

A Human-Centered Research Design Approach to Child Abuse Prevention

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Abstract

The goal of the research was to better understand factors that contributed to abuse and neglect of children in Fort Bend County, Texas and develop a pilot project to provide and introduce early intervention and prevention strategies, tools, training and information to reduce the incidence, duration and severity of child abuse and neglect.

Why Fort Bend County, Texas? Fort Bend County is a fast-growing, highly diverse community and has experienced an increase in reports of child abuse over the past decade. Child Advocates of Fort Bend (CAFB) is the county's full-service advocacy and direct services umbrella agency for children who have experienced abuse or neglect.

The county has a population of approximately 916,778 as of 2023 and is one of the fastest-growing counties in the United States. Between 2010 and 2023, the population increased 50.7% compared to the U.S. at 7.7% and Texas at 19%. Fort Bend County is one of the most diverse regions in the county with a majority-minority population and a harbinger for the changing demographics of Texas and more broadly of the U.S. (Understanding Houston, Kinder Survey 2024). In 2024, Asian American (22%), Black (20%) and Hispanic (25%) residents comprised two-thirds of Fort Bend County's population with white residents comprising 29% or less than one-third of the county's total population. In 2025, children 18 years and younger represent 29% of the total population. The vast majority of children under age five are people of color (78%) with a somewhat-even distribution of races/ethnicities in this age group. Between 2013 – 2024, the number of children of color under five years old increased by 30%, while the number of non-Hispanic white children in the same age group decreased. (U. S. Census Bureau, Understanding Houston, Kinder Houston Area, 2025). (See Appendix A).

There were 6785 reports of child abuse in 2024 representing 2.4% of the child population compared to 2951 reports or 1.5% of the child population in 2016. This reveals an increase of 171% in the past decade. The majority of these reports involved children who were African American or Hispanic/Latino (76% in 2016 and 78% in 2024).

With the high child population growth, disproportionate impact on children of color which is a population growing faster than the overall growth, and increases in the reports of child abuse, the need to better understand factors contributing to child abuse and neglect is critically important so that actions can be taken to reduce the incidence of child abuse and ensure the safety of the children of Fort Bend County.

Child Advocates of Fort Bend is part of the county's Multi-Disciplinary Team (MDT) providing a coordinated approach to child abuse and neglect cases. In addition to operating two nationally accredited programs Child Advocates of Fort Bend has been a leader and innovator in designing and implementing new and novel approaches for the identification and treatment of child abuse and neglect. CAFB is in the forefront of challenging decades-old conventions around child abuse

and neglect and is uniquely positioned to explore broadening the lens and moving upstream to include prevention and early intervention as a key component in the county's approach to child abuse and neglect.

Research Focus. The study's focus was micro-local to limit the scope to better understand what information, interventions, training or conditions could have prevented these children from experiencing abuse. Research findings will inform the development of prevention and outreach materials, education, information and resources to implement in Fort Bend County with the goal of reducing the incidence, severity and/or duration of child abuse. The research was conducted by Child Advocates of Fort Bend, a 501 c (3) nonprofit umbrella agency providing advocacy and direct services to 3500 children and families annually who have experienced physical abuse, neglect and/or sexual abuse. Child Advocates of Fort Bend operates four programs and 18 services including a Children's Advocacy Center (CAC) serving children who have experienced sexual abuse or severe physical abuse, CASA (Court Appointed Special Advocates) serving children in the foster care system who have experienced neglect or physical abuse, Community Engagement which provides safety education and outreach to children and adults throughout the community and Care Coordination of Commercially Sexually Exploited Youth (CSEY).

In 2023, a new initiative was launched by Child Advocates of Fort Bend as the lead agent to move upstream from child abuse victim recovery services to the prevention and early intervention of child abuse. Under the name Child Abuse Prevention – Collaborative (CAP-C), it is a partnership model bringing together 53 agencies and organizations, all involved in different aspects of children's safety, protection, health and welfare. (See Appendix B). Historically, these organizations operate largely independently, each carving out their niches and areas of expertise and specialty. Building connections across agencies, sharing information and joining together as a collective all united in one common goal create opportunities to broaden the lens and understanding of child abuse.

The research utilized a human-centered design approach with interviews of 72 stakeholders who had lived experience of or exposure to childhood sexual abuse, physical abuse, emotional abuse and/or neglect. Interviewees provided information on their direct and indirect experiences with abuse or neglect and offered recommendations on what could have prevented their abuse and/or might prevent other children from being abused.

Three Key Findings

The research identified three key themes repeatedly voiced by study participants.

1. Survivors said that they tried to tell but hesitated or were not heard.

Adult survivors said that in their childhoods during and following their abuse they either didn't tell anyone because they had been groomed and silenced by their abuser, they didn't know who to tell, they didn't think they would be supported if they told or worse, that they would be punished or their abuser punished (whom they may have feelings towards). If they tried to tell someone -- a parent, teacher, family member or other adult -- they were ignored, not believed, told to remain silent or the abuse was minimized.

2. Parents did not believe it could happen to their children.

Parents and other caregivers did not think their children were at risk for abuse, did not suspect the abuser who they may have known and trusted, were unaware of or underestimated risks associated with their children's unsupervised sleepovers or babysitters and one-on-one interactions with adults in leadership positions in extracurricular activities, athletics and camps. They also said that it was difficult to enforce limits on internet and online time and usage by children.

There were three long-held myths that influenced their perspective about abuse.

Myth #1: Abuse doesn't happen here or to my child.

Not true. Abuse happens throughout Fort Bend County across all ages and demographics. There were over 6000 reports of abuse in 2024. (CAFB, 2024)

Myth #2: Stranger Danger.

Not true. 90% of abuse is by someone the child knows, 76% is by a family member. (NCA, 2024)

Myth #3: There's nothing I can do.

Not true. 70% of abuse is preventable. (CAC TX, 2024)

It is important to correct these misunderstandings by educating parents about the realities of child abuse and abuser characteristics.

3. There is a lack of information and system challenges that create obstacles for early risk assessment and intervention. These fell into four areas depending on the cohort interviewed.

- a. Lack of Understanding of What Constitutes Abuse: Survivors, parents and teenagers were not fully aware of what constitutes abuse, what the legal definition of abuse is in the state of Texas and what are the civil or criminal charges that can be assessed. This inhibits actions to implement protective factors to prevent abuse.
- b. Barriers to Reporting: Child welfare workers, particularly Children's Protective Services (CPS) case workers said that recent Texas legislation has raised the standards for removal of children from their homes due to allegations of abuse or neglect. With these higher criteria, evidence of abuse or neglect must be rather severe before they are comfortable taking action. This inhibits early intervention prior to the abuse or neglect escalating to dangerous levels. This was also mentioned by CASA staff who said that the result has been fewer children removed but these cases are more severe with longer durations.

- c. **Challenges in Reporting Abuse:** Teachers said that there are inconsistencies across school districts in the protocols for reporting so when teachers move schools, they must learn what their principal's protocols for reporting are. They also said that they are busy in the classroom all day and often wait until the end of the day to make a report which causes delays in reporting and potentially jeopardizes the children's safety if they return home that afternoon. Some mentioned that they tell their counselor or principal and that person makes the report so that it is not delayed but this does not follow the requirement for mandated reporting by the outcry witness.
- d. **Missed Opportunities for Early Risk Assessment or Intervention:** Family practice doctors and pediatricians mentioned that they do not routinely ask questions about child maltreatment or whether there are protective factors in the homes when doing an exam or taking histories. This may result in missed opportunities to identify risks for abuse or neglect prior to observing physical signs or symptoms. This was not the case with forensic nurses who are trained in asking probing questions about the child's safety.

Detailed findings are presented in the findings section of this report.

Introduction

The need for this study is to address the high incidence of childhood abuse, learn if actions could have been taken to reduce or prevent its occurrence and develop a pilot program to prevent abuse, as discussed above. Child abuse is an Adverse Childhood Experience (ACE) with potentially lasting effects. It is also a common experience in America and around the world. Child abuse and neglect impacted 558,899 children and youth in the United States in 2022, the most recent year for which there is national data. (National Children's Alliance, 2022). In 2022, an estimated 1,990 children died from abuse and neglect in the United States, a number consistently on the rise over the previous five years (Child Maltreatment 2022, Children's Bureau, U.S. Dept of Health and Human Services). Child abuse affects children from every socioeconomic group – rich, poor and middle income and every gender, sexual orientation, race, ethnicity, religion and community. The youngest children are most vulnerable with 15% of all victims in their first year of life and 27% no more than two years old.

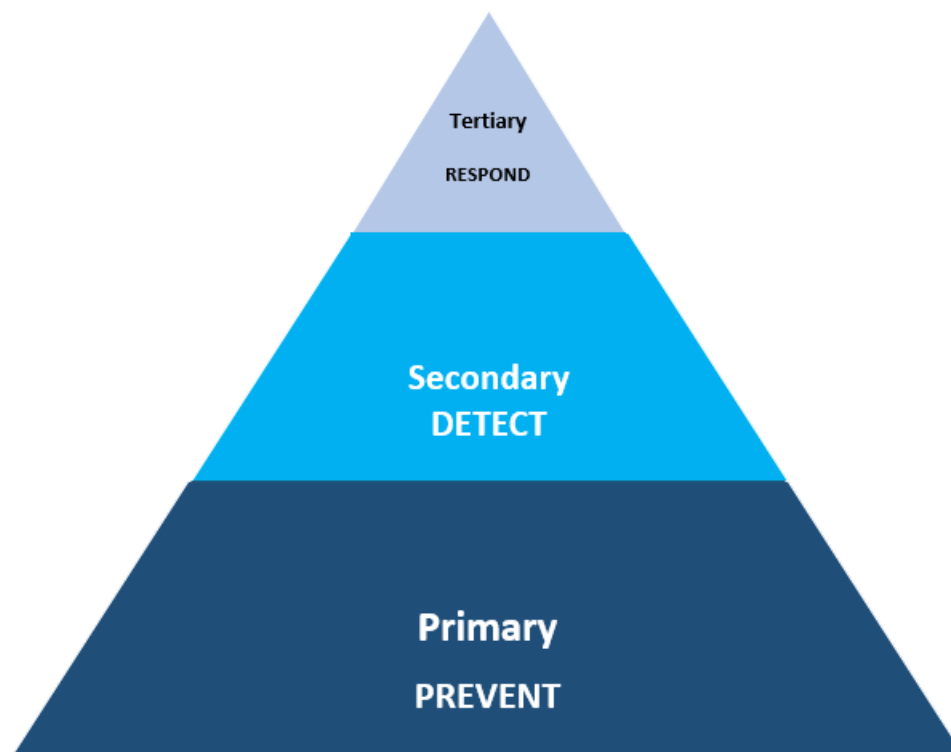
In Texas, there were 58,120 confirmed child victims of abuse and neglect in 2023 (Texas Dept of Family and Protective Services, 2023). In Fort Bend County, Texas, there were 6785 reports of abuse in 2024 which represented 2.4% of the child population, consistent with national statistics, of which 6645 were reported to the Child Protective Services (CPS) Child Abuse Hotline and an additional 140 were reported to law enforcement through 911 calls or directly to law enforcement officers or school resource officers.

