essential component of violence prevention efforts, and can include a focus on formal and informal policy at multiple levels (Cohen & Swift, 1999; Plummer 2013). Policy is often considered exclusively in terms of its formal manifestations, such as legislative reforms or institutional regulations. However, the implementation of formal policies relies on informal policies adopted by individuals, social groups, and communities (Plummer, 2013). Advocacy groups that adopt a narrow view of policy change that focus exclusively on pushing forward specific pieces of legislation may encounter failure either in passing the law or in having it successfully implemented (Hardy et al., 2011). A broader and more inclusive understanding of policy change that engages stakeholders and focuses on ongoing change may lead to more lasting success.

Even national laws are ultimately implemented on a local level. Coalitions and other collaborative groups are often better equipped than individuals or organizations to enact federal or state policies at the local level, as well as participate in other aspects of policy change such as identifying policies and programs that can address targeted issues (Litt et al., 2013). Funding and technical assistance can help support organizational and collaborative efforts to influence and implement policy change, and may be particularly important in ensuring that small organizations can participate in these efforts (Cheadle et al., 2011; Litt et al., 2013).

Increased funding for prevention work is often a targeted outcome of policy advocacy efforts. Even small amounts of funding given to organizations may potentially yield significant benefits to individuals and communities (Plummer,
Though there are other formal policies that are of interest to those working in violence prevention, such as mandated reporting of abuse, the requisition of adequate funds is crucial toward enabling the implementation and evaluation of prevention activities. In order to ensure that adequate funding is available for prevention work at multiple levels, some researchers recommend increased involvement in policy advocacy by academics and practitioners involved in prevention (Weissberg et al., 2003).

**Knowledge Translation.** In order for research to effectively influence practices and policies, research findings must be disseminated in a way that are most useful for the target audiences. The study of knowledge translation is a burgeoning field, and there is tremendous diversity in the terms and models associated with it (Mitton et al., 2007) Based on a review of 28 different models, Ward et al. (2009) defined five components of knowledge translation, which can work in a linear, cyclical, or multi-directional pattern. The five components, and examples of how they were defined in knowledge translation models, are as follows:

- **Problem identification** - identification of issues or problems by users or service providers, and communication of this to researchers;
- **Analysis of context** - examining individual, organizational, and structural factors that shape the context in which knowledge is to be applied;
- **Knowledge development and selection** – producing, synthesizing, and adapting knowledge;
- **Knowledge exchange activities** – distribution interventions focused on dissemination activities or linkage-type interventions focused on dialogue and interactions;
Knowledge use – the process of transferring knowledge into action.

In a follow up study, Ward et al. (2011) applied this model to a mental health organization in the UK, and found that knowledge exchange was a fluid and dynamic process, in which several components were operating simultaneously.

Another popular model of knowledge translation is the CDC’s Knowledge to Action Framework (Figure 3). The Knowledge to Action Framework is a dynamic model of knowledge translation that includes three major phases: research, translation, and institutionalization (Wilson et al., 2011). Their schematic is meant to describe a multidirectional process which can originate at any point, as researchers seek to share their results, and practitioners or policymakers seek evidence-based practices.

![Knowledge to Action Framework for Public Health](image)

**Figure 3: Knowledge to Action Framework for Public Health**

Though not exclusively centered on dissemination of information related to program implementation and effectiveness, this study builds on the Knowledge-to-
Action Framework. It is specifically concerned with the phases related to translation of knowledge into products, dissemination, and informing practice and policy. Using terms from Ward et al.’s (2009, 2011) model, this study is concerned with knowledge development and selection, exchange activities, and knowledge use.

**Conclusion**

Child abuse and neglect is a pervasive problem that can have long-term consequences on mental and physical health. Programs and policies dedicated to preventing CAN and promoting child well-being are investments in the long-term health and well-being of adults. Multi-level, multi-component, and strengths-based approaches to child maltreatment prevention and health promotion are necessary. The Hawai’i Children’s Trust Fund is committed to these approaches. However, there is a gap in our understanding of how to support organizations that want to take action on CAN prevention, particularly as it pertains to policy change. Thoughtful dissemination efforts can help to inform collective action by organizations dedicated to prevention, and can facilitate the achievement of policy goals.

**The Present Study**

This is a mixed methods action research study, meaning that the purpose of the study is not only to answer a scientific question, but also to address and work toward solving a problem of importance to the community (Anderson & Herr, 2007). This study builds on the field of knowledge translation research, and is centered on how dissemination of research can inform coalition decision-making and action related to policy change. It can be considered an intervention in which the goal is to
enhance the capacity of the HCTF Coalition to effectively use data to identify and achieve policy goals.

**Research Questions.** The overarching action-research question guiding this study is: How can dissemination of relevant research inform the policy goals and activities of a statewide coalition dedicated to preventing child abuse and neglect? Within this overarching question, there are several sub-questions:

1. What gaps currently exist between the information that is used by the HCTF Coalition and the information that Coalition members believe is important for effecting policy change?
2. How and to what extent can existing data meet the identified information needs of HCTF Coalition members?
3. How can thoughtfully repackaged and disseminated research help to inform HCTF Coalition activities related to policy change?

In addition to exploring the ways in which dissemination of relevant research findings can affect HCTF Coalition activities related to policy change, the study also seeks to answer the following practical questions:

4. What policy issues are of greatest importance to HCTF Coalition members?
5. What assets do Coalition members have that can help the HCTF Coalition achieve its policy goals?
Chapter 2: Methods

Study Design

This is a mixed methods action research study that included several steps (Figure 4). In the first step, responses to a prior survey of Coalition members were reviewed in order to identify research-related needs and policy goals. In the second step, the researcher led activities at a Coalition meeting devoted to group visioning, further identification of collective policy goals, and data collection regarding members’ perceived information needs. Data collected at this meeting were then analyzed and shared subsequently with Coalition members, and informed the researcher’s third step of the project. This third step centered on closing the gap between Coalition members’ perceived and realized information needs through knowledge translation activities. Finally, in the fourth step the researcher led a brief session devoted to enhancing Coalition capacity to effectively use data in policy-related activities, followed by an asset mapping exercise aimed at identifying collective assets that could be leveraged to achieve policy goals.
Step 1: Prior Work
- Review responses to Data & Policy Needs Survey
- Descriptive statistics
- Summarize policy goals and key actors
- Summarize research/data sources and needs
- Identify gaps between data sources and needs

Step 2: First Coalition Meeting
- Individual and group visioning activities
- Individual and group policy goal identification activities
- Completion of activity reflection, research & policy questions, and Knowledge Translation Survey

Step 3: Knowledge Translation Activities
- Analysis of data from first Coalition Meeting
- Use of results from first meeting to determine sources and formats for data products
- Development of data products and data repository

Step 4: Second Coalition Meeting
- Dissemination of data products
- Policy goal formulation and action planning
- Asset mapping activities
- Survey to ascertain usefulness of activities and products

Figure 4: Four-step policy intervention
The proposed relationship between research activities and desired outcomes is outlined in a logic model (Figure 5). The activities described above and listed in the model are designed to enhance the capacity of HCTF to attain policy goals related to CAN prevention through achievement of the following outcomes:

- HCTF has collectively identified most crucial policy goals
- HCTF members are better able to use data to support efforts to achieve policy-related goals
- HCTF members are aware of existing assets that can support the achievement of policy goals

The activities and outcomes are compatible with the broad definition of policy advocacy that relies on wide-ranging support, community inclusion, and long-term sustainability (Hardy et al., 2011; Plummer, 2013). That is, the goal of this intervention is not to achieve any specific policy goal or objective, but to support HCTF’s ability to work together to initiate and implement policy goals and objectives at multiple ecological levels.
Figure 5: HCTF Policy Intervention Logic Model

**Study Participants**

There were a total of 51 Coalition members that participated in Steps 1, 2, or 4 of this project (Step 3 was performed independently by the researcher). Of the 51 participants, 34 (66.6%) participated in one activity, 10 (19.6%) participated in two activities, and 7 (13.7%) participated in all three activities. The sampling frame for the initial online survey (Step 1) consisted of all active HCTF Coalition members. Active membership was defined as including all Coalition members that attended a meeting during the first year of the One Strong ‘Ohana campaign or requested OSO campaign materials (Cardazone, Sy, Chik, & Corlew, 2014). A total of 98 members fit this
criteria and were sent the initial online survey, which included an addendum devoted to Research & Policy. A total of 18 Coalition members completed this addendum, for a response rate of 18.4%. The low response rate was expected, since this survey was included as an optional addition to a longer survey.

Activities in Steps 2 and 4 took place at quarterly Coalition meetings, and all meeting attendees were invited to participate in the activities and complete the surveys. As attendance of one Coalition meeting had previously been used as sufficient criteria for determining active Coalition membership in Step 1, all participants in Steps 2 and 4 were by this definition considered HCTF Coalition members. Typically, meetings are attended by approximately one third to one half of active Coalition members. Of those members who did attend the two Coalition meeting, 2-3 Coalition members at each meeting chose either to not participate, or to participate but not complete a survey. In total, there were 31 participants that took part in visioning and policy goal activities and completed the survey in Step 2, and 26 members that participated in policy goal and asset mapping activities and completed the survey in Step 4.

**Step 1 – Prior Work: Assessing Policy Goals and Data Needs**

In April 2013, a survey was administered to active Coalition members and participants in the One Strong ‘Ohana campaign. The purpose of this survey was to assess the extent to which member organizations and agencies communicated with each other, as well as respondents’ satisfaction with the One Strong ‘Ohana campaign (Cardazone et al., 2014). Respondents were also invited to complete an optional brief add-on survey (Appendix A), about policy goals and data needs. This survey was composed of three main elements:
(1) **Open ended questions about policy goals**: Respondents were asked questions about HCTF’s future policy goals, and identification of individuals or organizations deemed most important to achieve those goals.

(2) **Open ended questions about data/information use and needs**: Respondents were asked to describe any data/information that is used by their organization to make decisions, and what data/information is needed to achieve practical or policy goals.

(3) **Ratings related to evidence-based decision making**: Respondents were asked to rate the extent to which they agreed with statements about their organization’s use of data in decision making, their confidence in their ability to find needed data, and their belief in the importance of evidence-based decision making to prevent CAN. These questions used a 5-point Likert-type scale, with responses ranging from “Strongly disagree” to “Strongly agree,” in regard to statements about evidence-based decision making.

The response rate for this survey was low due to the fact that it was added as an optional addendum to a rather long collaboration survey. However, the results were useful as an exploratory tool that helped to inform this study, including the development of questions and instruments. Analyses were conducted as follows:

Responses to open-ended questions about policy goals were used during the policy goal development activities. Specifically, policy goals identified by the survey helped inform group activities, and served as a starting point for group discussions about future policy directions that could be taken by HCTF (Step 2).

Responses to open-ended questions about current data/information use and needs were used to create a compendium of data sources, which was used to develop
the Knowledge Translation Questionnaire (Step 2), and shared with coalition members during the dissemination phase (Step 3). Data needs that were cited by multiple respondents were personally reviewed by the researcher, and to the extent possible, concrete information responding to these needs was provided during the dissemination phase.

Descriptive statistics were performed on ratings related to evidence-based decision making, to assess whether this is, in fact, a priority for members, and to see whether there is a perceived lack in participants’ ability to obtain information needed to make evidence-based decisions about CAN prevention.

**Step 2 – First Coalition Meeting: Group Visioning, Policy Goal Identification and Information Needs Assessment**

The first set of activities took place in the final 1.5 hours of a quarterly HCTF Coalition meeting held on August 30, 2013. Participants were seated at 5 round tables, and had just returned from a lunch break after participating in morning activities and listening to updates from HCTF leadership. The researcher distributed folders to Coalition attendees, each of which contained the following:

1. Consent form (Appendix B)
2. Policy Advocacy Questionnaire booklet (Appendix C)
3. Knowledge Translation survey (Appendix D)
4. Colored index cards (5 each green, pink, blue)

Each folder was numbered, and all items in the folder were marked with the corresponding number so that responses could be matched to participants while maintaining confidentiality.
Prior to initiating activities, the researcher gave a brief overview of the project, describing the overall aim of examining how data can inform coalition policy goals, and explaining the terms set forth in the consent form. All attendees signed the consent forms, and participants were encouraged to keep the first two pages for their own records. Then, the researcher led participants through a series of individual and group activities designed to elucidate HCTF Coalition members’ visions for the coalition, and to aid them in generating ideas for policy goals at state, community, and organizational levels.

Individual and group visioning activities were designed with the intent to set the stage for discussion of policy advocacy goals (Hardy, et al., 2011). Participants were first asked to silently and individually respond to a written prompt (Appendix B). The written prompt was adapted from Wolff’s (2010, p. 160) “Creating a Common Vision” activity, and asked participants to imagine that it was two years in the future and they were being interviewed for a newspaper article about the HCTF Coalition and its accomplishments. Respondents were asked to describe what the article would say, including reference to HCTF’s accomplishments as well as any changes in Coalition structure or functioning that occurred during this two year period. After participants wrote their responses, they were encouraged to share them with others at their table. They were then guided through the completion of a group activity that built on this initial written prompt, in which the members of each table collectively devised a title and wrote the key points that would be included in an article about the HCTF Coalition. A point person on each table then shared the title with the larger group and summarized the key points.
Next, participants were led through individual and group activities devoted to generating ideas for policy goals which would facilitate the achievement of accomplishments envisioned in the first set of activities. These policy-related goal setting activities were the second part of a three-part process which began with prior distribution of the Policy Goals & Data Needs Survey. Analysis of data from this survey revealed that respondents varied widely in their concept of what constituted a policy goal. These goals fit broadly into three categories: state/legislative policy goals, inter-organizational/community goals, and organizational goals. In order to promote clarity while allowing for flexibility in participant responses, the researcher made these categories explicit and sample responses from the survey were shared with participants for each of the three categories (Appendix B).

Participants were then encouraged to brainstorm and discuss policy goals with others at their table, and were told to choose one policy goal to focus on. An overview of the SMART method for goal definition (Figure 6) was given and participants were told to attempt to translate their chosen policy goal into a SMART goal. This activity was meant to be an introduction, as more time was devoted to it in the second Coalition meeting.
At the close of the meeting, attendees were asked to answer questions in the remainder of the Policy Advocacy Questionnaire booklet (Appendix C) and in the Knowledge Translation Survey (Appendix D). Remaining questions in the former included one section asking for feedback on the day’s activities, and one section with questions about data usage that were similar to that in the prior Policy Goals & Data Needs Survey (Appendix A). Questions in the Knowledge Translation Survey centered on participants’ preferences for types of data they would be interested in seeing, and formats they would prefer to see the data in. It also included a checklist asking participants whether they used or would be interested in using a list of data sources (e.g. KIDSCOUNT data set), which was compiled based on responses to the Policy Goals and Data Needs Survey. All materials were collected, though additional blank copies of the Policy Advocacy Questionnaire booklet were provided for participants to take home.
Step 3 – Knowledge Translation Activities

The knowledge translation phase consisted of three main activities: (a) analysis and dissemination of data collected from the first coalition meeting, (b) development of a data repository, and (c) production of data visualizations, infographics, and other materials based on responses to the Knowledge Translation Survey.

Analysis and Dissemination of Data from the First Meeting. Data collected during the first Coalition meeting included the following: (1) Vision statements from the individual and group visioning activities (2) Policy goals generated during the policy goal setting activities, (3) Ranking of data needs and desired data formats, (4) Items from the checklist of data sources that were desired and in use, (5) Responses to questions about attitudes and efficacy as it relates to research, and (6) Feedback from Coalition members regarding the usefulness of the day’s activities.

Qualitative analysis was performed to identify themes in the first two items, (1) vision statements and (2) policy goals. The data were reviewed and recurring regularities were identified (Patton, 2008). Codes were created and data were classified using the constant comparative method (Glaser, 1964). First, all vision statements and policy goals were reviewed multiple times. Then, open codes referring to specific concepts were created, which were then aggregated into larger themes. All qualitative analyses were performed using R-based Qualitative Data Analysis (RQDA), a free software application enabling integration of qualitative analysis with quantitative analyses using the R statistical programming language (Huang, 2014).
Ranked items (3) were analyzed using two methods. First, simple means were generated, assigning a point value corresponding to each item’s rank (e.g., $1 = 1$ point), and then items were ranked from lowest to highest based on their means. Second, Borda counts were calculated, assigning a point value to each option corresponding to its rank by each user. This method of calculation is commonly used when identifying the most broadly acceptable option among a set of ranked options. It has an advantage over simple majority counting (i.e., assigning a point every time an option is the first choice), because it also takes into account the order in which other items are ranked. Next, items from the knowledge translation checklist of data sources (4), were simply counted in order to determine which data sources were most commonly used and which sources participants were most interested in using.

Finally, basic descriptive statistics, including means and standard deviations, were calculated on responses to the next two items: (5) responses to questions about research, and (6) feedback on the usefulness of activities. This information was used to create bar graphs to facilitate easy dissemination.