Abuse takes many forms, including physical abuse, neglect, sexual abuse and emotional abuse (McKibben & Humphreys, 2020; Prinz, 2016). One in four girls and one in 6 boys in the U.S. are estimated to experience child sexual abuse (CDC, 2024). The majority of these children (estimated at 90%) are abused by someone they know, a trusted adult with 76% of these children being abused by a family member (National Children's Alliance, 2024). Disclosures of abuse are relatively low

with only an estimated one in 10 children disclosing sexual abuse (National Children's Alliance 2024).

The traditional approach to child abuse by child welfare agencies is to regard abuse or neglect as a criminal or civil justice issue with a focus on identification, restoration and justice after the abuse has already occurred. It is now time to expand and reframe child abuse as a public health issue with a criminal or civil element. It is through this reframing that we can broaden our focus and move upstream to impact the prevention of abuse.

In the diagram below, a public health approach is applied to child abuse prevention. At the top of the pyramid is the traditional Response (Tertiary Prevention) in which we intervene when child sexual abuse occurs to ensure safety, justice and healing for victims, while holding perpetrators accountable and reducing their likelihood of reoffending. These are long-term responses after abuse has occurred to deal with the long-term consequences of abuse. In the center of the pyramid is Detect (Secondary Prevention) which refers to immediate responses after abuse has occurred to deal with the short-term consequences of abuse. This would include recognizing early warning signs that child sexual abuse has happened to ensure timely intervention with victims and offenders. Although early intervention advances the traditional response approach and can prevent ongoing abuse, there is an opportunity to make significant impact by moving further upstream to Prevent (or Primary Prevention) which are approaches that take place before abuse has occurred to prevent initial victimization.



Child Sexual Abuse Prevention within the Public Health Model (CAC TX 2022)

Methodology

The research study qualified as part of a Human Centered Design Initiative funded by The George Foundation for innovative projects to impact systemwide change in Fort Bend County, Texas. It also was funded by the Henderson-Wessendorff Foundation. Human-centered design is a problem-solving technique that puts real people with lived experience at the center of the development process (Romero & Donaldson, 2023). Because child abuse and child abuse prevention are extremely complex, involve multiple systems, have evolved with institutional barriers established over years and often do not include the voice of those stakeholders most impacted – children, victims and parents, we utilized a human-centered design methodology. The goal is to keep the users' wants and preferences in mind during every phase of the process. The first phase of our research was dedicated to data collection with these stakeholders to learn about their experiences and gather their ideas about what could have prevented their abuse.

Researchers conducted qualitative research in Spring and Summer of 2024 using semi-structured one-on-one and small group interviews with 72 stakeholders with lived experience. Respondent demographics are shown in Table 5. Some respondents had experience in multiple sectors. For example, a foster parent was also a teacher and CASA Volunteer. A foster parent was also a nurse.

Interviewees were sorted into six groups to capture a range of individuals with direct and indirect experiences:

- 1) Survivors: adults who experienced abuse or neglect as children
- 2) Parents and foster parents of biological or adoptive children: caregivers of children who had experienced abuse
- 3) Educators: day care workers and owners, Pre-K, middle school and high school counselors and teachers, Early Childhood Intervention (ECI) specialists
- 4) Medical Providers: doctors, nurses and forensic nurse examiners
- 5) Child Welfare Professionals: Children's Protective Services caseworkers, County Attorneys who represent CPS, CASA (Court Appointed) Advocates and Advocacy Specialists, Children's Advocacy Center Therapists
- 6) Teenagers in high schools: adolescents who had not experienced abuse but were aware of fellow student who had experienced abuse.

The interview protocol was developed by the researchers and reviewed and approved by a CAP-C Research Committee comprised of six child welfare professionals. Refer to Appendix C for list of Research Committee members and affiliation.

The interviewees were identified and recruited by phone, text or email through professional and personal contacts. Educators were recruited from schools with the highest number of child abuse reports within the two largest school districts in Fort Bend County, Texas with a combined enrollment of 124,718 that represent 94.5% of the student population: Fort Bend Independent School District (FBISD) and Lamar Consolidated Independent School District (LCISD).

Each interview was conducted by two Research Subcommittee members, one of whom took notes. Interviewers were trained in welcoming the interviewees, offering water and snacks, reviewing the script, and asking questions in a non-accusatory, trauma-informed approach. The majority (63%) of interviews were conducted in person at the Child Advocates of Fort Bend building in trauma-designed family meeting rooms outfitted with upholstered furniture, weighted blanket, soundproofing and soft lighting. The building meets Praesidium Certified Guardian standards in sexual abuse prevention as being trauma informed. Focus groups were held in either these rooms or in small conference rooms that were also designed to be cheerful, well lit, with natural lighting, snacks and water. For those interviewees who were unable to attend in person due to transportation or travel constraints, interviews were conducted virtually via Microsoft Teams (25%) or at their place of employment (for daycare staff, 12%).

All interviewees completed a consent form. At the start of the interviews, the goals and format of the interviews were reviewed with interviewees. A therapy referral was offered if an interviewee felt uncomfortable during or after the interview. Focus groups were held with child abuse professionals, school staff, early childhood professionals and high school students. One-on-one interviews were conducted with survivors, medical professionals and parents due to the confidentiality and sensitive nature of the conversations. Each participant was told that they did not have to answer every question and that they could quit at any time.

The interviews were audio recorded. The recordings were transcribed, and interviewer notes were added to the transcriptions. The interviews were semi-structured with pre-determined themes to elicit discussion of interviewees experiences related to abuse or neglect and their ideas about prevention.

Interviews averaged 90 minutes although a few interviews were shorter (23 minutes) or longer (137 minutes) depending on the size of the group and allowing adequate time for interviewees to share their experiences. Focus groups averaged 120 minutes to allow time for all participants to speak and share their experiences although one focus group ended at 60 minutes and another at 137 minutes based on the number of participants and the extent of their comments. The number of participants in the focus groups ranged from 2-5 based on the number of participants who agreed to participate and showed up. Each participant was offered a \$50 Visa gift card upon completion of the interview or focus group.

The interviewees reflected the diversity of Fort Bend County. The average age of participants was 39 years with a range of 16 years (high school students with parent permission) to 65 years.

Age of Study Participants

Age	Number	Percentage
16-20 years	9	13%
21-30 years	14	19%
31-40 years	14	19%
41-50 years	16	23%
51-60 years	14	19%
61-65 years	5	7%
Total	72	100%

By gender, 58 females (80%) and 14 males (20%) participated which approximates gender for adult caregivers (mothers, foster mothers, grandmothers and other female caregivers) and professionals (teachers, counselors, child welfare workers) serving this population. The race and ethnicities of the participants are compared to the racial composition of children served by Child Advocates of Fort Bend below.

Racial Comparison of Study Participants and Children Served by CAFB

Race	Number	Percentage	Children Served by CAFB
Asian	7	10%	3%
Black	19	26%	44%
White	24	34%	18%
Hispanic/Latinx	21	29%	32%
Bi-Racial/Other	1	1%	3%
Total	72	100%	100%

The survivor's types of abuse included physical abuse and neglect 30%, sexual abuse 30%, neglect 20%, physical abuse 10% and sexual abuse and neglect 10%. The table below compares this to children served by Child Advocates of Fort Bend. Note that for CAFB percentages, there may have been co-occurrences of multiple forms of abuse, but it is categorized as the predominant reason as reported on the Child Abuse Intake Form or in the child's disclosure.

Type of Abuse by Study Participants and Children Served by CAFB

Type of Abuse	Number	Percentage	Children Served by CAFB
Neglect	14	20%	30%
Sexual Abuse	22	30%	55%
Physical Abuse	7	10%	15%
Physical Abuse & Neglect	22	30%	Incorporated in above
Sexual Abuse & Neglect	7	10%	Incorporated in above
Total	72	100%	100%

(See Appendix D, Tables 3A, 3B and 3C for detailed demographics of interviewees).

Following the interviews, the researchers employed content analysis to review the transcripts and interviewer notes. The Research Subcommittee of five individuals was trained in coding the notes by theme, words and occurrence. Each read the notes and transcripts and documented the incidence of recurring themes and words. The researchers read all the notes for all interviews. Coders used inductive approaches as themes naturally emerged during the coding process. Coders met to discuss their findings regularly.

Stakeholder Interview Questions by Theme

There was a uniform set of interview questions across all cohorts as well as questions customized for each cohort, appropriate to that group. All questions were prefaced by telling stakeholders to share only what they were comfortable sharing. (See Appendix E for detailed stakeholder interview questions).

Cohort	Interview Question Themes	Variables
Survivors (S)	S1Q: Abuse Dynamics: What were the circumstances around your abuse? S2Q: Abuser Characteristics: What was your relationship with your abuser? S3Q: Duration: How long did the abuse continue? S4Q: Disclosure: How did it stop? Did you tell someone? Who? S5Q: Response: What was the response after you told? S6Q: Prevention: What could have prevented the abuse? What could have helped you talk about it sooner?	S1V: Conditions, environment, duration, onset, age of child S2V: Known person, friend, family member, father/stepfather, mother/stepmother, sibling, cousin, grandparent, uncle, teacher, neighbor, other known; unknown person, met on internet S3V: One-time occurrence, multiple occurrences, months, years S4V: Self-report to parent, family member, teacher, other; reported by another person; reported to CPS, removed from home S5V: Believed, did not believe, supportive, unsupportive, advise offered, reported to CPS S6V: Information at school, public information, someone would have noticed warning signs, would have listened
Parents/ Foster Parents/ Adoptive Parents (P)	P1Q: Abuse Dynamics: What were the circumstances about your child's abuse? P2Q: Abuser Characteristics: Did you know your child's abuser? If so, what was your relationship with your child's abuser?	P1V: Conditions, environment, duration, onset, age of child P2V: Known person, friend, family member, father/stepfather, mother/stepmother, sibling, cousin, grandparent, uncle, teacher, neighbor, other known; unknown person, met on internet

	P3Q: Duration: How long did the abuse continue? P4Q: Disclosure: How did you find out about the abuse? P5Q: Response: What did you do when you found out? What happened next? P6Q: Prevention: What could have prevented the abuse? What is the best way to get information, tools and resources for parents?	P3V: One-time occurrence, multiple occurrences, months, years P4V: Child told me; family member told me; outside person told me; CPS report P5V: Questioned my child; believed my child's disclosure; did not believe my child's disclosure; sought medical help; sought counseling help; reported to authorities P6V: Social media, at school, at church, from my doctor, from a trusted friend or community member
Educators (E)	E1Q: Incidence of Abuse: Have you had students make outcries of abuse to you? Have you noticed any trends in the number of children or the types of abuse? E2Q: Warning Signs: What did you see that prompted you to think there could be abuse or neglect happening to a child? E3Q: Reporting: How did you approach the situation? What did you ask the child? Did you make a report? What are the protocols for reporting abuse in your school? E4Q: Prevention: What training and resources would be helpful to teachers, counselors, nurses and administrators to help prevent abuse?	E1V: Yes: daily, weekly, monthly, annually. Yes: more online exploitation, sexting; sharing images; teacher-student abuse; peer-peer abuse E2V: Changes in behavior, fear of getting in car or bus to go home, hungry, dirty, student mentioned harsh discipline E3V: Made a report, referred to counselor who made a report, referred to principal who made a report per our protocols, was reluctant to make report because of parental repercussions E4V: Signs and symptoms, how much to ask child, how much to put on report, reporter anonymity, what happens after a report is made
Child Welfare Professionals (CW)	CW 1Q: Clients Experiencing Abuse: Have you had children make outcries of abuse to you?	CW1V: Yes, one time, occasionally, frequently.