These results were shared with Coalition members in two primary forms, which were chosen based on responses to questions from (3) regarding desired data formats. The first was a Powerpoint presentation, which summarized all results. The second was an infographic, which necessarily had a more narrow focus, and included only highlights from the meeting, namely: the headlines developed during group visioning activities (1), the main categories of policy goals (2), and the results of rankings for desired data sources and formats (3). In addition to these products, which summarized the results, raw data were compiled and shared with all
respondents in a folder via DropBox, to ensure transparency and provide information for any Coalition members interested in delving deeper into the data.

**Development of Hawaiʻi CAN Data repository.** The Hawaiʻi CAN Data website ([http://www.hawaiicandata.org](http://www.hawaiicandata.org)) was created in order to share specific results and products developed from the project, as well as to generally increase the Coalition’s capacity to effectively share and use data related to the prevention of CAN. The website was developed with long-term sustainability as a goal, and includes three interactive databases. The first is devoted to data sources, and was seeded with information based on responses to the Knowledge Translation Survey. The second is devoted to data products, and was seeded with products developed for this project (e.g., data visualizations and infographics, as described below). The third is a directory of organizations engaged in CAN prevention and related work in Hawaiʻi. Although initial data were provided by the researcher, the databases were created in such a way that they could be updated by registered users, which is essential since data sources and products may quickly become outdated.

The website was created using the Concrete5 content management system ([www.concrete5.com](http://www.concrete5.com)) and hosted with Bluehost ([www.bluehost.com](http://www.bluehost.com)), with a contract ensuring that it will be operational for at least two years. Two proprietary add-ons were purchased in order to enable development of the interactive databases: Advanced Forms and Data Display. The first, Advanced Forms, allows the website administrator to create forms which can then be completed by users based on the administrator’s permission settings. The second, Data Display, integrates with Advanced Forms to enable the display of data collected in the forms as specified by the website administrator.
Data Visualizations and Infographics. In creating these products, the focus was on presenting information in a way that would be most accessible and usable by all coalition members. Both Borda counts and mean calculations indicated that participants were most interested in obtaining data in the form of data visualizations and infographics. Therefore, this was the primary focus for data product development. The data used in the development of these products was based on responses to questions regarding desired data sources, including the ranking of categories of desired data sources, and the checklist of specific data sources in use and desired by participants. Borda counts and mean calculations indicated that participants were most interested in obtaining data regarding effective CAN prevention programming and Hawai‘i CAN statistics.

Interactive data visualizations were created using Tableau Public 8.0 (www.tableausoftware.com/public), a free version of the proprietary Tableau data visualization software that is meant for use with public data. Data were typically transformed in order to conform to the Tableau guidelines, which require that each variable be represented only once per row, and that all totals and subtotals are removed.

Though initially several different visualizations were created using various data sources, after collecting initial feedback on early products, efforts were focused on creating a single interactive dashboard based on a frequently used and relevant source of data – substantiated CAN rates by region available from the Hawai‘i state Department of Human Services (DHS) annual Child Abuse and Neglect Reports. In the dashboard, several views were used in order to highlight different aspects, e.g.,
showing differences in average CAN rates by region vs. showing changes in CAN rates over time.

Since DHS data on CAN prevalence are presented in counts and not normed according to the population, demographic data were used in order to calculate rates of CAN in different geographic regions. Additionally, since the regions used in these reports are judicial districts rather than Census divisions, additional calculations had to be made using an equivalency guide for determining the relationship between judicial districts and Census county subdivisions. A complete list of data sources used for the initial set of data products is presented in Table 2.

Maps were created using ArcGIS 9.2 (ESRI, 2011). Data sources were joined to shapefiles based on Census county subdivisions and zip code tabulation area (ZCTA), both of which were obtained from the Hawai‘i Statewide GIS Program. Shapefiles are data formats that include geospatial data, allowing for the creation of maps with layered information. For instance, by joining data from the Census regarding poverty rates in different county subdivisions with the Census county subdivision shapefile, one can perform quantitative analyses such as spatial autocorrelation, which enables determinations about whether nearby regions are more similar. Additionally, joining data with shapefiles enables the manipulation of visual characteristics, for instance, by creating a map in which regions with higher levels of poverty are darker than regions with lower levels of poverty. This project made use of this latter feature of GIS mapping. When data was available at the county subdivision level or an equivalent (e.g. judicial districts), the county subdivision files were used. When zip codes were the only location-based data available, ZCTA files were used. Zip codes are based on routes and do not actually
correspond to separable regions, so ZCTAs are approximations of regions that are covered by different zip codes.

**Table 2: Data sources for knowledge translation products**

<table>
<thead>
<tr>
<th>Data product</th>
<th>Tools</th>
<th>Data sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Hawaii CAN rates 2007-2012 dashboard</td>
<td>Tableau Public,</td>
<td>(a) Rates of substantiated CAN by district from Hawaii Department of Human Services Child Abuse &amp; Neglect Reports</td>
</tr>
<tr>
<td>(interactive data visualization)</td>
<td>Microsoft Excel</td>
<td>(b) Demographic data (child population by county subdivision) from American Community Survey 5-year estimates</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(c) Creating Judicial District Geographic Areas (DBEDT) guide</td>
</tr>
<tr>
<td>(2) Home Visiting to Prevent Child Abuse &amp; Neglect infographic</td>
<td>Piktochart</td>
<td>Home Visiting Evidence of Effectiveness Review (HomVEE) Executive Summary</td>
</tr>
<tr>
<td>(4) CAN Rates, Family Poverty, and Public Awareness infographic</td>
<td>ArcGIS, Microsoft Excel, Adobe Photoshop</td>
<td>(a) Percentage of families with children living in poverty by Census county subdivision from American Community Survey 5-year estimates</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(b) Child abuse and neglect rates by region from sources used in (1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(c) One Strong ‘Ohana pre-campaign survey data on awareness of CAN contributing and protective factors based on zip code</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(d) GIS shapefiles for county subdivision and ZCTA (zip code tabulation areas)</td>
</tr>
</tbody>
</table>

Infographics were created using a variety of tools, including: Microsoft Powerpoint, the Adobe Creative Cloud suite ([http://creative.adobe.com](http://creative.adobe.com)), and
Piktochart ([www.piktochart.com](http://www.piktochart.com)). The latter is an online tool that includes templates, icons, and other materials that facilitate infographic creation by people with limited graphic design experience.

For all products, efforts were made to adhere to principles of effective data visualization, such as the strategic use of color to convey meaningful information, and the use of small multiples of similar graphics to allow for fast apprehension of large quantities of information (Tufte, 1990).

**Step 4 – Second Coalition Meeting: Policy Goal Formulation and Asset Mapping**

The results of the first three steps were used in the final step, which centered on policy goal definition and asset mapping. These activities took place at the next Coalition meeting, which, due to external circumstances, did not occur until April 11th, 2014, more than 7 months after the original meeting. A brief in-person update was given at an abbreviated meeting held in November 2013 after HCTF hosted a 20th anniversary celebration. A week prior to the April 11th Coalition meeting, the results from the first meeting were sent to Coalition members again, along with a link to the HawaiiCANData.org website.

Activities at the second Coalition meeting were abridged due to time constraints. Supplementary materials were provided to participants, including items that were collected by the researcher at the end of the first meeting, and items that were given to attendees to keep. The following materials were distributed to all Coalition meeting attendees:

(1) Consent form (Appendix B)
(2) Data-Informed Policy Advocacy Questionnaire (Appendix E)
(3) Policy Goal Formulation worksheet (Appendix F)
(4) Organization Profile form (Appendix G)
(5) Community Capitals handout (Appendix H)
(6) Data-Informed Policy Advocacy 16-page booklet (Appendix I)

All materials collected from individuals (1, 2, 4) were numbered so that responses could be matched. As in the first meeting, all attendees were asked to sign the consent form, both to ensure that new participants provided informed consent, and to enable responses from participants who were present at the first meeting to be matched with their other materials.

The researcher gave a brief overview of the project and discussed results from the first meeting, as well as provided an introduction to the HawaiiCANData.org website, and a sampling of data products that were created and included in the “Data In Use” section of the site.

Next, attendees were led through a Policy Goal Formulation activity. In order to make efficient use of the small time allocated for these activities, participants were encouraged to focus on the most popular category of goals generated during the first Coalition meeting—state/legislative goals related to funding. Attendees were encouraged to work in small groups with others at their table to formulate a 1-2 year SMART goal related to funding. This could be reformulations of goals proposed by others in the previous Coalition meeting, or entirely new goals. Participants were encouraged to refer to the Data-Informed Policy Advocacy booklet for more information about funding goals.
The Data-Informed Policy Advocacy 16-page color booklet (Appendix I) included the following:

- A brief overview of the project and introduction of the researcher;
- Summaries of results from the visioning and policy goal activities from the first Coalition meeting, including tag clouds describing policy goals;
- A comprehensive list of all policy goals submitted by participants in the first Coalition meeting relating to funding;
- A partial list of revenue sources used by other state Children’s Trust Funds, culled from the websites and Annual Reports from 20 other states;
- A list of resources related to policy advocacy;
- An introduction to the HawaiiCANdata.org website;
- A sample of data products created for this project including infographics and an overview of the interactive data visualization; and
- A list of resources related to Strengthening Families and the Protective Factors framework.

In addition to creating 1-2 year SMART goals, groups were encouraged to begin thinking about short-term objectives (what they would like to have done by the next Coalition meeting), and the next action they could take to bring them closer to reaching their objective. Although each attendee had a personal copy of the Policy Goal Formulation worksheet to use as a reference and to potentially use as a future resource, a worksheet was also distributed to each table to record the results of the group activities. These sheets were each marked with a letter of the alphabet (from
A-G), and were collected at the end of the meeting to be matched with assets from the next activity.

The next group activity was focused on identifying assets that could help Coalition members collectively achieve their 1-2 year SMART goals as well as their short-term objectives. Coalition members worked in their pre-existing groups, and were asked to identify community assets that could help to facilitate the previously identified policy priorities. The Community Capitals Framework (Emery & Flora, 2006) was used as a means of conceptualizing assets; capital can be considered assets that are invested. The Community Capitals Framework proposes 7 categories of capital that communities possess: human, social, cultural, political, financial, natural, and built capital. Human capital includes skills and abilities that people possess, as well as access to bodies of knowledge. Social capital refers to relationships between people or entities, and can be split into “bonding” capital between those who are tightly connected, and “bridging” capital, which loosely connects groups, organizations, or communities. Cultural capital refers broadly to the way people “know the world,” and includes tradition and language. Political capital concerns access to power, and the ability of people to influence their communities or social settings. Financial capital is the most commonly known form of capital, and it refers to financial assets that can be invested, as well as wealth that can be passed on for future investment. Natural capital refers to features of the natural environment, including open spaces and natural beauty; through a sense of place it is connected to cultural capital. Built capital refers to infrastructure, including buildings and utilities that can support activities. Participants were
introduced to these categories, and given a handout (Appendix H) briefly introducing each of the capitals.

Participants were encouraged to use the Community Capitals Framework as a launching point, but not to be overly restrictive in listing assets that only fit within the Framework, as some assets could be utilized in unexpected ways. Attendees were then asked to post their asset lists to the wall, and this Asset map was left up for the remainder of the meeting.

After these activities, Coalition members were asked to complete the Data-Informed Policy Advocacy Questionnaire (Appendix E). This questionnaire included questions regarding the following:

- The potential usefulness of the HawaiiCANData.org website and specific types of data products in helping the Coalition clarify and achieve its policy goals;
- The perceived usefulness of the policy goal formulation and asset mapping activities, as well as overall satisfaction with all activities;
- Their use of data in decision making, including a reprise of the 5 questions asked in the questionnaire distributed at the first Coalition meeting;
- An open-ended question about the potential use of data in policy advocacy;

However, because of the small number of responses to the first two surveys, there were no comparative analyses of the two sets of data. Rather, descriptive statistics were run simply to ascertain the perceived usefulness of the data products and meeting activities, and to obtain additional information on the extent to which
research is used by Coalition members to inform child maltreatment prevention activities.

After the meeting, a summary of all activities were provided to HCTF Coalition members through the HCTF Coalition email list. This summary included a list of policy goals and next actions, as well as an asset map, both of which were derived from the group activities that took place at the second Coalition meeting. The asset map will be presented in two forms: the first is simply a report of the assets given by each group associated with its respective goal; the second will be a map of all assets listed by Coalition members, grouped according to the Community Capitals Framework.

These activities were meant to be a starting point for continued discussion and collective action toward achieving policy goals that will help prevent child abuse and neglect in Hawai‘i. As such, the list of policy goals and the asset map were shared in a format that allows for continued use. Results of the final evaluation survey were also summarized in an infographic and shared with HCTF leadership and Coalition members.
Chapter 3: Results

I. Prior Work: Assessing Policy Goals and Data Needs

The Policy Goals and Data Needs Survey, which was included as an optional addendum to a separate Coalition survey regarding relationships among members and satisfaction with the One Strong ‘Ohana campaign, was completed by 18 active Coalition members, though not all respondents replied to all questions. Respondents were primarily employees of nonprofit organizations, but also included employees of state departments (e.g., the Department of Health), and individual Coalition members not claiming an organizational affiliation. All four counties of Hawai‘i were represented among survey respondents.

Policy Goals. Coalition members were asked two open-ended questions about policy:

(1) What policy issues do you think HCTF should focus on in the next 1-2 years?

(2) Which organizations or individuals are most crucial to achieving HCTF’s policy goals?

In analyzing the responses for themes, I found that 13 Coalition members offered responses clustering into four main areas: concerns about funding, collaboration/Coalition composition, training, and services for families. In some cases, a single participant listed multiple goals, while in others, these areas overlapped (e.g., obtaining funding for training).

Four participants mentioned funding, though there were some differences in the funding focus. For instance, one Coalition member was concerned exclusively
with prevention, writing “HCTF needs to make sure that CAN prevention funding does not dry up. We need advocates at the leg, and working to ensure that we do not lose any more programs,” Another Coalition member was concerned with prevention as well as child protection, writing “Appropriate funding and other resources for child protection (prevention and intervention).”

Four participants mentioned issues related to collaboration/coalition membership. These respondents were focused on Coalition-level activities, including expanding membership and engagement of certain groups (e.g., parents), as well as increasing collaboration. One member was specifically concerned with coordinating services, writing “Development of stronger collaborations among member organizations to avoid unnecessary overlap of services, and especially to coordinate service strengths to support each other to address CAN issues.”

Three participants listed training for direct service providers and other professionals as a priority. One member described a desire to see, “Training Curriculum on the protective factors for health and social services organizations....and healthcare professionals.”

Finally, three Coalition members were concerned with services, writing of the importance of maintaining services for families, and in some cases of reaching out to provide services to particular target populations. For instance, one member wrote generally that it was important to “Make sure appropriate and available services are in place to help families at risk of CAN”, while others specifically mentioned supporting target groups such as parents of teenagers or of toddlers. Others wrote of the importance of taking legislative action to support policies that would enable families to obtain specific services, such as one person who thought
that HCTF should focus on “Evidenced Based Policies supporting Parent Child Interaction Therapy Treatment.”

In response to the second question regarding which organizations or individuals were most crucial to achieving HCTF’s policy goals, 13 Coalition members provided responses that primarily fell into three groups: State government agencies and programs (e.g. DOH, DHS), specific non-governmental organizations (e.g. Prevent Child Abuse Hawai‘i, Good Beginnings Alliance), and non-specific references to organizations, groups, and individuals, (e.g. “neighbor island agencies,” “a statewide coordinating agency,” “cultural groups,” “field social workers, crisis line workers, school teachers, clergy,” “more people from communities, schools, churches, etc.”). Only one respondent specifically named an individual, who was noted for being particularly skilled at fostering collaboration.

**Data/Information Use and Needs.** There were two open-ended questions regarding data usage and needs:

1. What kind of information (e.g., state statistics on CAN) do you currently use to make organizational decisions regarding the prevention of child abuse and neglect?
2. What kind of information/data would be most helpful to your organization and to HCTF in its efforts to prevent CAN in Hawai‘i?

In response to the first question, 13 Coalition members provided answers that varied considerably, with some going into significant detail about a variety of data sources, “YRBS, CWSB Intake, PRAMS, Primary Care Data Book, Hawai‘i Data Warehouse, National Children’s Health Survey, CDC, Center on the Family, DOE, CDR, DVFR, Police monthly data on DV, WIC, Early Intervention, Medicaid,” and
others providing vague statements, “general stats given by research people.” The majority of respondents fell in between these two poles, with the modal response being 1 specifically named data source. The most common data sources listed were from state agencies, namely DOH and DHS (e.g., the DHS Databook).

In response to the second question, 12 Coalition members provided responses, which were clustered into three groups: 1) updated or more accessible versions of state statistics pertinent to CAN prevention, 2) data regarding program effectiveness, and 3) information that would facilitate collaboration. The most common comments were appeals regarding currently available state statistics, which included those expressing a general desire for statistics regarding CAN in the state, specific data regarding certain groups (e.g., “Data on infants and toddlers in the following categories: child abuse, sexual abuse, neglect, at risk for abuse and neglect, i.e., domestic violence, substance abuse”), those requesting updates to currently available documents, and those expressing the desire to have current data in a more easily accessible format. Regarding the latter, one person wrote “Hawai‘i DHS stats are not provided in uniform ways--making the agency data more user-friendly to practitioners and the public would be very helpful.”