	CW2Q: Have you noticed any trends in the number of children or types of abuse? CW 3Q: Reporting: Did you make a report? Who else was involved? CW 4Q: Prevention: What could have prevented the abuse? What resources or training would be helpful?	CW2V: Sexting, sharing images, more teacher:student abuse, children sexualized at younger ages due to viewing pornography, heavy online usage without parental controls CW3V: Yes, made report. Notified supervisor. CW4V: Training and accountability of parents, resources to families in need
Teenage High School Students (T)	T 1Q: Knowledge of Abuse: What do you consider abuse? Do you know classmates who have experienced abuse? T 2Q: Types of Abuse: What are you seeing in terms of risks or concerns in your school that could indicate or lead to abuse? T 3Q: Reporting: If you were being abused, who would you tell? What would inhibit you from telling? T 4Q: Information: Where do you get your information and who or what do you consider credible sources? T 5Q: Prevention: What could be the role of social media? What could be the role of student organizations or leaders? What could be the role of influencers?	T1V: Physical abuse when a classmate has marks or bruises. Sexual abuse when an adult forces a child to have sex. Yes, we know classmates. T2V: Classmates talking to strangers online, classmates sharing inappropriate pictures, teachers being inappropriate with classmates T3V: Yes, if being abused by someone outside the family. If by a parent, I don't know. Fear, being threatened, not knowing who to tell would inhibit me. T4V: Fellow classmates, teachers, parents, online, books T5V: Teenagers are all on social media so that would be the first choice for safety information. Secondly, the internet, websites, podcasts. Student organizations and leaders would be good because they are speaking to peers. Celebrities, musicians, athletes all could be influencers that teenagers would listen to.

Medical Professionals (M)	M 1Q: Knowledge of Abuse: What training have you received and what is required for medical professionals?	M1V: Annual virtual child abuse training is required for CME. Med school required limited training but that was a long time ago.
	M 2Q: Abuse Diagnosis: How do you assess or identify abuse/neglect or risk? Have you had children make an outcry to you? What warning signs or symptoms have you seen?	M2V: Look for physical signs, physical trauma, bruises, head trauma, broken bones, drugs at birth. Use visual exams, X-rays, MRI's. Ask parents if they know what happened. Refer to social workers in hospitals if exam is in hospital.
	M 3Q: Reporting: As a mandated reporter, what is your protocol?	M3V: Examining physician or nurse is required to make a report. We also notify our Medical Director and social workers.
	M 4Q: Prevention: What could have prevented the abuse?	M4V: Taking more time with the families and asking more questions to identify risk factors. Connecting at risk families with social services and community resources.
	M5Q: Does your office provide child abuse prevention education or counseling with expectant, new, or current parents?	M5V: No formal education but individual doctors talk to patients during the exams, social workers follow up with case management.
	M6Q: What resources do you currently have?	M6V: We don't have any specific child abuse prevention literature. We have safety information about car seats, seat belts, swim safety.
	M7Q: What resources are needed?	M7V: flyers to share with parents, safety information for patients, PSAs for waiting room and exam room TVs

Findings

The research identified a common theme for each user group based on responses by multiple respondents. Themes addressed circumstances around their personal experiences with abuse, their challenges with reporting or disclosing abuse, subsequent actions following the reports or disclosures, and perspectives and ideas for prevention. Summaries of detailed responses and recommendations are shown below and in Appendix F.

Survivors: I Didn't Tell or Wasn't Believed: All the survivors interviewed said that they did not speak up immediately following their abuse and experienced extended periods of abuse or neglect (months or years) without disclosing, being identified or reported due to a variety of personal, systemic or cultural barriers. All survivors said that they did not know who to tell and when they tried to tell, nothing happened to keep them safe and heal. Some said that it took a trigger for them to speak up which could be a sibling being abused, exhaustion from the abuse continuing, or the passage of time when years later they finally felt safe in telling.

The ten reasons survivors did not speak up are shown below.

Response Number	Survivor Response	Recommendations
S 1	S1R: They didn't know who to tell	S1Rec: Safe Adult: Children who have experienced abuse have experienced trauma and have often lost their trust in adults including their offending parents, foster parents, coaches or other formerly trusted adults. Help children identify a Safe Adult who might be a family member if abuse is by a non-family member or if abuse is by a family member, their "safe adult" might be a teacher, neighbor, friend, parent of friend, counselor, pastor, coach or CASA Advocate.
S 2	S2R: They didn't have the right words to say, or the words weren't recognized as abuse	S2Rec: Educate children that it's okay to speak up and what words to use. Practice role-play telling and be very specific in what words to use.
S 3	S3R: They did not think anything would be done to help them	S3Red: Educate children on Safe Adult; what happens after telling; safety resources
S 4	S4R: They had been groomed by the abuser and often their parents had also been groomed.	S4Red: Grooming: Survivors said that they wished they had known about grooming behaviors, boundaries and what constitutes a safe home. Abusers often groom both children and their parents so parents may not suspect, ignore or rationalize dangerous behaviors from abusers whom they know.

S 5	S5R: Known abuser: They were conflicted about feelings towards their abuser, mentioning love, attention and favors they were receiving.	S5Rec: Educate children on grooming; provide trauma-based therapy; provide post-recovery victim resources and support
S 6	S6R: Familial abuse: Their abuser was their parent, stepparent, foster parent or caregiver or their parent was complicit, and they would be silenced, disciplined, or threatened if they spoke up.	S6Rec: They recommended that children be educated about abuser characteristics and dispel the harmful myth that abusers are strangers. According to the National Children's Alliance (2022), 76% of children are victimized by a parent or legal guardian and over 90% of children are abused by someone they know. Women, men, and peers can be abusers.
S 7	S7R: They were fearful of repercussions or something bad happening to them, their siblings, their non-offending parent or even their abuser if they told.	S7Rec: Children identify a safe adult; provide post-recovery resources, therapy.
S 8	S8R: Abuse was normalized in their household, cultural disciplinary practices and inter-generational abuse.	S8Rec: Educate children and parents on laws governing what constitutes abuse in the U.S., provide culturally appropriate child safety resources to families
S 9	S9R: Foster Care Abuse: Some of the Survivors were abused while in foster care by a foster parent or foster sibling after having been removed from their home due to the initial abuse or neglect.	S9Rec: Conduct frequent wellness checks by CASA and CPS in and outside of the placement. Assign a CASA Advocate to every child in foster care. Build a trusted relationship with CASA so children feel comfortable speaking up. Many of the survivors said that their CASA Advocate was the one person who listened, advocated for their best interests and needs and helped them through their recovery and healing. Develop and distribute a Foster Care Children's Handbook including a Bill of Rights. Some of the survivors were unaware of their rights and how to activate their rights.
S 10	S10R: Sexual Exploitation: One survivor had experienced commercial	S10Rec: Educate children starting in elementary school and throughout secondary

	sexual exploitation as a child.	and high school about what constitutes trafficking and trafficker characteristics. Educate children and teenagers about the risks of social media, internet safety, sharing images, sexual material and sexploitation.
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Parents and Caregivers: It Would Never Happen to My Child/Stepchild/Foster Child: The overarching theme for parents, foster parents or adoptive parents was that they never thought their child would be abused. This was due to not being aware of the prevalence of familial abuse, of patterns of grooming by someone the child and perhaps parents knew and trusted and not understanding what protective factors they could implement. Conversely, some parents (and survivors) mentioned that they were told to keep quiet, not to get Children's Protective Services (CPS) involved because their child might be removed or that it would bring shame to their families.

The six responses and recommendations made by parents and caregivers are shown below.

Response Number	Parent Response	Recommendations
P 1	P1R: Familial Abuse: Parents did not know that most abuse is by a family member or someone the child and often parents know and trust.	P1Rec: Learn about grooming behaviors and how to protect their children. Learn warning signs and the importance of listening and connecting with their children every day. Establish a code word or signal if the child is fearful of someone. Establish a "Safe Adult" with their child.
P 2	P2R: Parents often dismiss the risk stating that "It could never happen to my child," or "This person would never abuse a child."	P2Rec: Educate parents about myths and facts about child abuse. Dispel "stranger danger" myths.
P 3	P3R: The parent, stepparent or grandparent may have been the abuser.	P3Rec: If the parent is the abuser, the role of the educator or other safe adults in the child's life should step in with the above recommendations.
P 4	P4R: Non-Reporting: Parents did not report because of shame to the family, fear of children being removed or didn't know what could	P4Rec: Educate parents on the risks of not reporting

	happen to their children, the abuser, or them.	Learn what happens after they report and that there are a variety of outcomes, most of which do not involve removal of their child
P 5	P5R: Parents said that they had not been aware of the Children's Advocacy Centers, and they were surprised to find such a warm and welcoming environment.	P5Rec: Understand the free services of Children's Advocacy Centers that are available to them, their child and family Learn about resources available to parents to help them through stressful times, adversity, substance abuse, mental illness and other experiences
P 6	P6R: Parents are not equipped with skills to support what their child is going through following abuse, trauma, behavioral changes	P6Rec: Train parents in Trust-Based Relational Intervention (TBRI) so they are equipped to parent a child experiencing trauma.

Educators: I Don't Have Time to Make a Report. Educators were aware of their responsibility to report child abuse but faced challenges in making a personal, timely report due to changing lack of uniform reporting protocols in their school districts, long hold times when making a report by phone, and being occupied teaching their students and unable to step away to make a report until later in the day. They were very supportive of implementing prevention efforts and welcomed the opportunity to host training and information sessions with students, teachers, counselors and parents.

The five responses and recommendations made by educators are shown below.

Response Number	Educator Response	Recommendations
E 1	E1R: School teachers were reluctant to report because they do not know what constitutes abuse or neglect	E1Rec: Have training in recognizing signs and symptoms of abuse and neglect, what constitutes abuse, internet safety and laws governing civil and criminal crimes regarding abuse and failure to report
E 2	E2R: There was inconsistency across the school district about reporting with each school having its own protocols	E2Rec: Learn their role as mandatory reporters, reporting requirements and the legal requirements not to pass this legal responsibility on to someone else

E 3	E3R: Teacher delay reporting because they do not have time while they are in the classroom all day	E3Rec: Learn the scope of what is required in a report and that full investigations are not their responsibility
E 4	E4R: Teachers fear parent retaliation even when report is anonymous	E4Rec: Teachers need the support of their principals, that “they have our backs”
E 5	E5R: Teachers were often unaware of what would happen after they made a report and often did not know the role of Children’s Advocacy Centers.	E5Rec: Learn what happens after they report Understand the services provided by Children’s Advocacy Centers, CPS and other social service and healthcare organizations.