Regarding program effectiveness, most participants were interested in identifying effective programs, while one person expressed an interest in having data that would support the effectiveness of the protective factors framework or the need for community resources. Responses related to collaboration included one member requesting a directory of all CAN prevention programs in the state and another member who sought information that would increase opportunities to apply for joint
funding. In addition to the three clusters, one individual expressed an interest in having the statewide CAN prevention plan, which is currently under development.

**Ratings Related to Evidence-Based Decision Making.** In addition to the two open-ended questions listed above, respondents were asked to rate the extent to which they agreed with statements about their organization’s use of data in decision making, their confidence in their ability to find needed data, and their belief in the importance of evidence-based decision making to prevent CAN. Results are presented in Table 3. On average, respondents expressed a belief that research should inform practice or policy decisions about CAN prevention in Hawai’i, with a mean rank of 4.3 on a scale from 1-5. In response to questions about their organization’s access to data and their own sense of self-efficacy regarding their ability to find needed data, mean scores were lower, at 3.1 and 3.5, respectively.

**Table 3: Preliminary survey data - Research needs and efficacy**

<table>
<thead>
<tr>
<th>How much do you agree with the following statements? (1 = Strongly disagree, 5 = Strongly agree)</th>
<th>n</th>
<th>Mean (1-5)</th>
<th>Std</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research should inform practical or policy decisions about CAN prevention in Hawai’i</td>
<td>16</td>
<td>4.3</td>
<td>0.87</td>
</tr>
<tr>
<td>My organization has the data it needs to make evidence-based decisions about CAN prevention</td>
<td>16</td>
<td>3.1</td>
<td>1.18</td>
</tr>
<tr>
<td>I feel confident in my ability to find data or research results that I need for my work</td>
<td>17</td>
<td>3.5</td>
<td>1.07</td>
</tr>
</tbody>
</table>
II. First Coalition Meeting: Group Visioning, Policy Goal Identification, and Information Needs Assessment

Activities at the first Coalition meeting were devoted to visioning and policy goal identification. Attendees were first asked to individually reflect on their vision for the near-term future of the HCTF Coalition. They were then asked to share their reflections in small groups. Following this, members were encouraged to suggest policy goals at three levels: state/legislative, inter-organizational/community, and organizational. After these activities, attendees completed the Knowledge Translation Survey which included questions about currently used and potential data sources, data products, and data formats. They were also asked to complete questions related to research needs and efficacy, as well as ratings of the day’s vision and policy activities. These results are presented in the subsequent sections.

Thirty-one Coalition members participated in activities at the first Coalition meeting and also submitted consent forms and completed questionnaires. Identifying information was not collected during the first Coalition meeting, but some information was available through Coalition records and previous surveys. Most participants were representatives of nonprofit organizations, though some were representatives of state departments or were private citizens. The majority of participants were from Honolulu County; Maui County was the second most popular source of participants. Of the 31 attendees who submitted data at the first Coalition meeting, 8 (25.8%) had also completed the prior survey from Step 1.

**Individual Visioning Activity.** Coalition members were asked to respond to a prompt in which they were to imagine that it was two years in the future and a local news outlet was writing a story about the success of the HCTF Coalition
(Appendix C: Policy Advocacy Questionnaire Booklet), and write a vignette describing what the article would say. Responses were collected from 26 participants. These vignettes were later ported into the RQDA system and analyzed using the procedures described in the methods section. Line-by-line analysis was followed by open coding of the vignettes. Codes were then grouped into five themes: funding, coalition composition, collaboration, coalition activities, and success.

The first theme centered on funding. This included increasing and stabilizing the funding stream for the HCTF Coalition itself, as well as providing funding opportunities for organizations engaged in CAN prevention. HCTF’s ability to continue to directly fund projects was prized, as was its ability to advocate for funding for prevention programming and services throughout the state. In addition to descriptions of increased funding opportunities, some members also described the resilience of the Coalition despite cuts in funding to the Coalition itself (e.g., “HCTF has come a long way, overcome transition period; lack funds; however, they have been resistant + continue to provide services/grants to the community”) and funding cuts experienced by organizational members (e.g., “coalition has worked through challenges such as losing members due to funding cuts @ various agencies”). Though members described “doing more with less,” even those who emphasized resilience still typically described an ideal scenario in which more funding was available for the Coalition and/or for programs.

The second theme concerned coalition composition. Members envisioned a Coalition that had expanded significantly, included representation from multiple sectors, and was statewide, including a clear presence on neighbor islands. One member wrote that the article “discusses the large multi-sector nature of the
coalition and the tons of members all across the state.” Another elaborated on the importance of the presence of the Coalition on Oahu’s neighbor islands, envisioning that the Coalition had appointed “a community coordinator on each island.”

The third theme centered on **collaboration.** The HCTF Coalition was envisioned as a driving force in bringing together agencies from different sectors, and helping to build the social networks of its members. This would result in more effective coordination of services for community members, enhanced capacity for collective action, and increased resource sharing. For instance, one member wrote that “Many community agencies and members gathered to form this coalition and have sworn to work together by sharing skills, strengths, and resources.” Two members also mentioned ‘one-stop-shops’ combining resources to support community members, with one writing, “They have started to build a smooth transition for families that have been hurt/affected by abuse, ex[ample], court, rehab, social services, counseling, extra-curricular activities, financial assistance, education, day care, health, etc. one stop shop.”

The fourth theme focused on **coalition activities.** Several members underscored the importance of focusing on the needs of the community, and described activities that would increase community engagement or be taken on behalf of or in partnership with communities. The Coalition would directly engage in activities dedicated to preventing child abuse and neglect, particularly those devoted to policy advocacy and increasing public awareness. Public awareness building included media efforts, trainings, and events. Several specifically mentioned the One Strong ‘Ohana campaign (e.g., “Furthered the efforts of the OSO campaign to include more commercials featuring Hawai’i’s families/children”), and/or a focus on
protective factors (e.g., “the protective factors are common language and practice”). The Coalition would also indirectly support prevention programming by allotting or facilitating the securement of funds for organizations that engage in CAN prevention, enabling them to provide support and resources for families. Involvement with schools was specifically mentioned by multiple Coalition members, such as one person who stated that “parent programs are a part of every school from preschool thru HS” and “schools or complexes of schools put on family fun fairs that include community resources for families as well as other fun activities (health, education, safety).”

Finally, Coalition members described what success would look like for the Coalition. Most frequently, and perhaps not surprisingly, Coalition members described substantial reductions in the prevalence of child abuse and neglect across the state. Goals ranged from the relatively modest (e.g., “The HCTF has played an integral role in reducing the incidence of child abuse and neglect”) to more ambitious scenarios (e.g., “the child abuse numbers have dwindled to historic lows,” and “HCTF has been a driving force in eradicating child abuse and neglect in Hawai‘i”). Some members specifically mentioned that evaluation would demonstrate these reductions or other markers of success for the Coalition’s efforts. Though the majority of respondents described direct reductions in CAN, some respondents cited reductions in proxies for CAN, such as “services needed for abused children,” or “lowered rates of ‘accidental’ child deaths in Hawai‘i.” Coalition success also included other positive elements, such as strengthened communities and strengthened families, respect for cultural diversity and values, and children who were protected and cared for in safe nurturing environments. As one participant wrote “HCTF’s
commitment to Hawai‘i’s keikis, opio, and ohana has led to families taking full responsibility for the nurturing and malama of the families in a way that has led to healthy happy families.”

To summarize, although Coalition members varied somewhat in their emphases and specifics, they were largely consistent in describing the relationship between these different themes. They generally described an ideal scenario in which the HCTF Coalition was a large, multi-sector coalition deeply engaged in communities throughout the state, including Oahu and neighbor islands. The Coalition facilitates connections between agencies, which leads to greater collaboration, coordination of services, and sharing of resources. HCTF itself is well-funded and is able to provide grants for prevention programming in the community. The Coalition engages in advocacy in order to secure funding for CAN prevention, and continues to have success with the One Strong ‘Ohana public awareness campaign. As a result of the HCTF Coalition’s success, there are measurable reductions in child abuse and neglect throughout the state, and beyond this, families and communities are stronger. Figure 7 presents a diagram of the relationships between these five themes. This image was shared with Coalition members at the second meeting.
**Group Visioning Activity.** In the Group Visioning activity, Coalition members were encouraged to share their individual visions in small groups, and then to work together to devise a headline and key points that would be included in an article about HCTF. The five resulting groups created the following headlines:

1. HCTF: A Coalition That Works
2. HCTF Coalition Succeeds At Strengthening Families Culminating in “Voyaging Festival”
3. Bill & Melinda Gates Foundation Recognizes the Achievements of HCTF with $10 Million Grant to Continue Its Work
4. HCTF Rocks
(5) Community Voice in Action

In two of the five cases, the headlines could be directly linked with specific ideas that were generated during the individual visioning session, and which proved popular with their respective groups. The reference to a $10 million grant from the Gates Foundation stemmed from the following vignette:

HCTF conducted a successful outreach and media campaign regarding strengthening families with protective factors that include 90% of all new parents in the state and all DOE schools. HCTF's evaluation shows an overall reduction in Child Abuse + neglect since the campaign started and an increase in awareness of parents + families regarding the needs of children and families that allow each child in Hawai‘i to live in a safe and nurturing family. HCTF was awarded $10 million from the Bill + Melinda Gates Foundation to continue its work.

The reference to a “voyaging festival” in one headline stemmed from an individual vignette in which “The coalition sponsored a huge voyaging festival that highlights the awesome cultural perspectives of families in Hawai‘i.” This headline also included a focus on strengthening families, one of the desired outcomes described in many of the individual visioning statements.

In addition to the headlines, four groups submitted descriptions of their key points. There were clear consistencies among the individual and group visioning statements. In fact, each of the four group visioning statements included all five themes. The first group, with the headline “HCTF: A Coalition That Works,” described a coalition that was multi-sector and brought agencies together facilitating better coordination of services, activities including public awareness building and policy advocacy, increased funding, and successful outcomes including reductions in
CAN and strengthened families. Interestingly, while the individual vignettes were focused almost exclusively on prevention, this group vision statement also included references to funding and coordination of services for abused children.

The second group, with the headline “HCTF Coalition Succeeds At Strengthening Families Culminating in ‘Voyaging Festival’”, described a statewide multi-sector coalition with involvement from the neighbor islands and which built stronger relationships through collaborative efforts, events and activities focused on the needs of the community, increased funding, respect for cultural diversity, and strengthened families.

The third group, with the headline “Bill & Melinda Gates Foundation Recognizes the Achievements of HCTF with $10 Million Grant to Continue Its Work,” described a coalition which functioned as a large “statewide coordinated multi-sector network” which facilitated research sharing, promoted public awareness of CAN and the protective factors through the One Strong ‘Ohana campaign, was resilient despite funding difficulties and continued to provide funding for direct service grants (and was rewarded for their work with a substantial grant from an outside foundation), and which produced measurable reductions in child abuse and neglect while promoting quality nurturing environments and better care for children.

The fourth group, with the pithy headline “HCTF Rocks” had a similarly terse description of key points, which nonetheless reiterated the key themes, describing a coalition engaged in “breaking down silos,” which is compatible both with creating a multi-sector coalition and with promoting collaboration, increased funding, public awareness of the protective factors and CAN prevention programs in schools including preschools “with parent engagement”, and significant reductions in CAN.
Policy Goal Formulation. The results from the prior survey (i.e., Policy Goals and Data Needs Survey – Step 1) suggested policy focus areas that included goals that might be traditionally thought of in terms of policy advocacy (e.g., working with the state legislature to ensure stable funding for prevention programming). However, results also included goals that could be relevant to specific organizations (e.g., supporting particular target populations), or that primarily concern inter-organizational relationships (e.g., ensuring coordination of services). To build on these results, participants at the first Coalition meeting were encouraged to focus policy goals at the state/legislative, inter-organizational/community, and organizational levels. They were also provided examples from among the prior survey responses for each level (see Appendix C: Policy Advocacy Questionnaire). Using these guidelines and examples, attendees at the Coalition meeting generated a list of policy goals for each of these levels.

Goals for each level were analyzed and grouped after the meeting, and then shared with Coalition members so that they could be used for further discussion. For both State and Organizational-level goals, this analysis revealed a great deal of consistency, while Community/Inter-organizational-level goals were more varied.

For State policy goals, the overwhelming majority of goals were related to securing state funding for CAN prevention programming. Of 29 participants who submitted goals, over two-thirds submitted goals related to the need for additional funding. These ranged from very general goals, e.g., “Secured funding for CAN prevention/child development,” to more detailed goals, e.g., “Develop legislation for the infrastructure development for $1.5 mil funding for services, evaluation/research, improved policy, training for professional development by the
end of 2015 legislative session.” Some goals focused on securing funding for HCTF, e.g., “Advocate to have more funding to support Hawai‘i Children's Trust Fund works in strengthening families,” while others were concerned with ensuring sustainability of funding for CAN prevention, e.g., “Support contracts/petitions to state law makers at least once every year from community members & agencies on why it’s important to continue funding for CAN prevention.”

State policy goals not related to funding were more disparate, and focused on regulations and mandates. For instance, one participant suggested “Mandatory kindergarten,” while another specifically targeted a law that they believed needed to be changed:

Change Hawai‘i state laws relating to CAN. Right now, it is not against the law to use physical/corporal punishment "within reason" by any caregiver of the child. ACT 031- approved 4/22/13

Community/Inter-organizational policy goals were clustered into four main categories: (1) Engagement with multiple agencies in individual communities/islands, (2) Resource sharing/“One-stop shops”, (3) Logistical support for collaboration, and (4) Community events and workshops.

Several people expressed a desire to engage deeply in individual communities and particularly to ensure their presence on each individual island. Representation from multiple community-based agencies was frequently described as an objective to meeting this goal. For instance, one goal was listed as “Determine and address immediate needs of individual communities. Connect through neighborhood school boards & family -community centers, health centers.”

Resource sharing emerged as a common goal, and the goal of having collocated services or “one-stop shops” for community residents was mentioned by
more than one participant. In one instance, this was described as a step related to the goal of engaging individual communities, i.e., “Have the community identify their needs and build a one stop shop to address their needs.” In addition, logistical support for collaboration was a broad category that included items such as “Support & fund staffing to coordinate collaboration,” and “Communication is organized & timely with other members.”

Finally, several people mentioned community events and/or workshops as a means toward effecting outcomes such as enhanced collaboration between organizations and promotion of HCTF’s values and message. For instance, one goal was “Creating workshops in community to share the family strengthening practice,” while another was to “Promote stronger collaborations between organizations by hosting culturally appropriate networking events (pot lucks, talk story).”

Turning to organizational goals, for the most part, these were largely centered around strengthening and supporting families, with many specifically mentioning the protective factors framework. For example, one organizational goal was to “Provide all new parents protective factor training within 6 months after having given birth.” Many expressed concern with providing holistic support to families and ensuring that they felt supported in CAN prevention efforts. For instance, one goal was that “Programs within the organization work together to support the family as a whole,” while another focused on the feelings of parents, stating that a desired outcome in which “Parents are not afraid to reach out for help – with child abuse neglect (domestic violence) issues.”

Policy goals were also re-coded using codes developed from the vision statements. When this was done, policy goals were found to be largely consistent
with individual and group visions. Nearly all of the policy goals aligned with at least one of the codes from the analysis of visioning activity data, and could be grouped into one of the five major themes: funding, coalition composition, collaboration, coalition activities, and success. For instance, obtaining increased funding for CAN prevention was prominent both in the visioning activity and in the policy goals. Maintaining the One Strong ‘Ohana public awareness campaign was likewise mentioned in the visioning activities and during the policy goal setting activities. Only two new codes were created when goals were re-analyzed in this way; these related to contract negotiations and changing specific laws (e.g., law regarding corporal punishment).

Re-coding information in this way demonstrated that some themes were more prominent at each of the three levels (Figure 8). Prominent themes included funding, collaboration, and activities. The central importance of funding was reinforced, as was its clear identification as a state/legislative issue. Collaboration emerged as a significant theme at all levels, and perhaps not surprisingly, was most pronounced at the community/inter-organizational level. Most of the categories originally identified at this level could be viewed as sub-categories under the larger theme of collaboration. However, collaboration was also mentioned at the other two levels, with people discussing collaboration between state agencies or different departments within organizations, as well as state funding to support collaboration. Coalition activities were also mentioned at all three levels, but were most prominent at the organizational level, particularly supporting families and using the protective factors framework. Furthermore, for the other two levels (state/legislative and inter-organizational/community), coalition activities were mostly mentioned in
conjunction with the other primary themes for those levels; e.g., events to support collaboration at the community/inter-organizational level, and funding to support specific CAN activities at the state level.

![Policy Goals Chart](image)

**Figure 8: Policy goals by Vision themes**

**Information Needs Assessment.** After discussion of the policy goals, participants were asked to complete the Knowledge Translation Survey, as a means of assessing the information needs of Coalition members. This survey included three sections: rankings of desired data products; rankings of desired data formats; and a checklist of data sources that were currently in use or that participants wished to use. The purpose of this information needs assessment was to inform activities in the next phase of the study, which centered on knowledge translation.

First, participants were asked to rank their preference for five types of data products: (1) Effective CAN prevention programs, (2) Hawai‘i CAN statistics, (3) Directory of CAN programs, (4) State/regional demographics, and (5) Research on
the consequences of CAN. They were also given the option of adding a sixth additional category, though most did not do so. Average rankings and Borda counts indicated the same order of preference for data products (Figure 9 and Figure 10). Coalition members were most interested in products concerning (1) Effective CAN prevention programs, followed by (2) Hawai‘i CAN statistics.

Figure 9: Order preferences of desired data products based on mean ranks

Figure 10: Order preferences of desired data products based on Borda counts
Participants were also asked to rank data formats in order of preference. Again, both mean rankings and Borda counts indicated the same order of preference (Figure 11 and Figure 12) with data visualizations/infographics ranking highest, followed by online videos. Printed reports and spreadsheets, which are often the most common formats for distributing data, were ranked the lowest.

**Figure 11: Order preference of desired data formats based on mean ranks**

**Figure 12: Order preference of desired data formats based on Borda counts**
Participants indicated that the most commonly used data sources were from the Hawai‘i State Department of Health (DOH) and Department of Human Services (DHS). This is consistent with the findings from the prior survey distributed to members in August 2013. A complete list of data sources in order of common use is presented in Figure 13.

In addition to asking participants about which data sources they currently used, they were also provided a list of sources and asked about which of those listed data sources they wished to use. In response, participants expressed interest in using many of the listed data sources, including several that were not commonly in use. The most desired data sources were from the Child Welfare Services Branch (CWSB) Intake, and the Domestic Violence Fatality Review (DVFR). A list of data sources in order of desired use is presented in Figure 14.

In Figure 15, data sources are ranked according to the difference between their desired and actual use (with a minimum value of 0). The Domestic Violence Fatality Review (DVFR) and Child Death Review (CDR) are tied for first place as data sources with the largest discrepancy.

Figure 16 presents a summary of integrating information from the three charts, with items placed in order according to difference from left to right, beginning with the CDR and DVFR, and lines indicating desired and actual use for each source.
### Data Sources In Use

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Health (DOH)</td>
<td>16</td>
</tr>
<tr>
<td>Department of Human Services (DHS)</td>
<td>9</td>
</tr>
<tr>
<td>National Child Abuse and Neglect Data System (NCANDS)</td>
<td>8</td>
</tr>
<tr>
<td>KIDS COUNT</td>
<td>8</td>
</tr>
<tr>
<td>Child and Family Service Reviews (CFSR)</td>
<td>8</td>
</tr>
<tr>
<td>University of Hawaii Center on the Family</td>
<td>7</td>
</tr>
<tr>
<td>Pregnancy Risk Assessment Monitoring (PRAMS)</td>
<td>7</td>
</tr>
<tr>
<td>Department of Education (DOE)</td>
<td>7</td>
</tr>
<tr>
<td>Perceptions of Child Abuse and Neglect in Hawaii</td>
<td>6</td>
</tr>
<tr>
<td>National Survey of Children’s Health (NSCH)</td>
<td>6</td>
</tr>
<tr>
<td>Department of Justice (DOJ)</td>
<td>6</td>
</tr>
<tr>
<td>Child Welfare Services Branch (CWSB) Intake</td>
<td>6</td>
</tr>
<tr>
<td>Youth Risk Behavioral Surveillance System (YRBSS)</td>
<td>5</td>
</tr>
<tr>
<td>National Institute Study of CAN (NIS-4)</td>
<td>4</td>
</tr>
<tr>
<td>Hawaii Health Data Warehouse (HHDW)</td>
<td>4</td>
</tr>
<tr>
<td>Domestic Violence Fatality Review (DVFR)</td>
<td>3</td>
</tr>
<tr>
<td>Adoption and Foster Care Analysis and Reporting System (AFCARS)</td>
<td>3</td>
</tr>
<tr>
<td>Child Death Review (CDR)</td>
<td>2</td>
</tr>
</tbody>
</table>

*Figure 13: Data sources in order of actual use*
Figure 14: Data sources in order of desired use

Data Sources Wanted

- Domestic Violence Fatality Review (DVFR) - 11
- Child Welfare Services Branch (CWSB) - 11
- Youth Risk Behavioral Surveillance System - 10
- Child Death Review (CDR) - 10
- Child and Family Service Reviews (CFSR) - 9
- Adoption and Foster Care Analysis and... - 9
- National Survey of Children’s Health (NSCH) - 8
- KIDS COUNT - 8
- Hawaii Health Data Warehouse (HHDW) - 8
- Department of Justice (DOJ) - 8
- University of Hawaii Center on the Family - 7
- National Institute Study of CAN (NIS-4) - 7
- Department of Human Services (DHS) - 7
- Department of Education (DOE) - 7
- Department of Health (DOH) - 3
Data Sources by Difference between Wanted & In Use

- Domestic Violence Fatality Review (DVFR) 8
- Child Death Review (CDR) 8
- Adoption and Foster Care Analysis and Reporting System (AFCARS) 6
- Youth Risk Behavioral Surveillance System (YRBSS) 5
- Child Welfare Services Branch (CWSB) Intake 5
- Hawaii Health Data Warehouse (HHDW) 4
- Perceptions of Child Abuse and Neglect in Hawaii 3
- National Institute Study of CAN (NIS-4) 3
- National Survey of Children’s Health (NSCH) 2
- Department of Justice (DOJ) 2
- Child and Family Service Reviews (CFSR) 1
- University of Hawaii Center on the Family
- Pregnancy Risk Assessment Monitoring (PRAMS) 0
- National Child Abuse and Neglect Data System (NCANDS) 0
- KIDS COUNT 0
- Department of Education (DOE) 0
- Department of Human Services (DHS) 0
- Department of Health (DOH) 0

Figure 15: Data sources in order of difference between desired and actual use
Research & Policy. In addition to the Knowledge Translation Survey, participants were asked to respond to questions regarding attitudes, efficacy, and use of research/data in programmatic and policy decision making. Three of the questions had been asked in the prior survey (Step 1). Two additional questions were also included. Participants were asked to rate their agreement on these five questions, on a scale from 1-5, where 1 = Strongly disagree, and 5 = Strongly agree. Overall, participants had relatively high scores on measures of attitudes toward the importance of research, and slightly lower scores related to the use of research, as well as their individual and organizational efficacy in finding research. The results are summarized in Figure 17.
Usefulness of Activities and Participant Satisfaction. Ratings of the usefulness of individual and group activities were generally high. In response to the question “How useful were the following activities? (Rate 1-5, 1 = Not useful, 5 = Extremely useful)”, the means for all activities were similar. Ratings for individual and group visioning activities were 4.4 and 4.5, respectively, while ratings for individual and group policy activities were 4.3 and 4.5, respectively (Figure 18). In response to a question about overall satisfaction with the day’s activities, the mean score was 4.5 on a scale from 1-5.
III. Knowledge Translation Activities

Prior to the second Coalition meeting, I focused on knowledge translation activities, many of which were built on findings from the Information Needs Assessment performed at the first meeting. First, the results of the first meeting were shared in multiple formats. Next, an online data repository was created in order to increase the capacity of Coalition members to find desired data sources and products. This included an interactive database of data sources, which was seeded with sources that participants at the first meeting indicated they desired to use. Finally, a selection of data products were developed reflecting the stated preferences of participants. Coalition members indicated that they were most interested in obtaining data products that focused on effective CAN prevention programming and Hawai‘i CAN statistics. Therefore, 4 products were created: (1) an interactive data visualization of Hawai‘i CAN rates by region, (2) an infographic summarizing
information about effective home visiting programs, (3) an infographic on perceptions of child abuse and neglect in Hawai‘i, and (4) a set of GIS maps of Hawai‘i summarizing information about regional differences in CAN rates, family poverty, and awareness of CAN contributing and protective factors.

**Dissemination of Previously Collected Data.** As described in the methods section, data collected at the first Coalition meeting were analyzed and disseminated to Coalition members shortly thereafter. In addition to a Powerpoint presentation summarizing key findings, and provision of raw data, an infographic was also created (Figure 19) with select findings from the session. These items were put in a Dropbox folder, and a link to the folder was shared with Coalition members via the Coalition email list shortly after the first Coalition meeting, and one week prior to the second Coalition meeting. Additionally, a 16-page booklet was created and distributed at the second Coalition meeting, which included findings from the first meeting’s visioning and policy activities, along with information about the data repository and data products, and resources related to policy advocacy (Appendix I). The booklet included a diagram depicting relationships between vision themes, and tag clouds illustrating policy goals.
Figure 19: Infographic summarizing findings from 1st Coalition meeting
Online Data Repository. After sharing the results from the first Coalition meeting, information from the Knowledge Translation Survey was used to inform the development of an online repository of CAN data sources and products. The HawaiiCANdata.org website (Figure 20) was created to share the data sources that were used and products developed during this project. Since data are frequently updated and new data sources are developed and released continually, the site was created in order to enable ongoing input of new data sources by the researcher or by Coalition members and others working in CAN prevention. There are three main sections of the site: Data Sources, Data in Use, and Hawai‘i CAN Resources.

Figure 20: Hawaii CAN Data website - home page

The list of Data Sources was seeded using documents pulled from the list of data sources used in the Knowledge Translation Survey. In nearly all cases, the listed data sources did not correspond to one document or database but to a source of multiple forms of data. Figure 21 shows the list view of data sources available on the
website, while Figure 22 shows the submission form enabling registered site users to submit new data sources.

The Data in Use section of the site was created to host data products developed for this project, and others like it. It can serve as a case example of data being used by community based organizations and other entities. The Hawai‘i CAN
Resources section will host an online directory of organizations working on CAN prevention in Hawai‘i. It includes searchable fields based on location and type, as well as a separate field devoted to highlighting whether the organization offers training or support related to one or more of the protective factors. The website is still being developed. There was a small spike in online activity the week before the second Coalition meeting, when a link to it was shared with the HCTF Coalition email list, and another small spike after the second Coalition meeting. In order to maximize the usefulness of this site, ongoing promotion, training, and community building will likely be necessary.

**Data Product Development.** In addition to the online data repository, specific data products were created based on feedback from the Knowledge Translation Survey. Interactive data visualizations and infographics were created to represent data from selected sources, including sources that were frequently in use by Coalition members, as well as sources in which there was a large discrepancy between desired and actual use.

**Product #1: Hawai‘i CAN rates by region, 2007-2012 data visualization**

The Department of Health and Department of Human Services statistics were the most commonly cited as being used by Coalition members in both the prior survey and in the knowledge translation survey, with one person specifically citing the statistics on CAN prevalence by region. However, some respondents to the prior survey noted a desire to have data from this source shared in a more easily accessible manner. The first interactive data visualizations were created with this in mind, as a way to introduce Coalition members to a new way to explore data from a familiar source.
The data were presented in four formats: (1a) Bar graphs which allow for easy at-a-glance comparison of CAN rates in different regions, and which include an option to filter by year, (1b) Line graphs depicting changes in CAN rates for each region over time, (1c) A map of the Hawaiian islands with CAN rates by county, and (1d), a treemap displaying nested rectangles representing each district, with the hue of each rectangle based on county, the shade based on CAN rate, and the size proportioned according to child population. The first three formats were also presented on a dashboard (Figure 23), which can be filtered by county or year (Figure 24).

Figure 23: Hawaii CAN Rates 2007-2012 dashboard
Each view offers a different perspective on the data. The bar graphs are useful when looking at all regions in Hawai‘i in a given year or for all years (2007-2012) combined, but do not make it easy to see change over time. For instance, though the district of Waianae has the highest CAN rate, the bar graph with the 6 year average obscures the fact that there has been a notable decline in substantiated CAN in the last several years. The line graphs make it easier to see changes within regions over time at-a-glance. These graphs are somewhat cacophonous in the full view, but include an option to filter by county and by district, which makes it easier to see changes between regions.

The presentation of average CAN rates by county (Figure 25) illustrates differences by county that may be masked by data when it is disaggregated based on district. In addition, each county has some data for which the district is unspecified, and this varies substantially across counties. While the district with the highest CAN
rate is in Honolulu, the county with the highest CAN rate is Hawai‘i. Hawai‘i County also has the highest proportion of data in which districts are unspecified.

The treemap (Figure 26) conveys information that is not presented elsewhere, regarding child population. This information can be important when identifying problems and choosing where to allocate resources, as well as helpful in interpreting results that may otherwise be unclear. For instance, districts with small populations are more liable to have rapid fluctuations in CAN rates, since a small number of cases can make a large difference in rate. This can be seen in the district of Hana, where the first two views (Figure 27) and (Figure 28) show skyrocketing rates of CAN in the year 2011, while the treemap view (Figure 29), showing the darkly
colored but small red rectangle in the lower left corner representing Hana, illustrates that this high rate is due to a relatively small number of actual cases of CAN in a district with a child population of only 535.

Figure 26: CAN rates by district w/child population

Figure 27: CAN rates for Maui districts, 2011
Figure 28: CAN rates for Maui, 2007-2012

Figure 29: CAN rates for Maui by child population, 2011
Product #2: Home Visiting to Prevent Child Abuse & Neglect infographic

In response to participants’ stated desire for information regarding effective CAN prevention programs, an infographic was created based on information from the comprehensive Home Visiting Evidence of Effectiveness Review (HomVEE; Avellar et al., 2013). Though the HomVEE review included information about the effectiveness of select home visiting programs in a variety of outcomes, this infographic specifically highlighted programs with evidence of effectiveness in preventing child maltreatment. The infographic was designed for a lay reader with a central theme guiding its development: home visiting programs can be effective in helping to prevent child abuse and neglect. The goal of this infographic was to tell a story rather than to translate large quantities of data, and a great deal of information was abbreviated or left out entirely in order to make an intelligible graphic.

The infographic has four sections: the first (top) section quickly describes home visiting programs for those who may be unfamiliar with them; the second section highlights the 6 programs that were identified by HomVEE as showing substantial evidence of effectiveness in preventing CAN; the third section describes the standards HomVEE used in determining effectiveness (e.g., rates of substantiated CAN, self-reports by parents using validated measures, ER visits and hospitalizations); and the fourth section illustrates the other potential benefits of home visiting by showing the proportion of these 6 programs that also demonstrated positive outcomes in the following areas: child health, maternal health, child development & school readiness, and positive parenting practices.
Figure 30: Home Visiting to prevent CAN infographic
Product #3: Perceptions of Child Abuse and Neglect in Hawai‘i

In 2011, HCTF and Joyful Heart sponsored a study on perceptions of child abuse and neglect in Hawai‘i in preparation for the One Strong ‘Ohana campaign. The results of this study were distributed widely in an attractive booklet. Although this presents a model example of how data can be distributed, the report was divided into general reports for the state of Hawai‘i and specific results for Honolulu’s “neighbors”, the counties of Maui, Kauai, and Hawai‘i.

Therefore, the third data product (Figure 31) sought to condense some of this data into one image, allowing for quick comparison of statistics between counties, using Tufte’s (1990) concept of “small multiples” and Gestalt principles of grouping. Though the result is dense and, therefore, potentially intimidating for users, use of these principles ensures that results can be read quickly. The logic behind small multiples is that repeated use of the same type of figure using the same type of metrics will reduce the time needed to understand data, since the viewer need not spend additional time processing each figure. In this case, 25 pie charts describe percentages of respondents to each of 5 questions, for the 4 counties of Hawai‘i and the state as a whole. Since this product was designed to facilitate quick comparison of answers to the same question between regions, the Gestalt laws of similarity and proximity were applied so that responses to the same question were in pie charts of the same color and spaced more closely together than responses to different questions by the same county.

Viewed as a whole, certain anomalies also may stand out. For instance, Hawaii County stands out among regions in terms of the percentage of people who report being abused as children (20% vs. a statewide rate of 9%). Observing the other
responses, it appears that this is complemented by a higher rate of Hawai‘i residents reporting that they believe child abuse is a major problem (89% vs. 80% statewide), though responses to other questions do not differ dramatically from the other neighbor islands. Honolulu County is also anomalous, reporting lower than average rates on several indicators of abuse prevalence, despite the fact that statewide means are brought closer to Honolulu’s figures due to its disproportionate population.