Child Welfare Professionals: Regulations and Laws Hamper my Ability to Take Actions Early On

Child welfare professionals represented by Children’s Protective Services, County Attorneys and District Attorneys voiced their frustration with the many challenges they face to protect children. Ranging from fighting a negative reputation of CPS to changes in legislation that raised the bar for removal of children to being under-resourced for the full scope of what would be needed to adequately support all the families in the community who are at risk or in abusive conditions or environments, child welfare professionals were very supportive of prevention efforts but recognized the challenges with implementation. They pointed out the valuable role of the CASA Advocate in facilitating a coordinated approach, being able to build a positive relationship with parents to effect changes in behavior and interfacing with the courts. They emphasized educating parents, connecting with community leaders and the faith community, and teaming with social service agencies to provide a full complement of wraparound services to families. They pointed to the need for family resource centers and home visits.

The five responses and recommendations given by child welfare providers are shown below.

Response Number	Child Welfare Response	Recommendations
CW 1	CW1R: CPS is often regarded in a negative light assuming that their only role is to remove children.	CW1Rec: Educate parents on ways they can protect their children and avoid removal.
CW 2	CW2R: CPS provides a range of services to help children and families.	CW2Rec: Educate parents about the beneficial services that CPS offers families at risk and in need of support. Facilitate an easier, streamlined process for families to access services by reducing barriers to enrollment and access. Provide Alternative Response (AR) and early intervention support to vulnerable

		families to avoid the incidence and progression of abuse within households and risk behaviors that may escalate to crisis levels before professionals intervene.
CW 3	CW3R: Criteria for removal of children has become more stringent and we fear for the safety of many children	CW3Rec: Public policy efforts with legislators to impact child safety legislation. Access services for families at risk (see above). More funding for home visit programs and Family Resource Centers.
CW 4	CW4R: Some parents are repeat offenders and do not complete court-ordered services.	CW4Rec: CASA Advocate can assist parents, build relationships, and influence them to complete their plan to have their children reunited.
CW 5	CW5R: Prevention services will need a lot more resources. Who will do this work? How will it be funded?	CW5Rec: Engage private and public resources, county agencies, CASA and others must join together in a collaborative approach to help families and prevent abuse and neglect. See CW2 and CW3, above.

Medical Professionals: We Need to Incorporate Risk Assessment in Patient Exams and Histories.

Doctors and nurses said that they must complete annual CME hours on child abuse, but the focus is on observing indications of physical abuse and reporting requirements. They said they could do more risk assessment by understanding early signs and symptoms and appropriate questions that could be asked during the exam and when taking patient histories. They welcomed training of medical staff by child abuse experts on a regular basis as new staff join clinics and hospitals. They also said they would use information flyers with parents and talk about protective factors and resources available to families needing support. They said that they would utilize short-format videos or PSAs in their waiting rooms and/or exam rooms and would need both English and Spanish versions. Forensic nurse examiners were very knowledgeable about signs and symptoms, questions to ask and were thorough in their exams. This however took longer, and they typically spent 1-1/2 to 2 hours with each patient during a Sexual Assault Exam (SANE). Primary Care Physicians, Family Physicians and Pediatricians typically would not have the time for this extensive appointment.

The five reasons medical professionals cited, and their recommendations are shown below.

Response Number	Medical Professional Response	Recommendations
M 1	M1R: Many doctors and nurses have not received current training, information and best practices around	M1Rec: Provide information to obstetricians and gynecologists so they can educate expectant parents about child safety. Provide training to primary care providers, internal medical doctors and nurses about signs and

	child abuse identification and diagnosis	symptoms of physical abuse, sexual abuse and neglect symptoms.
M 2	M2R: Doctors recognize they are positioned to address abuse as a public health epidemic with primary, secondary and tertiary incidence and prevention approaches	M2Rec: Provide training on adverse childhood experiences (ACEs) and the impact of trauma on the developing brain, and the correlation between early childhood trauma and lifelong physical disease and mental health.
M 3	M3R: Many doctors are not incorporating child abuse or neglect questions into physicals and histories	M3Rec: Assist pediatricians and primary care providers (PCPs) so they identify abuse during well-child exams. Incorporate wellness questions in protocols in patient histories and screenings.
M 4	M4R: Patients have idle time in waiting rooms that could be utilized for education.	M4Rec: Provide child abuse prevention PSAs and other patient-friendly information about M4Rec: child safety, positive parenting, and keeping children healthy in waiting rooms and exam rooms in medical clinics. Destigmatize seeking help for mental illness or substance abuse.
M 5	M5R: Trusted by Patients: Doctors and nurses are generally trusted by patients.	M5Rec: Utilize medical appointments and well-child exams as opportunities to educate, role-play, distribute safety literature and refer for family resources. Reinforce that it is okay to ask for help if parents are struggling with child rearing.

Teenage Students: Give Us Relatable Safety Information Delivered by Trusted People

Teenagers who have not experienced abuse saw many opportunities for safety information to be communicated if it came from a source respected by them, such as a peer classmate, celebrity or influencer. They recommended a student-designed safety campaign or safety campaign featuring teens so it would be relatable. They said they don't want to be "talked down to" by an adult and said that a fellow teenager who "looked like them" or a teen who had experienced abuse could be most effective in delivering these types of messages.

The four responses teenagers provided are shown below.

Response Number	Teenage Student Response	Recommendations
T 1	T1R: Teenagers who have not been abused have limited knowledge of sex trafficking, sexual exploitation and the consequences of sharing sexually explicit images.	T1Rec: Educate teens on child abuse, safety and “Safe Adult”
T 2	T2R: Some parents have not established internet usage limits or do not enforce them.	T2Rec: Educate parents on internet risks and how to incorporate safety measures with their children
T 3	T3R: Teens are skeptical of information from adults that is meant to scare them. Need it coming from a peer	T3Rec: Utilize teens to provide peer-to-peer information to their fellow students for higher adoption rates. Student leaders and classmates create messaging, videos or podcasts, booths at school, school clubs or organizations to provide information.
T 4	T4R: Teens are highly influenced by social media and influencers	T4Rec: Utilize celebrities, musicians, athletes or influencers who they respect for safety messaging

Discussion

The research reinforced the importance of working with survivors, parents, adults, educators, medical professionals, teenagers and the broader community to support the safety, health and wellbeing of our children. Using a public health model of child abuse, there are opportunities to address child abuse as a preventable epidemic with primary, secondary and tertiary approaches.

We propose developing a community-wide trauma approach with specific roles for people involved in children’s lives and community organizations to play in the prevention and early intervention of child abuse. From implementing protective factors in our homes, schools and youth-serving organizations, to implementing early identification and detection, to educating parents, caregivers and medical professionals, to working with educators during the child’s school years to training community leaders, we have the opportunity in Fort Bend County to dramatically reduce the risk for and incidence of child abuse. With a county-wide commitment to implementing a child safety campaign grounded in trauma-informed care, we can help thousands of children be safe before it rises to the level of child removal or criminal activity. Approaches should utilize the adults in children’s lives to identify and respond to signs more quickly, to educate children on risks and responses at young ages and throughout childhood, and to approach parenting through a trauma-informed lens with cultural competency and respect.

The Role of Parents as Protectors

Research has found that parenting interventions can effectively reduce physical and emotional child abuse (Backhaus, Leijten, Jochim, Melendez-Torres, & Gardner, 2023). One of the best ways to prevent child abuse is to help parents develop the skills and identify resources they need to understand and meet their child's emotional, physical and developmental needs and protect their children from harm (Wurtle & Kenny, 2010). Specific information regarding child abuse must include defining: 1) who are abusers (e.g., they are usually known to the child) and myths; 2) what are the signs and symptoms of abuse, early warning signs and grooming; 3) how best to communicate with your children, particularly in times of stress; 4) how to talk to your children about sexual abuse, commercial sexual exploitation (online and in-person), trafficking and healthy touch; 5) what are normal child development milestones, healthy brain development, adverse childhood experiences (ACEs), and age-appropriate expectations; 6) what are the roles and responsibilities of parenting; and 7) what should you do if you suspect that your child is being abused.

The mode and style of delivery of information and messaging is paramount to acceptance and adoption by parents (Prinz, 2016). What are the best ways to frame communications with parents? Sweetland (2021), with the Frameworks Institute, suggests that concepts such as childhood adversity, child maltreatment, or early traumatic experiences come biased with beliefs about "bad parents". This stigmatizes families who are stressed and reinforces labels about marginalized groups. One study found that focus group participants had positive associations with the name "Healthy Families America" as opposed to "Prevent Child Abuse" (Bostrom, 2003). This underscored the importance of reframing content and delivery methods to best meet parents where they are and avoid ridicule, punishment, shame or blame terminology. The Child Development Frame offers a non-threatening way for parents to feel okay about seeking advice and training about children from infancy through the teen years. Parents may be interested in learning about structure and disciplinary issues. Parenting requires learning and skill.

It is also critically important to engage and educate families and caregivers in prevention and safety efforts with a trauma-informed approach (Bartlett & Steber, 2019). Some parents we interviewed were familiar with Trust Based Relational Intervention (TBRI) and had found this trauma-informed methodology to be beneficial in learning skills and techniques to positively parent their children who had experienced trauma.

The World Health Organization (2022) recommended evidence-based parenting interventions for low- and middle-income parents of children and adolescents in group or individual formats. Group-delivered programs meet some parents' needs. Low intensity interventions delivered to large groups can be used to normalize parenting support and help parents see where they might need additional information (Bornstein, Cluver, Deater-Deckard, Hill, Jager, Krutikova, Lerner, & Yoshikawa, 2022; Prinz, 2016)

Reaching parents through media and social media were favored by many of our parent interviewees through short information "drip learning" topics. The use of media is another form of successful public health efforts (Prinz, 2016). Media can normalize the seeking of information by parents and

can provide modeling of positive prosocial parenting. Parenting programs with brief messaging and specific information could be used to reach large numbers of parents and achieve successful outcomes (Bornstein, et al., 2022).

The importance of culturally specific information was emphasized by parent participants. Relatability and delivery of messages from someone who “looks like me, speaks in my language, and has had similar experiences as me” was underscored by parents, foster parents and professionals who work with parents.

We recommend approaching child abuse awareness education and information from a grassroots effort within the various communities by utilizing trusted members of these communities to educate, deliver messaging and connect resources with families. Speak the same language, share the same customs, provide familiar food as well as social time for networking so that parents feel mutual support and that they are not alone in their challenges. Communities include ethnic or racial groups, faith or worship congregations, community centers, athletic teams, after-school centers and other cohorts, gatherings or places where parents and families already frequent. Trust must be the cornerstone so that parents accept child abuse information and don’t feel threatened or admonished. It is important not to shame, blame, criticize or generalize parental disciplinary or child-rearing practices, many of which may be deeply embedded in their family and cultural histories. Instead, use affirmations of positive parenting, inform about child safety laws and offer suggestions to better keep their children safe. Use positive language and support approaches such as child wellness, safety and raising healthy children rather than abuse terminology.