Figure 31: Perceptions of Child Abuse & Neglect in Hawaii - County comparisons
Product #4: GIS maps/Infographics of CAN rates, family poverty, and awareness of CAN contributing and protective factors

Prior to the launch of the OSO public awareness campaign, a randomized phone survey was conducted assessing Hawai‘i residents’ awareness of CAN contributing and protective factors. Responses to this initial data were mapped using ArcGIS. Figure 32 is a reproduction of a figure produced for an article exploring the potential uses of GIS and social network analysis for Coalition planning (Cardazone, et al., 2014). It depicts a map of the state of Hawai‘i, with regions shaded according to the average number of contributors that were perceived by respondents to be associated with child abuse and neglect. The scores of each region are depicted in a range from light gray (0.0–1.0), to dark gray (6.0–7.0), with higher contributor summary scores exhibiting darker shading. White regions are uninhabited or represent regions from which there were no survey respondents. The figure shows clear discrepancies between regions, with one of the most prominent differences present in the leeward side of Oahu, which is shaded light gray, indicating that the average respondent identified 0-1 out of 7 contributors to child abuse and neglect.
In addition to a color version of this map, three other maps GIS maps were created for the next set of infographics:

1) Awareness of CAN protective factors, derived from the same data set as that used for contributing factors;

2) CAN rates by region, derived from the same data as that used for the interactive visualization (Figure 23);

3) Family poverty by Census county subdivision, obtained from the American Community Survey 5-year estimates, and defined as the percentage of families with children living below the poverty rate.
These maps will be made available in full to Coalition members via the HawaiiCANData.org website, pending consultation with HCTF leadership. In addition, an infographic with a map from each set was created for each of the four counties of Hawai‘i (see Figure 33 for an example of Hawai‘i County). Refinement of these infographics based on user feedback is likely needed in order to make it maximally useful. Nonetheless, this image of Hawaii County was shared at the second Coalition meeting as an example the use of GIS mapping.

The purpose of these maps, besides facilitating exploratory analysis of geographic data, was to aid Coalition members in identifying regions which may require different forms of outreach. For instance, a region which has a high CAN rate, a low level of awareness of contributing or protective factors, and a relatively low level of family poverty may be specifically targeted for public awareness activities. In contrast, a region which exhibits a high CAN rate, a high level of awareness of CAN contributing and protective factors, and high levels of family poverty, may benefit more from concrete supports than from awareness-building activities. These maps could also help identify regions with low levels of CAN, which can be engaged to obtain more information on resilience against CAN, especially when other factors associated with CAN are present.
IV. Second Coalition Meeting: Policy Goal Formulation and Asset Mapping

At the second Coalition meeting, there was a brief presentation of the results of the first Coalition meeting and the products created during the Knowledge Translation phase of the study. Following this, attendees worked together in small groups on two group activities. The first was devoted to policy goal formulation and action planning, and built on the policy goal brainstorming activities in the first Coalition meeting. The second was an asset mapping activity designed to help
participants uncover individual and collective assets that could help further their policy goals. After this, participants were asked to complete a questionnaire (Appendix E), which included questions about the potential use of various data products, questions about research and policy, and ratings of the usefulness and satisfaction with the day’s activities.

Twenty-six Coalition members participated in activities at the second Coalition meeting and submitted consent forms and completed questionnaires. Of these, 20 submitted organizational profiles for the CAN resources directory. As in the first meeting, the majority of participants were representing nonprofit organizations. The most common job title was Executive Director/CEO/President. Most attendees were from Oahu, followed by Maui. Of the 26, 8 (30.8%) had completed the prior survey (Step 1), and 13 (50%) participated in the first Coalition meeting (Step 2).

**Policy Goal Formulation and Action Planning.** During the policy goal formulation and action planning activities, Coalition members were encouraged to examine the policy goals suggested in the previous meeting related to obtaining state funding for prevention. They could then either choose one of these goals and refine it, or create a new SMART goal related to increasing funding. They were then encouraged to consider short-term objectives and next actions that could bring them closer to achieving this goal. Due to time constraints and varying group dynamics, there were significant differences between groups in how much progress they made toward completing their worksheet as well as enthusiasm for the activity. In total, six groups devised the following objectives:

1. Develop and design One Strong ‘Ohana specialty license plate (to increase) public awareness and sustain the One Strong ‘Ohana campaign.
(2) Create an advocacy committee to gather and disseminate data to the legislative and general public around impact of prevention.

(3) Pass a constitutional amendment related to allowing state funds to be used for state-funded preschools and including CAN prevention education for parents.

(4) Develop materials to show cost of CAN to private sector.

(5) Secure funding for the establishment of 12 one-stop shops to promote collaboration.

(6) Legislative restoration of prevention money into the trust fund in the amount of $3 million per year for a total of $6 million for the biennium.

The first two groups identified next actions that could facilitate movement toward achievement of their objectives, and shared their goals and next actions with the larger group of all Coalition members. The remaining four groups shared information about their goals with the larger group, and some also identified specific actions steps; however, groups varied in their level of specificity, since only 15 minutes were given to complete this activity.

**Asset Mapping.** After formulating policy goals and specific objectives, groups were then given time to consider any assets that they, their organization, their community, or HCTF may possess that could help them to achieve their goals. Participants were introduced to the Community Capitals Framework (Emery & Flora, 2006) and encouraged to use this framework and their goals as a starting point for generating ideas about assets, but to be inclusive when considering assets, since they may find unexpected uses for assets that do not necessarily seem relevant to their goals. For instance, natural capital may not seem relevant to policy advocacy.
activities, but it can be; public parks can be used as gathering places for political rallies or community meetings, and the natural beauty of Hawai‘i brings many tourists who represent potential sources of revenue, either through taxes or other means. Groups then posted their asset lists on the wall so that others could observe them during the lunch break and the rest of the meeting. The asset lists were collected by the researcher to be recorded and shared back with the Coalition. Though they were not required to do so, many groups opted to list assets in terms of the Community Capitals Framework. Table 4 lists assets according to the 7 Community Capitals.

Though there was quite a bit of diversity in the types of assets listed both within and across groups, there were several recurrent motifs or specifically named assets. Thematic regularities included: extensive social networks, relationships with and knowledge derived from working with families, famous residents and supporters, Hawaiian cultural value of ‘ohana, relationships with legislators, HCTF’s social media presence, and for natural capitals, as one group wrote, “Hawai‘i, hello!” In general, relationships were an overarching theme among many different types of capital. There were also specific organizations or people mentioned by multiple people, such as Marizka Hargitay, star of Law & Order: SVU, who is a spokesperson for the One Strong ‘Ohana campaign through her role as CEO of Joyful Heart; and Suzanne Chun Oakland, a Hawai‘i State Senator who is also an HCTF Advisory Board and Coalition member.
<table>
<thead>
<tr>
<th>Capital</th>
<th>Type</th>
<th>Example(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human</td>
<td>Expertise</td>
<td>Marketing, admin/finance, education</td>
</tr>
<tr>
<td></td>
<td>People/groups</td>
<td>CAPP, therapists, families who use services</td>
</tr>
<tr>
<td></td>
<td>Resources</td>
<td>PCAN curriculum</td>
</tr>
<tr>
<td>Social</td>
<td>Social networks</td>
<td>Community networks in high risk areas, Extensive social networks in general (“everybody knows everybody”)</td>
</tr>
<tr>
<td></td>
<td>Organizations/insitutions</td>
<td>Relationships between member orgs, relationships with military, HPD, community based orgs</td>
</tr>
<tr>
<td></td>
<td>Media</td>
<td>Relationships w/media, strong social media presence, Potential or actual connections with famous people (e.g. Marizka Hargitay)</td>
</tr>
<tr>
<td>Cultural</td>
<td>Hawaiian/local cultural values and traditions</td>
<td>‘ohana, ho’oponopono</td>
</tr>
<tr>
<td></td>
<td>Culturally focused organizations</td>
<td>Kamehameha, OHA, QLCC, Alu Like</td>
</tr>
<tr>
<td></td>
<td>Diversity</td>
<td>Diverse communities</td>
</tr>
<tr>
<td>Political</td>
<td>Relationships with policy makers</td>
<td>Local politicians, legislative advocates, Suzanne Chun Oakland (State Senator &amp; AB member)</td>
</tr>
<tr>
<td></td>
<td>Organizations/groups</td>
<td>Keiki Caucus, CFS/PHOCUSED</td>
</tr>
<tr>
<td></td>
<td>Resources</td>
<td>E-advocacy system</td>
</tr>
<tr>
<td>Financial</td>
<td>Current and former sponsors</td>
<td>Zippy’s, Whole Foods, Jamba Juice</td>
</tr>
<tr>
<td></td>
<td>Connections to funders</td>
<td>Access to Keiki funders network, nonprofit board affiliated corporations</td>
</tr>
<tr>
<td></td>
<td>HCTF partner</td>
<td>Hawaii Community Foundation</td>
</tr>
<tr>
<td>Built</td>
<td>Specific buildings</td>
<td>KROC Center, Campbell Estates, Harry &amp; Jeanette Weinberg Building, Kauai Convention Center, Community College/Performing Arts Center</td>
</tr>
<tr>
<td></td>
<td>General location possibilities</td>
<td>Churches, schools, HCTF Coalition member organizations</td>
</tr>
<tr>
<td>Natural</td>
<td>Locations of interest</td>
<td>Kokee State Park, Poipu, Hanalei river/taro patches</td>
</tr>
<tr>
<td></td>
<td>Climate</td>
<td>Year-round good weather, outdoor potential for ECE learning</td>
</tr>
<tr>
<td></td>
<td>Community characteristics</td>
<td>Self-reliance within community due to isolation</td>
</tr>
</tbody>
</table>
**Data Products Reflection.** After the asset mapping activity, attendees were asked to complete a questionnaire (Appendix E). Participants were asked several questions related to the perceived usefulness of various data products in helping HCTF clarify or achieve its policy goals. Since dissemination between meetings was limited, these questions were phrased in terms of their potential usefulness. Responses were uniformly high with a limited range of 4.4 – 4.6 on a scale of 1-5, where 1 = Not useful and 5 = Extremely useful.

![Bar chart showing the usefulness of various data products](image)

**Figure 34: Usefulness of data products to achieving policy goals**

In addition, four participants gave ratings for “Other” data products, with an average rating of 4.5. The one participant who specified another product suggested...
the asset map. Another participant did not provide a rating but suggested a logic model in response to the final open-ended question in which participants were asked “Which product do you think may be most useful in helping HCTF clarify or achieve its policy goals? Why?” Seven people provided responses to this question. In addition to the suggestion of the logic model, two people named the website, two named the interactive data visualization/CAN stats, and two wrote about the general usefulness of the products. Participants indicated that the statistics from the data visualization and the website would help to determine needed services and areas. One participant wrote “Website that pulls statewide data w/statistics that community organizations can use for their programs”, while another wrote “Interactive data visualization (Hawai‘i CAN statistics) because it would help identify where the needs are so that program funding can be specific for coalition + advisory decision making.”

**Research & Policy.** As in the first Coalition meeting, participants were asked to rate their agreement on a variety of statements related to research and policy, on a scale from 1-5, where 1 = Strongly disagree, and 5 = Strongly agree. Once again, participants had relatively high scores in measures of attitudes toward the importance of research, and slightly lower scores related to the use of research and their individual and organizational efficacy in finding research. The mean scores for all responses in the first and second Coalition meetings are summarized in Figure 35.
This chart illustrates responses for all participants of both meeting. Though results appear at first glance to indicate a potential increase, statistical analyses were not done due to low sample sizes and a lack of consistency between the first and second meeting. This apparent increase is eliminated when the dataset was restricted only to respondents that attended and completed questionnaires at both Coalition meetings. There was a smaller overlap between these two groups than anticipated, with only 11 Coalition members attending and completing questionnaires at both meetings.
Attendees of the second Coalition meeting also answered the following open-ended question: “How do you think research/data can inform policy decisions about CAN prevention in Hawai‘i?” Ten participants provided brief responses, some of which were focused on the ability of data to guide decision making, e.g., “Make more objective fact-based decisions - use results to guide decisions, resource allocation, less reliance on relationships + more on data/performance/outcomes – objectivity.” Others were more focused on the potential use of data to convince policymakers and others to provide funding, e.g., “Data showing the need for prevention may better influence those who are number oriented,” or one person who simply wrote “justification!” Two people described the need for more research in specific areas. One person expressed a desire to see what works in terms of “concept dissemination” about CAN prevention in Hawai‘i. Another pointed out that while research is important, there is a specific need in Hawai‘i for more research about Native Hawaiian/Pacific Islander populations:

Research absolutely to inform, however, we need more research so we have more/better/comprehensive data on Native Hawaiian/Pacific Islander. Was just at symposium in AL & spoke w/Asst. Dt. General & others re: Hawaii, including US in studies because that data is need for programming as well as funding + including NH/HI as N. Alaska & N. Am are.

**Usefulness of Activities and Participant Satisfaction.** In response to the question “How useful were the following activities? (Rate 1-5, 1 = Not useful, 5 = Extremely useful)”, the means for both activities were identical at 3.9 (Figure 36). This is slightly lower than the mean scores for activities in the first Coalition meeting. In response to a question about overall satisfaction with the day’s activities, the mean score was 4.1 on a scale from 1-5.
Two open-ended questions about the day’s activities were asked. Eleven people responded to the question “How do you think today’s activities contributed to HCTF’s ability to achieve its policy goals?” Several people commented on the quality of ideas generated during group discussion, while one person noted that it was necessary that HCTF enact these ideas. One person indicated that they did not believe that the activities contributed to this aim. Two people alluded to the time constraints, with one person writing “Would have been great to have more outcomes/utilization of the asset mapping activity - and some time to talk over ideas.” The time constraints were again mentioned in response to the second open-ended question, which solicited any additional feedback about the day’s activities, with one person writing, “Would LOVE to do them with enough time.” One person noted that the method for determining groups may not have been ideal, since they
had two people leave their table and ended up with a very small group. Other additional comments were generally positive, e.g., “Thank you for everything!”
Chapter 4: Discussion

This project took an action research approach to answer the overarching question: “How can dissemination of relevant research inform the policy goals and activities of a statewide coalition dedicated to preventing child abuse and neglect?”

There is currently a shortage of literature regarding the efficacy of knowledge translation interventions, which are designed to enhance the use of research to inform practice and policy decisions (Ward et al., 2009). Additionally, there is increasing movement toward models of knowledge translation that are dynamic, multi-dimensional, and adaptive to local contexts and changing circumstances (Ward et al., 2009, 2011; Wilson et al., 2011). In recognition of this need, this project was designed to be an iterative and creative approach to responding to the needs and preferences of Coalition members, and, as such, continually incorporated information obtained from participants to inform subsequent actions. It adopted elements of the Knowledge-to-Action Framework, which was developed by the CDC to address the need for increased dissemination and use of evidence-based interventions to address chronic disease (Wilson et al., 2011), particularly through recognition of the multi-dimensional and recursive nature of knowledge translation.

In this section, I will first examine five sub-questions related to the overarching research question, connecting each sub-question with specific activities and results. Then, I will explore the extent to which these activities succeeded as an intervention in achieving outcomes stated in the logic model, and how elements of this intervention could be replicated in other settings. Following this discussion, I will provide specific concrete recommendations to the HCTF Coalition regarding next steps aimed at further enhancing the effective use of data to support policy
goals. Finally, I will explore the limitations of this intervention, and discuss implications for future research and action.

**Research Questions**

In order to explore the overarching question regarding the potential use of research to inform policy goals and activities, the first three sub-questions concerned the following: identifying gaps in access to or use of information, determining the adequacy of existing data sources to meet identified needs, and examining the potential usefulness of data products specifically developed in response to identified needs. In addition to these three sub-questions, there were two additional questions that explored practical queries regarding HCTF’s ability to identify policy goals and assets that can support achievement of these goals. In the following sections, I will address each of these five questions, using the data provided in the Results section, as well as my personal reflections arrived throughout the development, implementation, and evaluation of this project.

**Information Gaps.** The first sub-question was “What gaps currently exist between the information that is used by the HCTF Coalition and the information that Coalition members believe is important for effective policy change?

Data collected in steps 1,2, and 4 indicate that there are substantial gaps between the information and research that can be easily obtained by HCTF Coalition members and the information that members perceive as needed for informing programmatic and policy decisions. At each of the 3 steps, participants were asked to rate their agreement with statements concerning attitudes, efficacy, and use of data to inform practice and policy decisions. Findings indicate that Coalition members
generally believe that data should inform practice and policy decisions regarding CAN prevention. However, moderate ratings on questions regarding individual efficacy in using data and organizational access to and use of data to inform decisions indicated that there is substantial room for improvement. This discrepancy between the perceived importance of research and the actual implementation of data-informed decision making is reflective of the broader societal trend driving many knowledge translation efforts, in which claims about the importance of evidence-based decision making and accountability are not being met by the use of research to inform practice and policy (Mitton, et al., 2007; Ward et al., 2009).

Further, results indicate a discrepancy between members’ preferred format for receiving data and the formats that are most often available. Coalition members indicated they were most interested in obtaining data in formats that are rarely provided, such as data visualizations and infographics, and least interested in obtaining data in formats that are most commonly available, namely written reports and spreadsheets. This discrepancy may partially explain the inconsistency between members’ stated value of the importance of research and their actual ability to effectively use data in decision-making. This finding is consistent with the previous observations that the lack of data available in easily readable formats hampers the ability to engage in evidence-based practices and policy advocacy concerning CAN prevention (Toth & Manly, 2011). Therefore, the results from the current study make a strong case for the potential usefulness and receptivity toward a knowledge translation intervention designed to increase accessibility and use of data to inform programmatic and policy decisions.
Adequacy of Existing Data to Meet Information Needs. The second sub-question was “How and to what extent can existing data meet the identified information needs of HCTF Coalition members?” During the knowledge translation phase of the project, I attempted to address some of the information gaps identified and discussed in the first sub-question. Throughout this process, I found that there is an abundance of data that exist that can fill some of the gaps in access to information described by members, and which would be ideal candidates for a knowledge translation intervention. However, there were some gaps that could not be so easily filled, and which may require further research rather than knowledge translation activities.