The Role of Educators as Trainers

Schools play an important role in child safety, identification and reporting. Because most children attend educational settings outside their homes daily, schools provide opportunities for teachers and other school staff to detect child abuse risk factors (Gilbert et al., 2009; Glouchkow, Weegar, & Romano, 2023; Nickerson et al., 2019). School personnel are designated as mandated reporters of child abuse so providing training to teachers, counselors, social workers, nurses, principals and other school personnel regularly can help ensure that best practices of identification and reporting are implemented. Research by Glouchkow and colleagues (2023) suggest the need for more specific interventions to improve teachers’ decision-making with potential child maltreatment scenarios, especially for physical abuse so that children who are experiencing maltreatment may be more accurately detected and reported to DFPS.

Although there is an abundance of information on child abuse already available to schools, survivors said that it was not incorporated into ongoing curriculum and programs to reach every child beginning in preschool and elementary school and continuing through high school. Tools and instruction need to be very specific, and children need to practice and roleplay, so they know what to say, who to tell, how to say it and when to speak up.

The school staff we interviewed stressed that it is never too early to start. In fact, research on family violence (e.g., child abuse and neglect and intimate partner violence) has found that participating in Head Start programs is linked with improved parenting behaviors (Maguire-Jack, Hardi, Stormer,

Lee, Feely, Rostad, Ford, Merrick, Murphy, & Klika, 2022). Staff working with children as young as 3-4 years old need training to identify what constitutes abuse, how to keep children safe, risk factors, how to report and peer-on-peer abuse. As with parents, they need to know childhood development milestones, what is normal behavior for young children concerning their bodies and how to best reach children at different ages without scaring them or having them dismiss the information as irrelevant, embarrassing or non-applicable to them.

Providing age-appropriate student lessons in school-based programs from early childhood through adolescence has been shown to be very effective (Brassard & Fiorvanti, 2015). Studies have shown positive effects of school-based prevention programs on abuse-related knowledge, self-protection skills and abuse disclosure (Davis & Gidycz, 2000; Rispons et al, 1997; Tutty, 2000). Research suggests that programs using active modes of teaching (modeling, rehearsing and reinforcement) result in greater gains in knowledge than a didactic approach (Davis & Gidycz, 2000; Wurtele, Marrs, & Miller-Perrin, 1987; Wurtele & Miller-Perrin, 1992). Students need to learn skills in three areas: 1) Recognizing unsafe and sexually abusive situations and touches; 2) immediately reporting these situations to adults; and 3) assertively refusing these situations when possible (Davis & Gidycz, 2000; Rispons et al., 1997; Zwi et al., 2007).

Recently, studies have been conducted on the effectiveness of the Monique Burr Foundation's Child Safety Matters curriculum (Bright, Huq, Patel, Miller, and Finkelhor, 2022; Weeks, Whitaker, Pendarvis, Finkelhor, Neal-Rossi, & Rivers, 2021). This program is designed to educate children in kindergarten to Grade 5 about bullying, cyberbullying, four types of abuse (physical, sexual, emotional, and neglect), and digital dangers. It has been found that children who received the curriculum increased their awareness about potentially risky situations, and this knowledge was sustained to the follow-up assessment. Children in the control schools did not have similar gains. Child Advocates of Fort Bend is utilizing this curriculum in its outreach and education after being approved by the Fort Bend ISD and Lamar Consolidated ISD School Boards.

School districts have documented protocols for reporting abuse. However, in our research, teachers said that on occasion, they handed off reporting responsibilities to counselors or principals because of the challenges identified above. Teachers need to feel confident making reports and what happens after their report is filed. Work with daycare providers, school districts and administration to develop interactive training modules that are accessible throughout the school year as new teachers are hired. Provide tours of and produce a video showing the services offered to children and families at the Children's Advocacy Center and the advocacy services provided by CASA.

The Role of the Medical Community as Trusted Advisors

Doctors and nurses are positioned to have a significant impact on early intervention and prevention since they are seeing children regularly, discussing health issues, conducting physical examinations and providing medical care and counsel. Goodrum and Prinz (2022) recommend that pediatricians educate caregivers on safety practices to prevent exposure to potentially traumatic incidents. To identify trauma early and prevent its negative effects, pediatricians should utilize trauma screening measures in well-child visits across all ages. When trauma is identified,

pediatricians should immediately address safety concerns, provide education to the family, encourage parent-child communication about the traumatic event, and teach coping strategies.

Medical providers in the current research were very receptive to taking on this role and would benefit from being kept up to date with the best practices around physical abuse, sexual abuse, forensic examinations, medical neglect and trauma. They recommended educating pediatricians, obstetricians and gynecologists, family practice and internal medicine physicians and emergency room doctors. Education can also be provided directly to patients through videos, PSA's and flyers in medical clinic waiting rooms and exam rooms.

The Role of the Community as Supporters

Our research findings supported the idea that grassroots efforts targeting vulnerable communities can play a major role in the prevention and early intervention of child abuse. Interviewees reinforced that programs and information must “meet people where they are” and seamlessly be incorporated into venues, programming and activities where people are already engaged. These can include community centers, worship centers and the faith community, health clinics, doctors’ offices and hospitals, early childhood centers, food or clothing pantries and distribution centers, social services centers, drivers’ license offices, restrooms, fitness centers, sports and athletic complexes, apartment buildings and other areas where communities congregate.

It is not only the location where information is shared but by whom and how it is delivered. “Meeting people where they are” means identifying respected members of different communities who can serve as community educators, influencers or ambassadors to share safety information in grassroots approaches. These people should look like and speak in the language of their community members, live in their communities and have either lived experience or have firsthand knowledge of lived experiences of community members.

The importance of culture, customs and language is a cornerstone of community efforts. In the child welfare system in Fort Bend County, there is a disproportionate number of children of color identified and reported for child abuse and neglect, in particular Hispanic and African American children. For our Hispanic population, It is critically important to reach these children and parents in Spanish and ideally in their native dialect(s). Native speakers, materials and media must be presented in both Spanish and English and utilize culturally appropriate terminology, images and formats that are familiar and user-friendly.

The Role of Media as Communicators

Reaching children and adults through multi-modalities with targeted messaging for them was stressed by interviewees. Age-appropriate, language-specific, and delivered by someone with the same ethnicity or racial identity as the target audience are critical considerations to incorporate into the design and development of child abuse prevention programming. Various types of media could be utilized including TikTok, Instagram, Facebook and other online platforms, radio PSAs, drip learning sent to mobile phones, podcasts, videos developed by students for students and delivered in school home room announcements, evidence-based information provided by experts via video or app, videos in medical clinics, doctors waiting rooms and exam rooms, and PSAs in movie

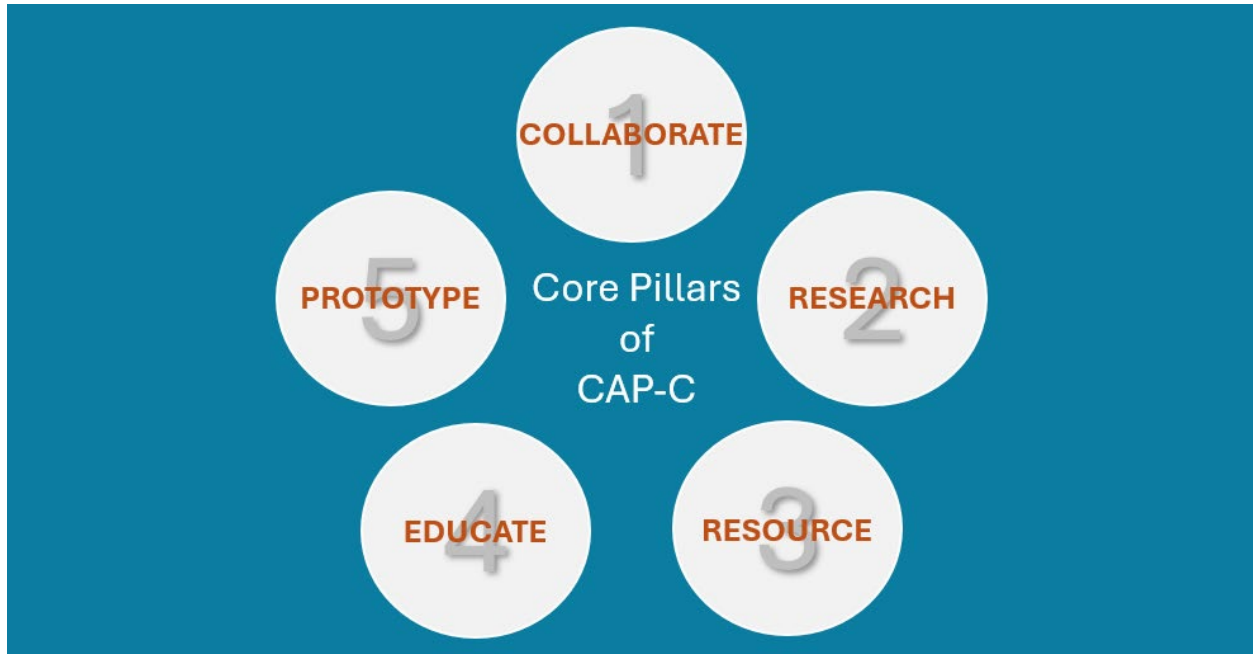
theaters and on streaming platforms that precede feature-length movies are opportunities to present safety information and positive parenting tips.

Next Steps: Child Abuse Prevention Collaborative (CAP-C)

Research findings will serve as the foundation for a county-wide child abuse prevention initiative called CAP-C: Child Abuse Prevention Collaborative. CAP-C is designed around five core pillars:

- 1) Collaborate: CAP-C convenes child welfare agencies across Fort Bend County as one unified group with a common purpose – to align with one voice and advance the understanding of what could have prevented child abuse. Each of these CAP-C member organizations provides services to children and families who have been abused or are at risk of being abused. Many are direct service providers, others are educators or medical professionals and others are subject matter experts. The collaborative meets monthly to share information, coordinate outreach services and build relationships for systemwide change.
- 2) Research: This human centered design research study of survivors and stakeholders of survivors will inform the development of programming and information for the prevention and early intervention of child abuse.
- 3) Resource: A CAP-C website will be a “go to” source for information, resources, presentations, videos and other tools for professionals to access. Containing over 1600 items and growing through an “open source” approach, users can download these resources for free and utilize them within their communities.
- 4) Educate: The first step in child abuse prevention is awareness that child abuse exists in our community. Professionals, parents, children and adults across the community will receive training in prevention, early intervention and trauma-informed care with the goal of creating an informed community to keep children safe.
- 5) Prototype: A Child Safety Campaign for parents, caregivers, adults and children will provide safety information, tips and actions in a memorable, age-appropriate manner. The campaign will incorporate social media, short-format video, traditional media, and print. Pilot locations include schools, daycare and early childhood centers, medical clinics, youth serving organizations, churches and houses of worship and community centers. Community advocates will help facilitate the dissemination and adoption of best practices of prevention and child safety. The process will be iterative with adjustments made and prototyping in new settings to broaden reach across the county.