In the first category, there were many specific data sources identified and included in the Knowledge Translation Survey checklist that are relatively easy to access and which some members already use. The “Data Sources” section of the HawaiiCANdata.org website was created with these sources in mind, since it may be possible to increase use of these data simply by increasing awareness that such sources exist and giving Coalition members an easy means of locating them when needed via a searchable database. This category also includes information that exists but is not available in easily accessible formats. Therefore, the “Data in Use” section of the HawaiiCANdata.org website was created to include data products that summarize data into more user-friendly formats. A selection of data products were also created in response to users preferences regarding the type of information (i.e., Hawai‘i CAN statistics, effective CAN prevention programs), and the format in which information is presented and shared (i.e., data visualization and infographics).
However, members also indicated a desire to obtain data that are not readily available. For instance, among the data sources that were included in the Knowledge Translation Survey checklist, there were some listed as highly desired by Coalition members, but which had not been updated in several years. In such cases, data collection may have ceased, or data may continue to be collected but efforts to share data with the general public via websites or data repositories have not been maintained. It requires ongoing commitment by data producers to ensure that needed data are collected, analyzed, and shared.

In other instances, needed data may also be insufficient or lacking, particularly data that are specifically relevant to local cultural and community contexts. For example, one Coalition member cited the need for additional research on Native Hawaiians and Pacific Islanders, especially in national data sets. The common practice of aggregating Asian and Pacific Islanders together has become a recognized problem, as it masks large health disparities (Ro & Yee, 2010). Coalition members also cited the desire for access to relevant information about effective CAN prevention programs. Although there are substantial data on the effectiveness of various CAN prevention interventions, such data may not be as desirable if the study was conducted in vastly different contexts or with different populations than those targeted for services in Hawai‘i.

**Repackaging and Disseminating Data.** The third sub-question was “How can thoughtfully repackaged and disseminated research help to inform HCTF Coalition activities related to policy change?” Data collected at the second Coalition meeting can help to answer this question. Meeting attendees were asked to rate the potential usefulness of various data products, including infographics, GIS maps,
interactive data visualizations, and the HawaiiCANdata.org website. Ratings for these products were uniformly high, indicating that Coalition members believe there is significant potential for data products to help inform policy change activities. Attendees also answered open-ended questions regarding the usefulness of these kinds of products in particular and of data in general to inform policy. Responses to these questions generally fell into two major categories: (1) those that emphasized the intrinsic usefulness of data to help inform programmatic and policy decisions about where and how to allocate resources; and (2) those that emphasized the extrinsic usefulness of increased access to data as a means of justifying activities to policy makers and potential funders.

In addition to providing insight into Coalition members’ beliefs of the usefulness of data products to inform policy decisions, this sub-question can also be considered from an action research perspective. That is, “How can I as an action researcher repackate and disseminate data to help inform HCTF policy activities?” My experiences were congruent with the emphasis on the non-linear and recursive nature of knowledge translation (Mitton et al., 2007; Ward et al., 2009, Wilson et al., 2011). As part of the translation process, it is particularly important to ensure that the sources of data are accurate and that products are not potentially misleading. Bowen and Graham (2013) provide an example of a Canadian health region that sought to analyze and share information about patient safety concerns. However, they failed to involve regional health information staff in the process, which resulted in the creation of a report that failed to take into account important contextual issues, and was therefore roundly criticized. This underscores the benefits of an
participatory action research approach that includes early and frequent involvement of relevant stakeholders.

For this project, the importance of obtaining and incorporating user feedback to the development and refinement of data products became increasingly clear during the knowledge translation phase. Before sharing products with HCTF, I presented some of my interactive data visualizations to the research team working on the statewide CAN prevention plan. They provided invaluable feedback regarding which products would be most useful, and what information could potentially be misleading or would benefit from modifications or additions. For example, the interactive bar chart displaying CAN rates by district was initially calculated using state data on substantiated CAN reports as a proportion of overall population, rather than child population, due to initial difficulties in obtaining detailed information about regional demographics. In addition, there was no baseline CAN rates with which district rates could be compared, either for the state or for individual counties.

In response to their feedback, I switched my approach from creating many interactive visualizations to focusing on creating a single dashboard depicting regional differences in CAN rates. The dashboard included a simple map of the islands with the CAN rates for each county, and a text box with the CAN rate for the state as a whole. The overall statewide rate was not part of any of the visualizations, but provided a crucial reference point. Inclusion of the county rates was particularly helpful in illustrating the shortfalls of looking at data by district only, especially since the greater proportion of substantiated CAN with unspecified districts in Hawai‘i County to some extent masked that county’s overall higher CAN rate in graphs comparing district rates. During the refinement of these models, I studied principles
of data visualization (Tuft, 1990), and made multiple modifications to data products
in order to better adhere to these principles. These modifications included strategic
use of color to convey meaningful information, logical arrangement of ordered data
(i.e., arranging district data from highest to lowest CAN rate, rather than
alphabetically), and inclusion of both macro- and micro-level views of data, enabling
users to see a summary dashboard as well as expanded views of each element of the
dashboard.

**HCTF Policy Priorities.** The fourth sub-question was “What policy issues
are of greatest importance to HCTF Coalition members?” This practical question was
explored in steps 1, 2, and 4 of the project. In the first step, Coalition members were
asked an open-ended question regarding the policy issues they believed HCTF
should focus on in the next 1-2 years. Responses to these questions included a broad
range of issues at multiple levels, including state, community, and organizational
levels. Rather than focusing exclusively on narrow definitions of policy change, e.g.,
as legislative action involving elected policy makers, Coalition members had a
broader definition. Using a broad definition may be more realistic for members, and
such a definition may increase the likelihood that policy change efforts will be
successful. It is also consistent with the conceptualizations of policy advocacy that
include informal and formal efforts at multiple levels, which requires ongoing
community support in order to be implemented and sustained over time (Cohen &
Switft, 1999; Hardy et al., 2011; Plummer, 2013).

In the second step, attendees of the first Coalition meeting were asked to
generate policy ideas at multiple levels. As with step 1, goals related to funding and
collaboration were most commonly named by members, particularly in the vision
statements generated by individuals and groups. During this meeting, it also became apparent that securing funding for CAN prevention was exclusively identified as a state/legislative goal. Collaboration, though primarily identified with the community/inter-organizational level, was also emphasized at other levels, e.g., increasing collaboration within an organization at the organizational level, or increasing collaboration between state departments, or funding for collaborative efforts, at the state/legislative level.

It is not surprising that these two themes figured prominently. HCTF is fundamentally an entity whose primary purpose is to secure funding for CAN prevention in Hawai‘i, and a coalition is by definition a collaboration. Also, the unique structure of HCTF, which by statute currently includes an Advisory Board, Advisory Committee, and a Coalition, was built upon the belief that stakeholders invested in the prevention of child abuse and neglect should inform the distribution of funds by HCTF. The policy goals created by HCTF Coalition members during this process also point to other potential functions of the Coalition, as the Coalition can be mobilized to advocate for further funding for HCTF and CAN prevention in general, and collaborations between organizations can ensure that the funding that does exist can be used in a way that maximizes benefits to families and communities.

**HCTF Assets.** The fifth sub-question was “What assets do Coalition members have that can help the HCTF Coalition achieve its policy goals?” Through the asset mapping activity that took place during the second Coalition meeting, participants identified dozens of assets that could potentially help HCTF achieve its policy goals. This list includes some unique and enviable assets such as a strong social media presence, existing corporate sponsors, a relationship with a well-
known actress, an established brand and unifying framework, and a state legislator who is both a member of the Advisory Board and an active member of the Coalition.

The Community Capitals Framework (Emery & Flora, 2006) proved useful in inspiring participants to consider a wide range of potential assets. Though there were multiple suggestions for each category, there was one form of capital that stood out as being especially important: social capital. To some extent, social capital is infused throughout many of the other capitals. For instance, political capital includes access to power brokers, while financial capital includes relationships with potential investors.

There are factors particular to this group that likely influenced the centrality of social capital to Coalition members. Hawai‘i residents tend to be more collectivistic than residents of other states, prizing relationships over individualism (Triandis, 1995). The word ‘ohana itself refers not only to nuclear families, but to extended social networks. The One Strong ‘Ohana campaign is aptly named, as it can be seen to refer not only to building strong families in order to reduce CAN, but also to the network-based approach HCTF has adopted to achieve this aim.

Coalitions are founded on individual and organizational relationships, and the abundance of social capital bodes well for the HCTF Coalition. Social capital has been increasingly recognized as an intermediate outcome for establishing coalition effectiveness, since coalitions are primarily able to achieve change through their ability to strengthen relationships (Allen, Javdani, Lehrner, & Walden, 2012; Javdani & Allen, 2011; Nowell & Foster-Fishman, 2011).

Social capital may be especially pertinent to policy advocacy efforts. Nowell (2009) found support for the prediction that stakeholder relationships would be
particularly important to the success of systems change outcomes, including policy change efforts. While more internally-focused outcomes concerning changes to member activities may be strongly influenced by other factors such as leadership, broad community-focused outcomes, such as policy change, typically require long-term collective action, and therefore rely heavily on the strength of stakeholder relationships.

Discussions of social capital in relation to coalitions are often focused on the relationships between members. However, in order for a coalition to be effective, it cannot be so densely connected that it does not have sufficient access to outside information and resources (Valente, Chou, & Pentz, 2007). HCTF Coalition assets related to social capital included both internal relationships between organizations and individual members, and external relationships with funders, supporters, policy makers, and service recipients. Building on the centrality of social capital, the Coalition may benefit from engaging in a variation on asset mapping that is still centered on furthering policy goals, but is specifically concerned with mapping relationships.

**Knowledge Translation & Policy Intervention.** This project can be considered a pilot intervention. Evaluation of this as an intervention adds to the small body of literature regarding the implementation and efficacy of knowledge translation interventions (Ward et al., 2009). Returning to the logic model presented at the outset of the project (Figure 5), we can to some extent assess the success of this intervention.

Examining the outputs, there were dozens of policy ideas generated, assets mapped, and items catalogued in the online repository. The number of meeting
attendees was lower than expected, and assessment of website usage is still at a very early stage. Unfortunately, due to low sample sizes, changes in participant efficacy measures could not be assessed. However, ratings for participant satisfaction with activities were generally high.

Regarding the outcomes, there is some evidence supporting the achievement of all three, though there is also a need for further monitoring of the progress in achieving some of these outcomes. The first outcome listed in the logic model was that the “HCTF Coalition has collectively identified the most crucial policy goals.” Through multiple activities, Coalition meeting attendees had opportunities to identify and refine policy goals, with analysis indicating that the most crucial policy goals were those related to funding. There is sufficient evidence to assert that funding is a central concern, though future investigation may center on refining goals and action plans, or assessing Coalition members’ quantitative ratings of the importance of various policy goals.

It is a bit more challenging to determine whether the second outcome was achieved. This outcome was that “HCTF Coalition members are better able to use data to support policy-related goals.” Ability to assess this was hampered by the inability to analyze changes in efficacy measures over time. Furthermore, knowledge translation activities did not take place until very shortly before the second Coalition meeting. Therefore, it is unlikely that Coalition members had sufficient experience with these products to make a significant difference in their ability to effectively use data in their work by the time follow-up data was collected at the second Coalition meeting. Additional data collection concerning member efficacy and actual use of data, including the products developed during the knowledge translation phase, to
further policy goals, will be necessary to provide adequate substantiation for the achievement of this outcome. However, high ratings for the potential use of data products, including the online repository and various data visualizations and infographics, indicate that Coalition members believe in the usefulness of these products in enhancing their ability to use data in order to support policy goals.

There was also some support for the third outcome, “HCTF Coalition members are aware of existing assets that can support the achievement of policy goals.” Through participation in the asset mapping activities in the second Coalition meeting, Coalition members identified many assets that can support policy goals. Currently, only those Coalition members who participated in these activities or who take the time to peruse the raw data or the table of assets compiled and shared after the second Coalition meeting are aware of these assets. Therefore, an important next step in this project will be to collaborate with stakeholders and potentially with a graphic designer to create a visual asset map to be actively shared with all Coalition members. As with other data products, it is expected that taking the time to develop an asset map that is visually pleasing and comprehensible will increase the usefulness of the product. In recognition of the dynamic and iterative nature of knowledge translation (Ward et al. 2009; Wilson et al., 2011), it may be best to use the data collected during this meeting as a starting point for a more comprehensive assembly of HCTF Coalition member assets. Once the asset map is fully developed and shared, further assessment of Coalition members’ awareness of the assets and perceived usefulness of the asset map may help to provide a more thorough estimation of the extent to which this outcome was achieved.
In addition to whether outcomes were achieved, it is also helpful to examine the process involved in delivering the intervention, as this can provide insight into the strategies used as well as suggest future avenues for knowledge translation activities. One way to examine this process is to consider members’ perceptions of the usefulness of the intervention. Though there were variations in user ratings of the usefulness of different activities, it is at this point difficult to disentangle assessments of the activities themselves from the circumstances of their delivery. The group policy goal activities that took place in the first and second Coalition meeting were very similar. However, ratings for each instance were more similar to ratings of other activities performed the same day than they were to each other. Though this could be due to different audiences and variations in the nature of the activities, there were noticeable differences between the two meetings in context and implementation that are important to mention.

At the first Coalition meeting, the activities took place soon after lunch, over the course of 1.5 hours. They assumed no prior knowledge of the project, and began with an idealistic “visioning” activity, culminating in group discussions about policy goals. By contrast, at the second Coalition meeting, the activities took place immediately before lunch and after several consecutive hours of activities and presentations. Further, the time allotted for these activities was reduced from 2 hours to only 1 hour. Activities at this second meeting assumed prior knowledge of the project to a greater degree than was probably warranted, and began with the rather challenging task of building on previously generated policy goals to create specific SMART goals and action plans.

Although activities at the first Coalition meeting were rated more favorably
than activities at the second Coalition meeting, all ratings were generally high. Therefore, despite the limited scope of this intervention and the limitations in the ability to definitively assess success in achieving desired outcomes, there does seem to be some justification for replication, or at least further pilot testing in other settings. Ideally, more time would be allotted for each set of activities, and activities would be provided more regularly. It will also be important to allow sufficient time before following up with members in order to assess whether proposed outcomes were achieved. Even with these caveats, data collected during this project provide support for the contention that interventions focused on knowledge translation are needed and may be welcome by coalitions.

**Recommendations to HCTF**

The Hawai‘i Children’s Trust Fund Coalition is a unique collaborative with a unified mission and philosophy, an increasingly recognized brand via the One Strong ‘Ohana campaign, an accomplished track record, fantastic ideas, and many assets. However, it has also encountered a number of significant challenges. Through my experiences with HCTF, both in the execution of this project and the analysis of its results, in my previous experience as an evaluator for the One Strong ‘Ohana campaign, and through my membership in the HCTF Coalition over the last three years, I have become apprised of many of the difficulties it has faced. I have also consistently admired its many strengths, including its resilience despite these many challenges. In this section I will offer my recommendations to the HCTF Coalition on knowledge translation activities, including recommendations specifically concerned with policy advocacy and data use.
Currently, the HCTF Coalition meets quarterly throughout the year, with limited activity otherwise. In order for the Coalition to thrive, it would be beneficial to have active committees that can keep HCTF active throughout the year. As an example, during step 4 of this project, one group created a SMART goal mandating the development of an Advocacy Committee dedicated to gathering and disseminating data to convince legislators of the necessity of CAN prevention.

In addition to the development of an Advocacy Committee, during a small group activity, attendees at the second Coalition meeting developed several SMART goals specifically related to funding. When planning this activity, I was concerned that it might be perceived as redundant with previous goal-setting activities, or that it would not be ideally suited to small group work, since all groups would be focused on the same overarching goal of increasing funding for CAN prevention. As it turned out, both of these fears were unfounded, as there was substantial diversity in the specific shorter-term goals groups chose to achieve the overarching goal. Interestingly, groups differed not only in the specifics of their SMART goals, but also in their general emphases. Some groups focused on providing mechanisms for enacting policy change (Advocacy Committee) and convincing others to provide funding (developing materials showing the cost of CAN to the private sector). Others focused on specifics of how much money should be allocated ($3 million per year to HCTF) or projects that should be funded (preschools, one-stop shops), and one group focused on a specific source of funding (specialty license plates).

Activities such as nominal group processes that are designed to facilitate group ranking of multiple options may help Coalition members to prioritize among identified goals (Wolff, 2010). This type of exercise would probably be most useful
when deciding between multiple goals within one category, such as the SMART goals related to funding, rather than deciding between a broad variety of goals. Building on the results from steps 1 and 2, this process could conceivably be repeated, with Coalition members refining and then prioritizing among goals related to other themes such as collaboration. This may be supplemented with online surveying of all Coalition members, so that members who are not able to attend Coalition meetings have opportunities to provide input on policy goal priorities. However, it may also be useful to consider external circumstances when determining priorities, for instance, by connecting with others engaged in policy advocacy related to CAN prevention, and determining whether there are pre-existing efforts that are compatible with HCTF Coalition policy goals.