Below are the five Core Pillars of CAP-C. On the following page is the CAP- C Blueprint for Child Abuse Prevention and Outreach which shows our plan for prototyping our Child Safety Campaign by location and media.

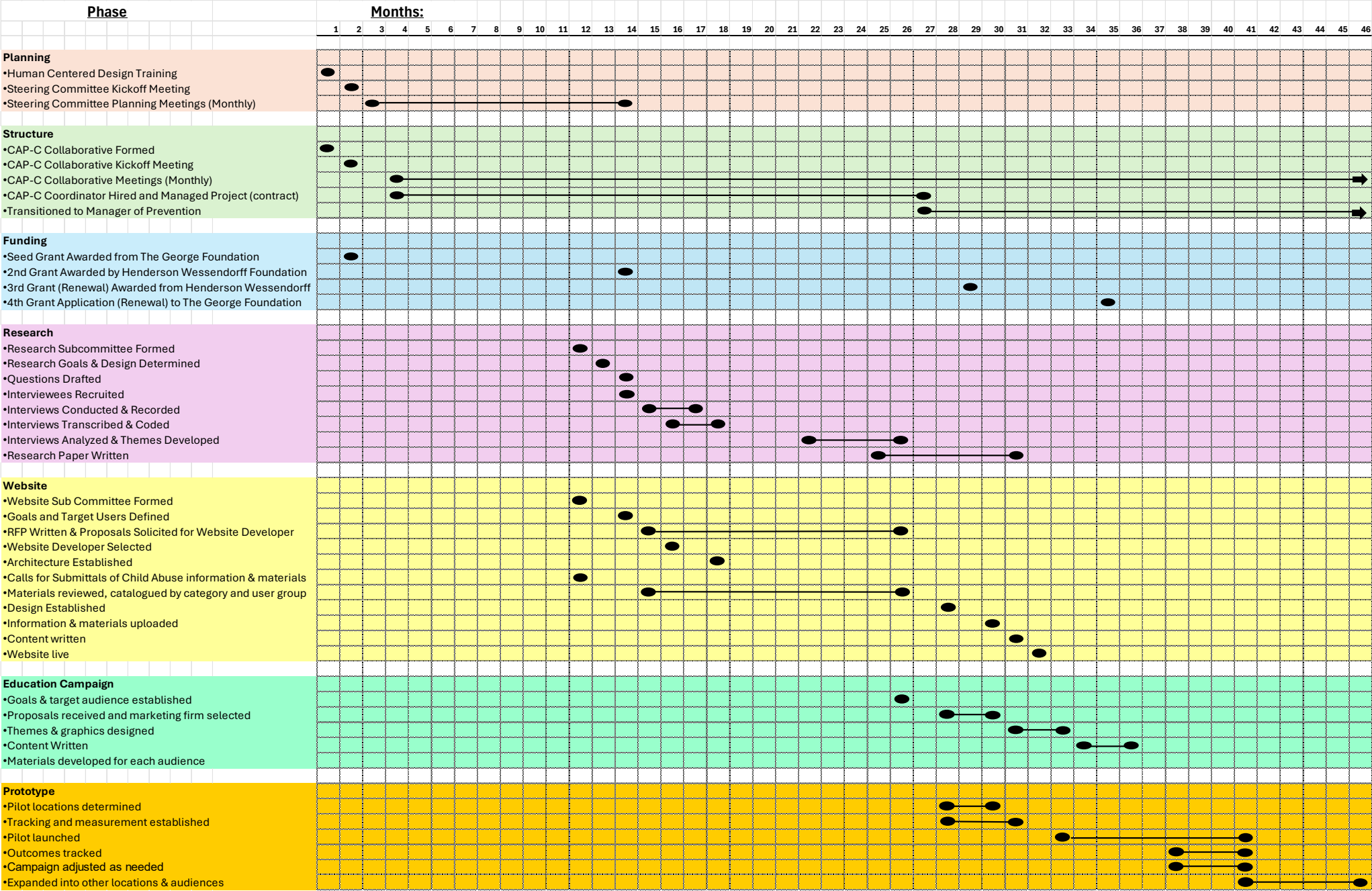




BLUEPRINT for PREVENTION AND OUTREACH



CAP-C Timeline and Roadmap



About the Authors

Ruthanne Mefford has served for 16 years as the CEO of Child Advocates of Fort Bend (CAFB), a nonprofit umbrella agency serving 4000 children and families in Fort Bend County, TX. She oversees the operations of a Children's Advocacy Center, Court Appointed Advocacy Program (CASA), Community Engagement Program and Child Abuse Prevention Collaborative (CAP-C). Mefford has a BA in Psychology from Stanford University where she did research on early childhood development, child parent attachment behavior and the impact of media violence on children's behavior and trauma. She has an MBA and serves on foundation, community, and nonprofit boards.

Sue Profilet, PhD, served as the CAP-C Coordinator at Child Advocates of Fort Bend from 2022 - 2025. She has conducted research and worked clinically in the child advocacy and behavioral health areas for 13 years. She has worked extensively with families experiencing trauma from child abuse, building resiliency, and advancing outcomes. Profilet earned a Ph.D. from the University of Illinois at Urbana-Champaign in 1995 on the topic of parental influences on young children's social competence. She has 8 years of experience teaching child development and psychology at the college level. In 2018, she became a TBRI® Practitioner.

Appendix A: Population, Child Population and Diversity of Fort Bend County, Texas

	2016	2020	2023	2024	2016-2024 increase
Population:					
Total Population	723,000	822,779	916,778	958,434	33%
Child Population	190,860	253,725	265,856	277,946	46%
%	26%	32%	29%	29%	
Diversity:					
White	24%	30%	22%	29%	20%
Black	35%	20%	21%	20%	-43%
Hispanic/Latino	31%	24%	28%	25%	-19%
Asian	4%	22%	22%	22%	450%
Bi-Racial/Other	6%	4%	7%	4%	-33%
Total	100%	100%	100%	100%	

Appendix B: Child Abuse Prevention Collaborative (CAP-C) Member Agencies

Number	Agency Name
1	Access Health Community Health Center
2	Adullam Home for Boys
3	Aid to Victims of Domestic Violence
4	Arms Wide Adoption Services
5	Attack Poverty
6	Big Brothers Big Sisters
7	Child Advocates of Fort Bend
8	CASA of Fort Bend
9	Children's Advocacy Center of Fort Bend
10	Catholic Charities
11	Coalition to Combat Human Trafficking
12	Community Member
13	Crimestoppers Houston
14	DA's Human Trafficking Task Force
15	Daya, Inc.
16	DePelchin Children's Center
17	Dept. of Family and Protective Services Community Engagement
18	DFPS Faith Based and Community
19	District Attorney's Office
20	Fort Bend County Court 4
21	Fort Bend ISD
22	Fort Bend ISD Police Department
23	Fort Bend Regional Council on Substance Abuse
24	Fort Bend Star Newspaper
25	Fort Bend Women's Center
26	Ft Bend Behavioral Health Services
27	Gingerbread House Daycare Center & Kids Academy
28	Girl Scouts of San Jacinto Council
29	Health and Human Services
30	Henderson-Wessendorff Foundation
31	Katy Cares
32	Kids and Cops
33	Lamar Consolidated ISD
34	Lamar Consolidated ISD Student Programs
35	Lamar Consolidated ISD Student Services
36	LCISD Counseling
37	LEADWELL
38	Parks Youth Ranch
39	TBRI Collaborative
40	Project Protect Our Children
41	Stafford Municipal School District
42	Sugar Land Police Department
43	Texas Agri- Life
44	Texas Forensic Nurse Examiners
45	The George Foundation
46	The Landing
47	The Sanctuary Foster Care
48	Therapist
49	Unbound Now
50	University of Texas Health Houston
51	UT Health Houston
52	YMCA Fort Bend
53	YMCA Katy

Appendix C: Research Subcommittee and Affiliations

Name	Affiliation
Sue Profilet, PhD	CAP-C Coordinator
Ruthanne Mefford	CEO, Child Advocates of Fort Bend
Karen Beham	CASA Volunteer
Jim Lockwood	CAFB Board Member
Jada Bradden	Executive Director, Parks Youth Ranch
Metoyer Martin, LCSW	Sr. Director of Strategic Programs and Services, CAFB

Appendix D: Table 1: Demographics of Interviewees

Group	N	%	Age Range and Average	Gender	Ethnicity
Early Childhood and Day Care Staff	12	17%	19 to 65, Average = 45	Male = 1, Female = 11	Black = 2 Hispanic = 6 Non-Hispanic White = 4
Parent	9	13%	30 to 57 Average = 41	Male = 4 Female = 5	Hispanic = 3 Non-Hispanic White = 5 Other = 1
Child Abuse Professional	13	18%	34 to 65 Average = 48	Male = 3 Female = 10	Asian = 1 Black = 3 Hispanic = 5 Non-Hispanic White = 4
Survivors	10	14%	19 to 54 Average = 33	Male = 1 Female = 9	Black = 6 Hispanic = 2 Non-Hispanic White = 2
School Staff	11	15%	27 to 62 Average = 44	Male = 0 Female = 11	Black = 6 Hispanic = 1 Non-Hispanic White = 4
Medical Personnel	10	14%	28 to 54 Average = 40	Male = 1 Female = 9	Asian = 2 Black = 1 Hispanic = 2 Non-Hispanic White = 5
High School Students	7	10%	16 to 18 Average = 17	Male = 4 Female = 3	Asian = 4 Black = 1 Hispanic = 2 Non-Hispanic White = 0

Table 2:. Demographics of Interviewees (detail)

Overall Age		
16-20	9	13%
21-30	12	17%
31-40	14	20%
41-50	16	23%
51-60	14	20%
61-65	5	7%
Overall Gender		
Male	14	19%
Female	58	81%
Overall Race/Ethnicity		
Asian	7	10%
Black	19	26%
Hispanic	21	29%
Non-Hispanic White	24	33%
Other	1	1%

Table 3: Type of Abuse of Interviewees

Age	Gender	Race	Type of Abuse
30	F	Black	Physical abuse and neglect
27	F	Black	Physical abuse and neglect
31	F	Black	Physical abuse and neglect
26	F	Black	Neglect
28	F	Black	Neglect
19	F	Hispanic	Sexual abuse
23	F	Hispanic	Sexual abuse
54	F	White	Sexual abuse
47	F	Black	Physical abuse
42	M	White	Sexual abuse and neglect

Appendix E: Detailed Stakeholder Questions

Cohort	Interview Questions
Survivors	Please tell us a little about yourself. Did you tell someone when the abuse occurred? If yes, did you get help immediately? Who did you tell? If not, when did you tell? Why didn't you tell when it happened? Was there something that could have helped you talk about it sooner? What are some things that could have helped you or that could have helped someone else? Do you think something could have been done to prevent it? If yes, what types of things? What information or resources could have helped you? If not, why not? What could have been done differently? Is there anything we should know about your community and culture and child abuse? What organizations and resources were helpful to you and why?
Parents	Please tell us a little about yourself and your children. Can you talk about what happened to your children? Why do you think this abuse/neglect happened? Do you think this could have been prevented? If not, why not? What information, tools or resources would have helped you or your children? What is the best way to get this information to your family? What is the best way to teach your children about abuse? Is there anything we should know about your community or culture? What organizations were helpful to you and why?
Educators	What is your role at work? Have you had children make outcries of abuse to you? What did you see that prompted you to think there could be abuse or neglect happening to a child? How did you approach the situation? What did you ask the child? What prompted you to act? What did you do? What are some warning signs that could have prevented the abuse? What resources are needed to prevent it? What training is required for keeping your license updated? Have you seen any cultural differences such as discipline?
Child Abuse Professionals	How long have you worked in the field with families and children who have been abused or neglected? Have you had children make an outcry to you? If yes, what did you do and why? What could have prevented the abuse? What type of abuse prevention is the most important? What resources are needed Do you see anything cultural such as discipline?
Teenage High School Students	What organizations are you in? Do the leaders influence you? What issues concern you? What acts do you consider abuse? From whom do you learn this? If children don't learn this from their parents, from whom would they learn? Would you learn about child abuse prevention from social media? How could you become an influencer if you were provided with information to share? If you were abused, who would you tell? What would inhibit you from telling if you had been abused? Do you get information about these topics online or from written material?
Medical Professionals	How long have you worked in the field working with children who may have been abused or neglected? How do you assess or identify abuse/neglect? Have you had children make an outcry to you? What could have prevented this? Looking back, what were some warning signs that might have prevented it? Do you meet with parents? What type of abuse prevention is the most important? What resources do you currently have? Does your office do any child abuse prevention with future, new, or current parents? What resources are needed? Do you see anything that is cultural?

Appendix F: Detailed Responses and Recommendations by Cohort

		Survivors
Responses		Recommendations
1	Abuser threatens/grooms the child to stay silent. Fearful of speaking up. It takes years to tell. We didn't know who to tell. Schools offered drug DARE information and programs, but nothing on abuse.	• Mandatory training in schools - teach kids it's not your fault. Normalize speaking up. Tell someone who will believe you: • Presentations, Social Media Campaign, Printed Materials - Teach adults to listen, to identify behaviors, to be "Safe Adult".
2	Partner of abuser/other parent is unprotective of child. Abuse is "normalized" in a child's household; child doesn't differentiate between abusive behavior and appropriate behavior and parenting.	• Educate parents on signs and symptoms. Hold them accountable if they don't report. Education on domestic violence • Educate kids on what to do if other parent is unprotective. Teach/role play safe adult. • Educate kids on what constitutes a safe home; positive parenting • Educate teachers, childcare workers, medical and faith leaders on signs and symptoms, and support strategies.
3	• When the child did speak up, nothing was done. Told police officers, doctors who reported to CPS but no further action. • Particularly in rural areas and wealthy areas. • CPS cases are about 3 things - drugs, alcohol, debt which are symptoms of underlying depression.	• Train police/create patrol card on: how to respond, TBRI, how trauma affects the brain, generational effects, ACE's • Work w/legislature to change law - parents should not be present when kids are questioned. • Focus on the parents, possibly at church. Teach parents other ways of happiness. Focus on lower income communities. Use scare tactics - If you do "X", your kids can be removed. Create confidential hotline where parents can get help.
4	Child trafficked at young age by family member.	• Early intervention - Teach kids about sexual exploitation, risks, grooming, and characteristics of abusers. • Create support systems and resources for vulnerable children
5	Risk of ongoing, further abuse.	Teach how to establish boundaries, self-empowerment, and make good choices. Remove them from a bad environment so healing can occur or train on how they react to their environment.
6	Trauma is ongoing as a result of abuse. Children who are being/have been abused need to relate to others who have also experienced abuse.	Train parents, foster parents in TBRI. Provide vouchers for free counseling for abuse victims. Trauma-focused therapy, EMDR, Mindfulness. Support group with other foster children.
7	Foster Care - multiple placements, very little stability. Many foster parents don't treat foster children well. Continued abuse.	• CASA volunteer was the only stability. • Develop Children's Handbook for kids in foster care. • Regular wellness checks and surprise visits by CPS

Parents		
Responses		Recommendations
1	Teachers need to understand signs of abuse and they are reluctant to report to CPS due to fear of retaliation; change Texas Law	Train teachers on signs and symptoms of abuse, have teachers get an anonymous box or time set aside for students to talk to them, Schools should provide protection for teachers who report
2	Parent education on trauma, warning signs, child safety, and they need support groups for parents and foster parents with children who have experienced trauma	Train parents on warning signs of abuse and to speak up, child safety, TBRI and how to use the approaches, share TBRI videos, start support groups: dad's group, mom's group, grandparent's group, provide information TBRI and information about abuse, provide post-adoptive resources, mental health resources before, during adoption
3	Students need to speak up and identify safe adults, and learn safety and abuse prevention	Train children to identify and talk to safe adults, PE teachers can present safety information to students during health class.
4	Community needs to learn more about CAFB, CASA, and CAC	More outreach to faith leaders and community about what CAFB services.
5	Train clergy	Train clergy about reporting, child safety, and background checks in hiring staff, train them to have closed campuses for church camps, require training every 2 years, provide safety videos with tests, implement a process for reporting abuse.
6	Train law enforcement	Train law enforcement on TBRI

Educators: Secondary Teachers and Counselors

Responses		Recommendations
1	Educate Parents	Where: • Refer to outside agencies with diverse clinicians or culturally appropriate people • Events at school, such as Science Night • On Skyward, pamphlets or videos Topics: • Social media, texting - impose limitations, safety risks • What constitutes abuse/neglect and U.S. standards of discipline • Child safety and abuse prevention
2	Train Junior High School and High School students to be leaders of other students in terms of child abuse prevention	Where: • Assemblies, volunteering at CAFB, during P.E. periods, school news shows Topics: • Coping and communication skills • How to "read" their parents, diffuse a situation, go their room or a friend's • Social media • Safety information • Encourage their friends to speak up about abuse • Teen dating relationships, sexting, and sharing images on phones
3	Train teachers and other school staff on child abuse prevention and reporting	• Offer it twice a year • CAFB train counselors • Provide online videos to school staff • Provide flyers for educators to read • In-person presentations • Incentive summer training for credit in their school
4	School district protocols vary from district to district, school to school, and year to year	Create new video - reporting protocols, signs and symptoms, work with principals to document and train reporting protocols
5	Educators are not familiar with CAFB, CASA, and CAC	Educate them on roles of each, host educator tours of agency, provide education tied to student curriculum, video of CAC, in-person presentations
6	Texas Law - No more anonymous reporting because it makes teachers reluctant to report	Counselors and teachers can report together, include discussion of family support to educators who feel hesitant in reporting.

Educators: Early Childhood and Day Care Workers

Responses		Recommendations
1	Parent education. Parents may have difficulty communicating with children. Children often have difficult behaviors. It is difficult to reach parents with prevention information. Multigenerational living can create different styles of discipline and expectations.	• Provide parent education and coach, use trauma-informed care. • Post prevention information on social media • Use drip learning to educate parents • Incorporate into story time at the library • Create short videos and tik toks for parents • Use parent peers because parents trust other parents • Present to parents at community events, Frogs, Snails, and Fairytales, Playspace • Provide information to parents (parenting tips) by texts, emails, flyers, and in monthly newsletters. Heavy focus in April. • Develop materials in Spanish. • Invite parents and grandparents to open houses and parent-teacher meetings. • CAFB can present at the George Family Dev. Center • Provide information and training (TBRI) for dads. • Include information with resources at the front desks. • Create QR code. • Provide information at grocery stores, booths, hospitals, schools. • Present parenting topics monthly at daycare and invite friends and neighbors • Teach parents TBRI and how to talk to children. • Give parents and teachers ACEs training.
2	Teachers need training on child abuse awareness and prevention.	• If the teacher is suspicious of abuse, train them on what to do next. • Make sure that daycare teachers are doing the required annual training and passing the test. • Train daycare workers on TBRI.
3	Educators and parents need to learn the roles of CPS, CASA, and CAC.	Teach parents and teachers what CPS, CASA, and CAC do and what services they provide.

Professionals: CASA, CAC, CPS		
Responses		Recommendations
1	Inconsistencies among schools and districts in defining abuse, and reporting protocols.	Train schools on the Texas legal definition of abuse. Provide information on where to go to find their district's/school's protocols on reporting abuse.
2	Teachers and Counselors are unfamiliar with CASA and CAC. Don't know what happens after a report is made.	Tours of CAFB, on-site training, training of school personnel. Develop video/virtual tour of CAC.
3	Abuse has to become severe before people/professionals intervene.	CPS utilize a more Alternative Response (AR), CASA work with families earlier in the process, e.g. court-ordered cases. Educate on safety and resources CPS can provide.
4	Educate parents	Where: • Include in school Parent Handbooks • Educational packets • Outline Training • Utilize parent peers to teach, start Parent Support Groups • Teach parents at YMCA, neighborhood centers, places of worship. Topics: • Grooming and sexual abuse • Human Trafficking • Parenting Skills • Effectively communicating with your kids at different ages. • Internet safety • Provide information in Spanish

Medical		
Responses		Recommendations
1	Doctors, Nurses not trained in child abuse. Are not being asked about it.	Train Ob/GYN's so they can educate pregnant moms and expectant parents. Train pediatricians during "well-child" exams to ask questions: "Do you feel safe at home?", or "Is there anywhere that you don't feel safe?", or "Is there anyone that makes you feel weird?", starting at 4–5-year-olds. Make it part of protocols when doing medical histories and screenings. Pediatricians ask parents about parenting, incorporate safety tips into "How to Change a Diaper Training", offer group classes for new parents.
2	Cultural differences in parenting disciplining sexual norms: Asian - taboo, behind closed doors Hispanic - teen pregnancy more common Black - complacent, tolerant of corporal punishment, violence.	Doctors can ask parents open-ended questions; "What are some ways you use negative reinforcement?" Offer TBRI training for parents.
3	Hospital resources may not be coordinated; it takes too long to take comprehensive history if questions about discipline and social factors are included and making a report. Defer to social workers.	Tie in hospital social workers. Create a "Child Protection Huddle" including Law Enforcement, Primary Nurse, Forensic Nurse, Risk Management representative, Social Worker, House Supervisor.
4	Abuse is normalized.	Don't teach abuse. Teach what healthy relationships look like. Start at 7–8-year-olds.
5	Child's reactions to abuse are age dependent. 3–9-year-olds play and chat. 10-18-year-olds blame themselves; "I should have known better not to...get into the car, go to the party, drink."	Nurse/Doctor affirms that it's not their fault. You're not in trouble. Nothing you did caused you to make this person do this to you.
6	Provide abuse information to patients while in clinic, on phones and in community	• Develop PSAs for My Health Sphere kiosks placed throughout the community. (Helping Hands, Second Mile Mission, Friends of North Richmond, Seniors Meals on Wheels, Catholic Charities) • Provide information on email blasts to AccessHealth patients (20,000) • Present at monthly Family Practice meetings. • Create patient card with QR code.