Regarding knowledge translation efforts, the Advocacy Committee could work in partnership with me and others in order to promote usage of the HawaiiCANdata.org website, and increase generation and use of data products, particularly those relevant to policy advocacy. Though the products that have already been created may prove useful to Coalition members in a variety of functions, I may have taken an approach that was narrowly focused on developing products aimed at achieving a single goal over a longer period of time. For example, once I determined that the second Coalition meeting would be focused on goals related to funding, I added a section to the Data-Informed Policy Advocacy Booklet (Appendix E) that summarized information on how other CTFs throughout the U.S. obtain funding. This type of data had not been previously mentioned by any Coalition member and was not included in the Knowledge Translation Survey. However, it was obviously pertinent to the overarching policy goal of increasing funding for prevention
programming. It did end up informing the SMART goal developed by one group, who plan to follow the model of other CTFs and develop a specialty license plate to promote awareness of the One Strong ‘Ohana campaign as a means to generate an additional source of ongoing funding for HCTF.

For now, given the resource constraints faced by the HCTF Coalition, I believe that knowledge translation activities may be limited to such focused efforts. However, long-term plans to improve the use of data by organizations may include other more intensive efforts. This could include focusing on the development of common indicators enabling organizations to share and make use of data regarding the efficacy of prevention interventions in Hawai‘i. It may also include the allotment of resources for technical assistance to increase the ability of organizations to use data to inform practice and to further desired policy goals.

**Limitations of this Study**

There were several limitations of this study. At each of the three data collection points (steps 1, 2, and 4), there were very small sample sizes. In addition, participants may not have been representative of all Coalition members, as those members that attended meetings, participated in activities, and completed the surveys may be more committed to the Coalition than others. No comparisons were made between Coalition members that did participate in Steps 1, 2, or 4, and those that did not. Furthermore, there was only a partial overlap in respondents at each time period, such that it was not possible to determine whether there were statistically significant changes in responses to questions that were asked at multiple time points. These questions, regarding attitudes, efficacy, and use of data, were...
designed to serve as pre- and post- intervention measures of the extent to which these activities accomplished some of the project’s stated aims. The inability to use these data is therefore a significant limitation.

There were also limitations in the data collection tools developed for this project. All of the instruments were created specifically for this project, and so do not have proven validity. Therefore, even if there was a sufficient sample size to conduct statistical analysis on pre- and post- intervention questions regarding data use and efficacy, it is not certain that the questions asked would have been valid (or reliable) measures of the desired outcome. It should also be noted that the Knowledge Translation Survey referred does not explicitly refer to the use of data as it relates to policy goals and activities, even though this was the focus of the study. Although respondents were aware that this was the focus of the study and completed the survey immediately after engaging in policy goal setting activities, the wording in this survey could have been clearer.

Finally, the decision not to collect data regarding Coalition characteristics, other than that collected in the optional Organizational Profile (Appendix G) and information collected from Coalition records, meant that it was not possible to consider potential differences in responses to questions based on characteristics of individuals or the organizations they were representing. This was a conscious decision, made due to the time constraints at both Coalition meetings and the fact that consideration of differences between members was not an explicit focus of this study. However, if a combination of data from all time points yielded a sample large enough to analyze such differences, it may have provided useful information.
In addition to the problems regarding sample size and data collection instruments, there were flaws in the execution of this intervention. Notably, there were several concerns related to timing, including a long time lag between step 2 and step 4, limited time to enact activities in both of these steps, and a small window of time between dissemination of products developed in step 3 and intended use and evaluation of these products in step 4. Regarding the time lag, the first Coalition meeting took place in August 2013. Follow-up activities were scheduled to take place at the following meeting in November 2013, over the course of 2 hours. The next Coalition meeting was pre-empted by a 20th anniversary celebration, while the following meeting was postponed for other reasons. Therefore, step 4 did not take place until April 2014, more than 7 months after step 2. This time lag between meetings was problematic, as it meant that even Coalition members who participated in step 2 activities had difficulty recalling the activities. The activities in step 4, which were planned to take a minimum of 2 hours, had to be condensed since 1 hour was allotted for them at the April meeting. This made it difficult for some groups to complete activities, particularly the formulation of SMART goals and action plans.

Further, data products developed during step 3 were shared via links in a single email, distributed one week prior to the second Coalition meeting, thus providing insufficient time for these products to have a significant impact on policy goal planning or member data use and efficacy. Though it is possible that there may have been changes had dissemination taken place over a longer time period, it is likely that active promotion of data products would have been necessary in order to reach Coalition members. Engagement in knowledge translation activities, including
the development, refinement, and dissemination of data products, is a multi-step process and likely requires long-term investment before changes in efficacy and behavior can be reasonably assessed. Moreover, evaluations of fully developed knowledge translation interventions should also include more rigorous means of establishing efficacy, including assessment of changes in data use and the impact of these changes on practice or policy. When feasible, use of comparison or control groups is preferred in order to more firmly establish causal relationships between knowledge translation activities and outcomes.

**Implications for Future Research and Action**

There is a recognized need for increased research on the implementation and evaluation of specific knowledge translation interventions (Ward et al., 2009). Although the ability to evaluate the efficacy of this intervention was somewhat limited, and future research would be needed to determine the success of this intervention in terms of its promotion of data use and its impact on Coalition activities, it still provides a potentially useful depiction of how one may implement a knowledge translation intervention with a Coalition that is dedicated to improving Coalition capacity to engage in policy change. Though there is cause for optimism given the Coalition members’ high ratings for the usefulness of activities and data products, there are important recommendations for maximizing the effect of this and other similar interventions, as well as variations on how this intervention can be implemented with different target audiences.

First, I contend that this project indicates the benefits of directly asking people what kind of data they want and how they want it to be presented. Most data
are presented in reports or spreadsheets, yet participants in this study indicated that these formats were their least preferred for receiving information. Instead, Coalition members indicated that they would most prefer to receive data in the form of data visualizations or infographics. When data were shared in these preferred formats, members responded positively, giving high ratings for the potential usefulness of data products that were created according to their preferences.

Second, this project indicates that knowledge translation activities should ideally be conducted on a broader scale. There is such an abundance of data and potential uses for data that it is impossible for a single person, or even a single organization, to generate all the products that could potentially be used to inform policy decision-making regarding CAN. However, Coalition members did indicate that such products were potentially very useful.

There are several approaches to conducting knowledge translation activities on a broader scale. One approach is building capacity for organizations to create and share their own products. The creation of the HawaiiCANData.org online data repository was partially inspired by the recognition of the need to increase access to many types and sources of data. Capacity could be further built through the provision of training for interested Coalition members.

Another approach would be to advocate for alternative data formats to be developed by entities that are collecting and sharing data. Data collection and analysis can be a very labor and resource intensive process. When the goal of data collection and analysis is to inform a single organization’s activities, it may not be necessary or feasible to spend a great deal of time on dissemination. However, when data are being shared with a broad audience, with the intention of informing
activities on a statewide or national scale, I would argue that the time and resources spent in data dissemination should rival that of collection and analysis.

Third, the strategy and target audience need to be considered when determining which data products to develop. If the goal is to obtain funding but the strategy involves raising awareness in the general public, then media-friendly items such as infographics may be most useful. Data products that were not created for this project but that may be useful in reaching the media or policy makers include videos and 1-page policy briefs. Products such as the website and interactive data visualizations may still be useful in efforts to reach external entities, but are not products for wide-spread dissemination. Rather, they are potential tools that can be used by Coalition members to create another product, such as a grant proposal or a policy brief.

Fourth, although there is merit to integrating knowledge translation and policy advocacy activities, future interventions may group these activities in a different way or even conceptualize the intervention as having two separable but related components. One component could be aimed at enhancing capacity to participate in policy advocacy activities, and would include the visioning activities, policy goal formulation and action planning activities, and asset mapping activities. The other component would be more specifically focused on knowledge translation activities, and would include the following:

- Open-ended questions about desired or used data sources such as those asked in step 1;
- Formal assessment, building on responses to the open-ended questions, regarding the use of data sources and the desired use of different data
sources and formats, such as that provided through the Knowledge Translation Survey in step 2; and

- The use of such assessments to inform the development of data products that can help to directly address gaps between perceived and desired access to data sources and formats, or build capacity to address such gaps, as performed in step 3.

Sixth, the development of the HawaiiCANdata.org online data repository is one element of this intervention that can be widely replicated across multiple communities and sectors, should it prove useful. At this point, Coalition members have expressed enthusiasm and belief in the potential usefulness of this site, via quantitative ratings, responses to open-ended questions, and informal comments. However, member engagement with the site has been limited.

If engagement with the website does increase, as evidenced by increases in site visits, registered users, and user contributions to the three interactive sections of the site, there may be a strong case for expansion and replication of the site. Currently data are typically available to individuals and organizations via two pathways: directly from the source, or through large comprehensive data repositories. An interactive online data repository that is geographically and topically targeted, and which includes links to relevant data sources alongside data products that may be useful to the targeted audience, may prove useful not only in improving access to data, but also as a means by which organizations can share their own data. Active promotion of the site will be necessary in order to increase use. If these efforts are successful and the site is considered useful, then it could be replicated in a number of contexts, starting with other CTFs throughout the country.
Finally, knowledge translation efforts may benefit from a community-based participatory approach. This type of approach requires a substantial investment of time and energy in developing relationships and understanding the needs of community partners. In this case, the project benefited from a longstanding relationship between the researcher and the HCTF Coalition, which facilitated data collection and informed analysis and data product development. The benefits of having an ongoing relationship with stakeholders throughout the knowledge translation process have been noted (Ward et al., 2011). However, this experience goes a step farther, illustrating the benefits of developing a mutual understanding and sense of trust between the researcher and community partners prior to the initiation of knowledge translation activities. Such a relationship can help the researcher to assess community readiness for knowledge translation activities, ensure that activities are compatible with the goals of community partners, and may increase the likelihood that the results of these activities are well received.

**Conclusions**

This action research study aimed to address a dearth of information in the literature regarding the implementation and efficacy of knowledge translation interventions. Specifically, knowledge translation activities were implemented using elements of the Knowledge-to-Action Framework provided by CDC, with a focus on the policy advocacy efforts of a statewide Coalition dedicated to CAN prevention. Results showed that a knowledge translation intervention was efficacious in achieving outcomes related to helping Coalition members identify policy goals and assets to meet those goals. Whether Coalition members are better able to use data to
achieve their policy goals remains to be seen, but there is initial support as data products generated from this project were developed to be in line with members’ preferences for these products (e.g., data visualizations, infographics) and were generally well received. Although the results of this project are promising, it is important to note that these types of interventions are likely to be non-linear, recursive, and complex endeavors (Wilson et al., 2011). Therefore, additional research is needed to fully understand the utility of such interventions to meet their desired outcomes. To do this, research projects must allocate sufficient time for translation activities to be implemented and evaluated. With more work in this area to explicate the process as well as the outcomes of knowledge translation activities, research data that continue to be collected may be put to better use by agencies and coalitions dedicated to preventing significant societal and public health problems.
References


## Appendix A: Policy and Research Needs Survey

### Hawaii Children’s Trust Fund / One Strong ‘Ohana Collaboration Survey

**Policy Goals & Research / Data Needs Survey**

The purpose of this survey is to assess policy goals as well as data needs and assets of HCTF coalition members related to CAN prevention.

18. What policy issues do you think HCTF should focus on in the next 1-2 years?

19. Which organizations or individuals are most crucial to achieving HCTF’s policy goals?

20. What kind of information (e.g. state statistics on CAN) do you currently use to make organizational decisions regarding the prevention of child abuse and neglect?

21. What kind of information / data would be most helpful to your organization and to HCTF in its efforts to prevent CAN in Hawaii?

22. How much do you agree with the following statements?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>My organization has the data it needs to make evidence-based decisions about CAN prevention</td>
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<tr>
<td>I feel confident in my ability to find data or research results that I need for my work</td>
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</tr>
<tr>
<td>Research should inform practical or policy decisions about CAN prevention in Hawaii</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

23. Do you have any other comments regarding research or policy related to CAN?
One Strong Ohana: Strengthening Families and Communities to Prevent Child Abuse and Neglect in Hawaii

My name is Gina Cardazone, and I am a graduate student at the University of Hawaii (UH). In partial fulfillment of the requirements for my Ph.D. degree in Psychology, I am conducting a research study on the ways in which dissemination of research can help inform coalition policy goals. Participation in this study will involve taking part in group activities during an HCTF coalition meeting, and completing a confidential survey at the end of these activities. I am asking you to participate in this project because you are an active member of the HCTF coalition.

Project Description – Activities and Time Commitment: Participants engage in group activities that will take place during an HCTF coalition meeting, and will then fill out a survey that is distributed after these activities. Survey questions are primarily multiple choice, though you will also have opportunities to share comments. Completion of the survey will take approximately 10-15 minutes.

Benefits and Risks: There will be no direct benefit to you for participating in this survey. The results of this project may contribute to a better understanding of HCTF’s policy goals, and more broadly how research can help inform coalition policy goals. There is little risk to you in participating in this project.

Confidentiality and Privacy: During this research project, I will keep all collected data in a secure location. Only my University of Hawaii advisor and I will have access to the data, although legally authorized agencies, including the UH Human Studies Program, can review research records.

Voluntary Participation: Participation in this project is voluntary. You can freely choose to participate or to not participate in these activities, and there will be no penalty or loss of benefits for either decision. If you agree to participate, you can stop at any time without any penalty or loss of benefits to which you are otherwise entitled.

Questions: If you have any questions about this study, you can contact me at 415-533-6192 or cardazon@hawaii.edu. You can also contact my faculty advisory, Dr. Charlene Baker, at bakercha@hawaii.edu. If you have any questions about your rights as a research participant, you can contact the UH Committee on Human Studies at 808.956.5007 or uhirb@hawaii.edu.
If you agree to participate in this project, please sign and date this signature page and return it to:

Gina Cardazone, Principal Investigator

**Signature:**

I have read and understand the information provided to me about participating in the research project, *One Strong Ohana: Strengthening Families and Communities to Prevent Child Abuse and Neglect in Hawaii*.

My signature below indicates that I agree to participate in this research project.

Printed name: ______________________________

Signature: _________________________________

Date: ______________________________

Please retain the first page of this consent form for your records.
Appendix C: Policy Advocacy Questionnaire Booklet

Envisioning the Future: 'Policy Advocacy to Prevent Child Abuse & Neglect'
Imagine...

It is September 2015, and your local newspaper has decided to do a feature story on the Hawaii Children’s Trust Fund coalition. The story will focus on the changes and accomplishments that have occurred through the coalition’s efforts over the past 2 years. The reporters have interviewed you and many other community and coalition members about the history of the coalition, problems and issues in the community, how residents came together, and the changes the community has undergone. The article will focus equally on the accomplishments and on the changes in the way the coalition functions and is structured.

Research & Policy

How much do you agree with the following statements?

(1) My organization highly values the use of research evidence in decision making

(2) Research evidence is consistently used in program planning decision making

(3) My organization has the data it needs to make evidence-based decisions about CAN prevention

(4) I feel confident in my ability to find data or research results that I need for my work

(5) Research should inform practical or policy decisions about CAN prevention in Hawai‘i
Activity Reflection

Please rate the following on a scale from 1-5, where 1 = Not useful and 5 = Extremely useful.

How useful do you believe the following activities were in helping HCTF clarify its policy goals?

(1) Individual visioning activity 1 2 3 4 5
(2) Group visioning activity 1 2 3 4 5
(3) Individual policy goal brainstorming 1 2 3 4 5
(4) Group policy goal formulation 1 2 3 4 5

How do you think today’s activities contributed to HCTF’s ability to achieve its policy goals?

HCTF in the News

What does the article say?
Policy & Action

The word “policy” may have different meanings for different people. It can refer to legislative policy at the federal or state levels. It can also refer to community level and organizational protocols or agreements. HCTF coalition members have shared ideas related to all three types.

State / Legislative Goals

As a statewide organization, the HCTF coalition may be able to collaborate in order to further goals that can support all member organizations. For instance, several people have stated that ensuring funding for CAN prevention is a policy goal.

“HCTF needs to make sure that CAN prevention funding does not dry up. We need advocates at the leg, and working to ensure that we do not lose any more programs.”

Community / Inter-organizational Goals

Policy goals may also exist at the community or inter-organizational level. A coalition has a unique ability to promote connections between organizations, and policies that eliminate redundancies and enable mutual support.

“Development of stronger collaborations among member organizations to avoid unnecessary overlap of services, and especially to coordinate service strengths to support each other to address CAN issues.”

Organizational Goals

Many goals can be promoted at multiple levels. For instance, the below goal can be considered on a state, community, or organizational level.

“Support for parents of teenagers”
Appendix D: Knowledge Translation Survey

HCTF Knowledge Translation Survey

The information in this form will inform the data dissemination activities that take place over the next few months.

Data Products Wish List

Please rank order items in each of these lists by preference from 1 – 6.