Teenage High School Students		
Responses		Recommendations
1	Students need to be educated on safety, social media, risks and consequences of behavior, texting, dating, who to tell if they have been abused, where to find child abuse prevention information	• Teach children about social media risks • Teach children about the consequences of inappropriate texting • Provide safe dating education information • Teach children about toxic relationships and dating • Teach children how to identify safe adults and to talk to them • Have students put up posters at school with various messages • Teach students in small groups • Have students make short videos to share on social media or YouTube • Support student leaders in starting a club at school • High school students can volunteer/intern through the George Foundation or through opportunities from counselors at school • Work with high school students to create morning announcements about various topics.
2	Parent education is needed	• Social media - parental permission before downloading, restrict usage until high school, leave phone at home unless after school activities, parents establish number of hours can be on social media, young children have too much access to social media, and they see and copy inappropriate things • Educate parents on human trafficking

Appendix G: Detailed Timeline and Roadmap

Phase	Activity	Date	Comments
Planning	Human Centered Design Training	January 2023	Presented by Dave Evans, Stanford University D School, Design Thinking. Sponsored by The George Foundation
	Steering Committee Kickoff Meeting	February 2023	Board Members (5), CEO, Staff (4)
	Steering Committee Planning Meetings (Monthly)	March 2023 - February 2024 Monthly	developed CAP-C case statement, goals, membership in collaborative
Structure	CAP-C Collaborative Formed	January 2023	Initially 35 agencies in Group A are child welfare professionals; another 30 in Group B who are users of information
	CAP-C Collaborative Kickoff Meeting	February 2023	Presented case statement, goals and vision
	CAP-C Collaborative Meetings (Monthly)	April 2023 and ongoing. 36 months and continuing	Tracking attendance/participation by agency and representative. Filled gaps by adding 15 additional agencies. Learning at each mtg w expert panels
	CAP-C Coordinator Hired and Managed Project (contract)	April 2023 - March 2025	Direct report to CEO, 12-month contract
	Transitioned to Manager of Prevention	March 2025	Transitioned from contract to full-time staff position
Funding	Seed Grant Awarded from The George Foundation	February 2023	\$35,000
	2nd Grant Awarded by Henderson Wessendorff Foundation	February 2024	\$40,000
	3rd Grant (Renewal) Awarded from Henderson Wessendorff	May 2025	235,000 for 2 years
	4th Grant Application (Renewal) to The George Foundation	Fall 2025	TBD
Research	Research Sub Committee Formed	December 2023	6 members: CEO, CAP-C Coordinator, CAFB Board of Directors, Youth Shelter Executive Director, Behavioral Health Services/CASA Volunteer, CAFB Sr. Director Strategic Services
	Research Goals and Design Determined	January 2024	Individual and small group interviews, 6 stakeholder groups: survivors, parents/caregivers, educators, child welfare professionals, medical, teenagers
	Questions Drafted	February 2024	20 questions: 15 uniform; 5 specialized by cohort
	Interviewees Recruited	February 2024	72 interviewees
	Interviews Conducted and Recorded	March - May 2024	106 hours
	Interviews Transcribed & Coded	April - June 2024	3 months
	Interviews Analyzed and Themes Developed	October 2024 - February 2025	
	Research Paper Written	January 2025 - July 2025	
Website	Website Sub Committee Formed	December 2023	5 members: CEO, CAP-C Coordinator/Manager Prevention & Outreach, Marketing Specialist, CAFB Board Members
	Goals and Target Users Defined	January 2024	Goals: easily accessible resource website with child abuse information for use by professionals

	RFP Written and Proposals Solicited for Website Developer	March 2024 - February 2025	5 proposals received
	Website Developer Selected	April 2024	3 finalists interviewed and scored on evaluation checklist
	Architecture Established	June 2024	6 User groups: Child welfare, educators, law enforcement, medical professionals, parents, caregivers, grandparents, youth servicing organizations 3 Topics: abuse overview, protection and prevention, reporting, response and treatment 8 Data Types: activities, articles, books, flyers/handouts/pamphlets, phone numbers, podcasts, training, videos/webinars
	Call for Submittals of Child Abuse information & materials	December 2023	>1600 submittals
	Materials reviewed, catalogued by category and user group	March 024 - February 2025	6 User groups; topics: child abuse defined, identification, response, prevention
	Design Established	April 2025	User friendly, able to be updated easily with new submittals
	Information & Materials uploaded	June 2025	
	Content Written	July 2025	
	Website Live	August 2025	
Education Campaign	Goals and Target Audience Established	February 2025	Relatability, protect your children, seek safety; parents and children
	Proposals Received and Marketing Firm Selected	April 2025 - June 2025	Limb Design Group
	Themes and Graphics Designed	July 2025 - September 2025	3 options presented
	Content Written	October 2025 - December 2025	Customize for different audience and cohorts
	Materials Developed for each Audience	TBD	Short format videos, social media, flyers, posters, banners, apps, TBD
Prototype	Pilot Locations Established	April 2025 - June 2025	Medical, daycare, schools, YSOs, worship centers, sports, community centers
	Tracking and Measurement Established	April 2025 - July 2025	Increase in awareness pre and post;
	Pilot launched	September 2025 - May 2026	Medical: Access Health; daycare: Gingerbread Academy; Schools: LCISD, FBISD; YSOs: TBD; Churches/worship centers; Sports: TBD; Community centers: TBD
	Outcomes Tracked	February 2026 - May 2026	TBD
	Campaign adjusted as needed	February 2026 - May 2026	TBD
	Expanded into other Locations/Audiences	May 2026 - October 2026	TBD

References

- Backhaus, S., Leijten, P., Jochim, J., Melendez-Torres, G.J., & Gardner, F. (2023). Effects over time of parenting interventions to reduce physical and emotional violence against children: A systematic review and meta-analysis, *eCinicalMedicine*, 60, 1-15.
- Barlett, J.D. & Steber, K. (2019). How to implement trauma-informed care to build resilience to childhood trauma. *Child Trends*.
- Bornstein, M.H., Cluver, L., Deater-Deckard, K., Hill, N.E., Jager, J., Krutikova, S., Lerner, R.M., & Yoshikawa, H. (2022), The future of parenting programs: I Design, *Parenting*, 22:3 21-234, DOI: 10.1080/15295192.2022.2087040.
- Bostrom, M. (2003). Developing community connections: Qualitative research regarding framing policies. *Public Knowledge*.
- Brassard, M.R., & Fiorvanti, C.M. (2015). School-based child abuse prevention programs. *Special Issue: Child Maltreatment and the School Psychologist, Psychology in the Schools*, 52(1), 40-60.
- Bright, M.A., Huq, M.S., Patel, S., Miller, M.D., & Finkelhor, D. (2022). Child safety matters: Randomized control trial of a school-based, child victimization prevention curriculum. *Journal of Interpersonal Violence*, 37, 538-556.
- Child Maltreatment Fatalities and Near Fatalities Annual Report*. Texas Department of Family and Protective Services. (2024). <http://www.dfps.texas.gov/>
- Davis, M.K., Gidycz, C.A. (2000). Child sexual abuse prevention programs: A meta-analysis. *Journal of Clinical Child Psychology*, 29(2), 257-265.
- Gilbert, R., Thoburn, J., Kemp, A., Sidebotham, P., Radford, L., Glaser, D., & Macmillan, H. (2009). *Recognizing and responding to child maltreatment*. Lancet, 373, 167-180.
- Glouchkow, A., Weegar, K., & Romano, E. (2023). Teachers' response to child maltreatment. *Journal of Child and Adolescent Trauma*, 16, 95-108.
- Goodrum, N.M., & Prinz, R.J. (2022) Family-based prevention of child traumatic stress. *Pediatric Clinics of North America*, 69, 633-644.
- Maguire-Jack, K. Hardi, F., Stormer, B., Lee, J.Y., Feely, M., Rostad, W., Ford, D.C., Merrick, M.T., Murphy, C.A., & Klika, J.B., (2022). Early childhood education and care policies in the U.S. and their impact on family violence. *Children and Youth Services Review*, 142, 1-14.
- McKibbin, G., & Humphreys, C. (2020), Future directions in child sexual abuse prevention: An Australian perspective. *Child Abuse and Neglect*, 105, 104422.
- National Statistics on Child Abuse*. National Children's Alliance. (2024, August <http://www.nationalchildrensalliance.org/>
- Nickerson, A., Tullledge, J., Manges, M., Kesselring, S., Parks, T., Livingston, J., Dudley, M. (2019). Randomized control trial of the Child Protection Unit: Grade and gender as moderators of CSA prevention concepts in elementary students. *Child Abuse and Neglect*, 96, 101-104.

- Prinz, R.J. (2016). Parenting and family support within a broad child abuse prevention strategy. *Child Abuse and Neglect*, 51, 400-405.
- Rispens, J., Aleman, A., & Goudena, P. (1997). Prevention of child sexual abuse victimization: A meta-analysis of school programs. *Child Abuse and Neglect*, 21, 975-987.
- Romero, V., & Donaldson, H. (2023). Human-centered design thinking and public health education: A scoping review. *Health Promotion Journal of Australia*, 35(3), 688-700.
- Sweetland, J. (2021). Reframing childhood adversity: Promoting upstream approaches, [https:// preventchildabuse.org/wp-content/uploads/2021/03/Reframing_Childhood-Adversity-Promoting-Upstream-Approaches-031621.pdf](https://preventchildabuse.org/wp-content/uploads/2021/03/Reframing_Childhood-Adversity-Promoting-Upstream-Approaches-031621.pdf).
- Tutty, L. (2000). What children learn from sexual abuse prevention programs: Difficult concepts and developmental issues. *Research on Social Work Practice*, 10(3), 275-300.
- Weeks, E.A., Whitaker, D.J., Pendarvis, S., Finkelhur, D., Neal-Rossi, C., & Rivers, D. (2021). Evaluation of the Child Safety Matters curriculum for improving knowledge about victimization among elementary school children: A randomized trial. *Journal of Child Sexual Abuse*, 30(8), 977-993.
- WHO guidelines on parenting interventions to prevent maltreatment and enhance parent-child relationships with children aged 0-17 years. Geneva: World Health Organization; 2022. License: CC BY-NC-SA 3.0IGO.
- Wurtele, S.K., & Kenny, M.C. (2010). Partnering with parents to prevent childhood sexual abuse. *Child Abuse Review*, 19(2), 130-152.
- Wurtele, S.K., Marrs, S.R., & Miller-Perrin, C.L. (1987). Practice makes perfect: The role of participant modeling in sexual abuse prevention programs. *Journal of Consulting and Clinical Psychology*, 55(4), 599-602.
- Wurtele, S.K., & Miller-Perrin, C.L. (1992). Preventing child sexual abuse: Sharing the responsibility. Lincoln, NE: University of Nebraska.
- Zwi, K., Woolfenden, S., Wheeler, D.M., O'Brian, T., Tait, P., & Williams, K.J. (2007). School-based education programs for the prevention of child sexual abuse. Cochrane Database of Systematic Reviews.