<table>
<thead>
<tr>
<th>Products</th>
<th>Formats</th>
</tr>
</thead>
<tbody>
<tr>
<td>__ Hawaii CAN statistics</td>
<td>__ Printed report</td>
</tr>
<tr>
<td>__ State/regional demographics</td>
<td>__ Data visualization/infographic</td>
</tr>
<tr>
<td>__ Directory of CAN programs</td>
<td>__ Online video</td>
</tr>
<tr>
<td>__ Research on consequences of CAN</td>
<td>__ Powerpoint presentation</td>
</tr>
<tr>
<td>__ Effective CAN prevention programs</td>
<td>__ Spreadsheet/Excel file</td>
</tr>
<tr>
<td>__ Other (specify)</td>
<td>__ Other (specify)</td>
</tr>
</tbody>
</table>

Potential Research Resources

<table>
<thead>
<tr>
<th>Data Source</th>
<th>I use this</th>
<th>I want to use this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adoption and Foster Care Analysis and Reporting System (AFCARS)</td>
<td>☐</td>
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<tr>
<td>Child Death Review (CDR)</td>
<td>☐</td>
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<tr>
<td>Child and Family Service Reviews (CFSR)</td>
<td>☐</td>
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<tr>
<td>Child Welfare Services Branch (CWSB) Intake</td>
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<tr>
<td>Department of Education (DOE)</td>
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<td>Department of Health (DOH)</td>
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<tr>
<td>Department of Human Services (DHS)</td>
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<tr>
<td>Department of Justice (DOJ)</td>
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<tr>
<td>Domestic Violence Fatality Review (DVFR)</td>
<td>☐</td>
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<tr>
<td>Hawaii Health Data Warehouse (HHDW)</td>
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<tr>
<td>KIDS COUNT</td>
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<tr>
<td>National Child Abuse and Neglect Data System (NCANDS)</td>
<td>☐</td>
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<tr>
<td>National Institute Study of CAN (NIS-4)</td>
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<tr>
<td>National Survey of Children’s Health (NSCH)</td>
<td>☐</td>
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<tr>
<td>Perceptions of Child Abuse and Neglect in Hawaii</td>
<td>☐</td>
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<tr>
<td>Pregnancy Risk Assessment Monitoring (PRAMS)</td>
<td>☐</td>
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<tr>
<td>University of Hawaii Center on the Family</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Youth Risk Behavioral Surveillance System (YRBSS)</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>
Appendix E: Data-Informed Policy Advocacy Questionnaire

Activity Reflection

Please rate the following on a scale from 1-5, where 1 = Not useful and 5 = Extremely useful.

How useful do you believe the following activities were in helping HCTF clarify its policy goals?

1. Policy goal formulation activity
   
   1 2 3 4 5

2. Asset mapping activity
   
   1 2 3 4 5

How do you think today's activities contributed to HCTF's ability to achieve its policy goals?

How satisfied are you with today's activities?
(1 = Not satisfied, 5 = Extremely satisfied)

1 2 3 4 5

Do you have any additional thoughts about today's activities?
Data Products Reflection

Please rate the following on a scale from 1-5, where 1 = Not useful and 5 = Extremely useful.

How useful do you believe the following products may be in helping HCTF clarify or achieve its policy goals?

1. Hawaii CAN Data website
   1 2 3 4 5

2. Interactive data visualization (Hawaii CAN statistics)
   1 2 3 4 5

3. GIS maps (child maltreatment, etc.)
   1 2 3 4 5

4. Other infographics (Home visiting, Perceptions of CAN, etc.)
   1 2 3 4 5

5. Data-Informed Policy Advocacy booklet
   1 2 3 4 5

6. Other (please specify):
   1 2 3 4 5

Which product do you think may be most useful in helping HCTF clarify or achieve its policy goals? Why?

Research & Policy

How much do you agree with the following statements?
(1 = Strongly disagree, 5 = Strongly agree)

1. My organization highly values the use of research evidence in decision making
   1 2 3 4 5

2. Research evidence is consistently used in program planning decision making
   1 2 3 4 5

3. My organization has the data it needs to make evidence-based decisions about CAN prevention
   1 2 3 4 5

4. I feel confident in my ability to find data or research results that I need for my work
   1 2 3 4 5

5. Research should inform practical or policy decisions about CAN prevention in Hawai‘i
   1 2 3 4 5

How do you think research/data can inform policy decisions about CAN prevention in Hawaii?
Appendix F: Policy Goal Formulation worksheet

Policy Goal Formulation & Action Planning Worksheet

Vision: "Increased funding for prevention of child abuse and neglect in Hawaii"

1: 2 year SMART objective:

- Specific: Who will be targeted? What will be accomplished?
- Measurable: How will you know when you have achieved change?
- Achievable: Can't be accomplished given your existing resources and constraints?
- Realistic: Does it address your primary problem and offer a reasonable approach?
- Time bound: When will the objective be met?

Short term objective: By the next Coalition meeting, how will you know you are getting closer to reaching your objective? What do you intend to accomplish by then?

Next Action: What is the next action that you have to take to get you closer to reaching your objective?

Roles & responsibilities: Who will be responsible for initiating the next action? Who will report back on the team's progress at the next Coalition meeting?
### Team 'Contact List'

<table>
<thead>
<tr>
<th>Name</th>
<th>Email address</th>
<th>Role</th>
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</tbody>
</table>

### Sample 'Action Plan' Template

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>By Whom</th>
<th>By When</th>
<th>Resources and Support</th>
<th>Potential Barriers or Resistance</th>
<th>Communication Plan for Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>What needs to be done?</td>
<td>Who will take action?</td>
<td>By what date will the action be done?</td>
<td>Resources available</td>
<td>Resources needed (financial, human, political, and otherwise)</td>
<td>What individuals and organizations might resist? How?</td>
</tr>
<tr>
<td>Step 1</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
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<tr>
<td>Step 2</td>
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<tr>
<td>Step 3</td>
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# Appendix G: Organization Profile Form

## CAN Resources Organization Profile

<table>
<thead>
<tr>
<th>Organization name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type:</th>
<th>Does your organization offer services or training related to the following protective factors? (check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Nonprofit or community org</td>
<td>☐ Nurturing and attachment</td>
</tr>
<tr>
<td>☐ Government agency</td>
<td>☐ Knowledge of child development</td>
</tr>
<tr>
<td>☐ Other (please specify):</td>
<td>☐ Social connections</td>
</tr>
<tr>
<td>Category:</td>
<td>☐ Parental resilience</td>
</tr>
<tr>
<td>☐ Community development</td>
<td>☐ Concrete support in times of need</td>
</tr>
<tr>
<td>☐ Education</td>
<td>☐ Social and emotional development of children</td>
</tr>
<tr>
<td>☐ Health &amp; human services</td>
<td></td>
</tr>
<tr>
<td>☐ Legal advocacy</td>
<td></td>
</tr>
<tr>
<td>☐ Multi-service agency</td>
<td></td>
</tr>
<tr>
<td>☐ Other (please specify)</td>
<td></td>
</tr>
</tbody>
</table>

For the next 4 questions, please refer to the State of Hawaii Counties & Districts map *(use back of page if necessary)*:

1. Organization primary location (District):
2. Location where you work, if different than above (District):
3. Regions served by the organization (Districts and/or Counties):
4. Regions you work with/in (Districts and/or Counties):

Can we include your organization in the HawaiiCANData.org Resource Directory?

☐ Yes, please add this information
☐ Yes, but I prefer to alter this information or add it myself
☐ No

What is your job title / role? *(for research purposes only, will not be included in Directory)*

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Appendix H: Community Capitals Handout

Community Capitals

The Community Capitals Framework proposes 7 types of assets that can be invested in communities. These are all important, and interact with each other to influence outcomes.

**HUMAN CAPITAL**
Skills and abilities
Access to resources and bodies of knowledge

**CULTURAL CAPITAL**
Cultural values
Activities
Intercultural relations

**SOCIAL CAPITAL**
Connections among people and organizations
Trust and reciprocity

**FINANCIAL CAPITAL**
Government, business, or individual investments in community

**POLITICAL CAPITAL**
Access to power brokers
Transparency and inclusion in political processes

**NATURAL CAPITAL**
Public recreation areas
Clean water and air
Natural beauty

**BUILT CAPITAL**
Well-maintained infrastructure
Buildings, roads, utilities
Appendix I: Data-Informed Policy Advocacy 16-page Booklet
About this project

This project was designed to help the HCTF Coalition determine policy advocacy goals that can further its mission of strengthening families and communities to prevent child abuse and neglect. It also explores the question of how the Coalition can use data to support its policy goals. It has 4 steps:

Step 1: Preliminary survey — In April 2013, a Policy & Research Needs preliminary survey was sent to all active Coalition members as an optional addendum to a survey about the OSO campaign.

Step 2: First Coalition meeting — In August 2013, I led individual and group activities dedicated to developing HCTF’s vision and generating policy goals, and also collected further information on data use and needs.

Step 3: Knowledge translation activities — Results from the first meeting were analyzed and shared with Coalition members, and used to develop an online data repository (www.HawaiiCANData.org) and data products including interactive visualizations and infographics.

Step 4: Second Coalition meeting — In April 2014, I am working with the HCTF Coalition again to build on previous activities, leading activities that will be dedicated to formulating actionable policy goals, and mapping assets that can help support the achievement of those goals.

About me

My name is Gina Cardazone. I’m a doctoral student at UH Manoa’s Community & Cultural Psychology program, and this project is the focus of my dissertation. I began working with HCTF in 2011 as a member of the evaluation team for the One Strong ‘Ohana campaign.

HCTF Visioning Activity

At the August 2013 Coalition meeting, attendees were asked to imagine that it was 2 years in the future, and there was going to be a newspaper story focused on HCTF and its success. Coalition members individually wrote their visions, and then gathered together to generate headlines and key points for articles.

HCTF Headlines

HCTF: A Coalition That Works
Bill & Melinda Gates Foundation Recognizes Achievements of HCTF with $10 Million Grant to Continue Its Work

HCTF Coalition Succeeds at Strengthening Families Culminating in “Voyaging Festival” Community Voice in Action

HCTF Rocks!
**HCTF Visions** were remarkably consistent. Throughout, members described a Coalition that is large, statewide, and multisector, and that brings together organizations, enabling collaboration, coordination of services, and resource sharing, including the creation of community “one-stop shops.”

HCTF is well funded and able to provide grants for organizations, and there is more funding for CAN prevention and services in the state. The Coalition and its members are therefore able to engage in many activities, including building awareness of the protective factors. The result is that families and communities are stronger, and CAN is dramatically reduced.
Policy Goals

After the visioning activity, Coalition meeting attendees were asked to generate ideas for policy goals at three levels: Organizational, Community / Inter-organizational, and State / Legislative. Policy goals were largely congruent with member visions, though there were different areas of focus at each level.

Organizational Goals mostly centered on providing services and support for families, including training in the protective factors. Collaboration and coordination within and across agencies was also noted.

Examples:
- Have a specific curriculum for different agencies to use relating to Protective Factors
- Programs within the organization work together to support the family as a whole
- HCTF needs to create/continue evaluation criteria so programs are using same data points across the state. So we have data to support policy/leg/budget requests

Community / Inter-organizational goals were mostly focused on collaboration, though this was often integrated with aspects of coalition composition and coalition activities. Goals included: building a statewide multisector coalition, providing logistical support for collaboration, hosting events, raising public awareness, engaging communities to discover their needs and advocate on their behalf, sharing resources, and creating one-stop shops.

Examples:
- There be teams of cross sector coalitions that support/understand trans-disciplinary work to solve common goals to reduce PCAN
- Communication is organized & timely with other members
- Sharing information & resources more frequently & consistently
- Having the community identify their needs and build a one stop shop to address the needs
- Promote stronger collaborations between organizations by hosting culturally-appropriate networking events (pot lucks, talk story)
Spotlight on Funding

Increased funding was one of many themes during the vision exercise, but it was dominant during the policy goal brainstorming activity. Most policy goals submitted were at the state level, and most of these focused on funding. All other policy goals can be obtained in the Dropbox folder created for this project, under Coalition Meeting #1 → Member Responses.

Funding prevention

• Legislation for the infrastructure development for $1.5 mil for services, evaluation/research, improved policy, training for professional development by the end of 2015 legislative session
• Neighborhood Places – Family Center – community based places for families to access support and resources – now $150,000 * 10 = 1.5 mil
• Secured funding for EC programs that include/mandate meaningful partnerships and cultural considerations
• State-funded preschool
• Increased funding for PCAN programs - research to support funding; public awareness; access to community venue for non-profit meeting, tele-video conference; HCTF

Ensuring stability of funding

• Support contracts/petitions to state law makers at least once every year from community members & agencies on why its important to continue funding for CAN prevention – presenting studies/stats on how many people use CAN prevention services, the demand for CAN services
• Statutory mandate to include a % of funding from all new movies filmed in Hawaii to PCAN
• State increased funding for HCTF by placing it in the general funds
• Making a constant state fund for CAN
• Committed public funding for child abuse and neglect prevention services and programs
• Increased statewide awareness + advocacy that will ensure funding + support
• Advocate to have more funding to support Hawaii Children’s Trust Fund works in strengthening families

Negotiating contracts

• NPO’s are providing service like builders. We know our jobs, told you what we would do, you contracted, let us do it
• Provide leverage, through collaborative effort, to push back against unrealistic contract demands
CTF Funding Sources

In a review of the annual reports and records of 20 Children’s Trust Funds, multiple sources of funding were found.

**Commonly cited sources of revenue**

Federal grants - CBCAP & other
State - general funds, grants, fees (e.g. marriage license, birth certificate)
Specialty license plates
Individual & corporate donors

**Largest sources of revenue**

State general funds, grants, fees
Federal grants - CBCAP & other
Tobacco settlement funds

Alabama:
- Children First Trust Fund (tobacco settlement)
- Federal - CBCAP, TANF, & others
- General Funds
- Specialty license plates, income tax checkoff

Massachusetts:
- State Healthy Families home visiting program, State CTF account
- Friends of the Children’s Trust Fund (private), Federal grants

Michigan:
- Trust investments, Federal CBCAP, Auction
- Specialty license plates, heirloom certificates

Missouri:
- Federal grants (CBCAP & others), Marriage license fees, Vital records, Donations, Income tax checkoff, Interest, Specialty license plate

Advocacy Resources

**Funding, evidence-based prevention, & policy**

Child Welfare Information Gateway
http://www.childwelfare.gov/
- Funding child abuse and neglect prevention https://www.childwelfare.gov/preventing/developing/funding.cfm
- Evidence-based prevention practices
  - https://www.childwelfare.gov/preventing/evidence/
- State statutes search https://www.childwelfare.gov/system-wide/laws_policies/state/

Others:
- California Evidence-Based Clearinghouse for Child Welfare
  - http://www.cebc4cw.org/
- The Community Guide to Preventive Services
  - http://www.thecommunityguide.org/
- State Child Welfare Policy Database
  - http://www.childwelfarepolicy.org/
- Alliance for Early Success http://earlysuccess.org/
- Center for the Study of Social Policy http://www.cssp.org/
- Family Strengthening Policy Center
  - http://nationalassembly/fspc/

**Hawaii legislation and advocacy**

- Hawaii State Legislature http://www.capitol.hawaii.gov/
- Hawaii Public Access Room http://lrbhawaii.org/par/
- PHOCUSED (Protecting Hawaii’s Ohana, Children, Underserved, Elderly, & Disabled) http://phocused-hawaii.org/

**Community tools and concepts**

- Community Toolbox http://ctb.ku.edu/en
- Hui Kupa’a collective impact
  - http://www.phocused-hawaii.org/node/6
- Pay for Success http://payforsuccess.org/
Hawaii CAN Data

In an effort to respond to Coalition members’ desire for more easily accessible data related to CAN prevention, several products were created. The first is a data repository, available at HawaiiCANData.org

This includes a searchable database of Data Sources relevant to CAN prevention. Additional sources can be added by any registered user of the website.

As with the Data Sources, the Data in Use items have detailed views with more information. The detailed view on this item may explain the source and method behind creating it, as well as more information about how to use it. Anyone can add items to this section as well, and it can be used not only for data products, but also for case examples of how organizations have used data effectively to inform programs or policies.

The third section of the site will be a Resource Directory of organizations in Hawaii dedicated to preventing CAN.
Additional data products were created based on HCTF Coalition member feedback, and have been added or will soon be added to the HawaiiCANData website.

This includes the infographic at left, based on data about effective home visiting programs (note that Healthy Families America includes Hawaii’s Healthy Start program). This is based on the comprehensive Home Visiting Evidence of Effectiveness Review (HomVEE).

The graphic on the top of the next page shows four maps of the island of Hawaii, with data overlaid on each. Darker colors indicate higher percentages of family poverty (from American Communities Survey data), higher rates of child maltreatment (2007-2012 average from the state Annual Reports), and fewer CAN contributing and protective factors identified by residents (from One Strong ‘Ohana pre-survey data).
CTFs, Strengthening Families, & Protective Factors

National Alliance of Children's Trust and Prevention Funds
http://www.ctf alliance.org/

CTF Online training course in Protective Factors
http://www.ctf alliance.org/onlinetraining.htm

Protective Factors Framework https://www.childwelfare.gov/preventing/promoting/protectfactors/

Protective Factors Survey
http://friendsnrc.org/protective-factors-survey


Questions or feedback?
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