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International child abuse prevention: insights from *ACT Raising Safe Kids*

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Background: Evidence-based practices are often viewed as lofty goals endorsed by wealthy academics in developed nations, but impossible to implement in other contexts. This article will provide evidence suggesting that, to the contrary, we can indeed scale up western-developed parenting interventions that can be both effective and warmly received by parents in diverse cultural and economic contexts. **Methods/Results:** This paper gives a brief overview of the *ACT Raising Safe Kids Program* and summarizes the results of evaluation studies done with parents around the world. It discusses specific strategies facilitators use to modify the program as necessary to fit cultural contexts while also maintaining fidelity, implementing the manualized curriculum under varied, and complex circumstances. **Conclusions:** It is hoped that the lessons learned from our work will inspire practitioners to adapt *ACT* or other programs to diverse contexts, evaluate those programs, and thereby improve the mental health and life trajectories of children and families around the world.

Key Practitioner Message

- Evidence-based parenting interventions work to increase nurturing and decrease harsh parenting practices.
- The *ACT Raising Safe Kids* program is an example of a western-developed, evidence-informed program that is affordable, flexible, and highly portable; it can be implemented with caregivers from diverse cultures in virtually any setting.
- Well-trained mental health providers and program implementers and evaluators can effectively work with parents from diverse backgrounds to reduce coercive parenting practices and prevent child abuse.

Keywords: Child abuse; prevention; program evaluation; parenting interventions; parent–child relationships

Introduction

Childhood maltreatment consists of both an omission of essential caregiving (e.g., neglect) and commission of specific acts of harm (e.g., abuse) (Centers for Disease Control & Prevention [CDC], 2015; Mennen, Kim, Sang, & Trickett, 2010). Childhood maltreatment is linked to both negative physical and mental health outcomes (Kim & Cicchetti, 2010; Mackenzie, Kotch, Lee, Augsberger, & Hutto, 2011). These negative outcomes cost the United States $124 billion annually (CDC, 2015) in services provided, such as physical and mental health care, legal services and incarceration, and educational interventions (DiLillo, Fortier, & Perry, 2006). These costs outweigh those incurred over a lifetime by such chronic health problems as diabetes (Wildeman et al., 2014).

Moreover, the brain develops in an experience-dependent manner, with connections formed based on repetitive patterns of experience (Perry, 2008). Cumulative security threats, child as child maltreatment, which occur repeatedly over time, may organize the brain in a manner that leads to symptoms of mental and physical illness (Sameroff, 2000; Shonkoff, 2012). One key aspect

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of experience-dependent brain organization is attachment formation, the bonding between caregivers and children, which lays the foundation for either optimal or impaired later functioning.

John Bowlby (1977, 1982), the author of attachment theory, discussed how attachment security is enhanced by physical and emotional warmth and the availability of caregivers to respond to children's needs. Children who experience maltreatment at an early age may come to view relationships as unpredictable, cold, rejecting, or frightening. Consequently, maltreated children are likely to develop insecure attachments and subsequent problems in all areas of functioning (Baer & Martinez, 2006; Walker, Holman, & Busby, 2009). Contemporary research has confirmed that child abuse and neglect have multidimensional and long-term impacts, affecting all areas of growth and development (Vachon, Krueger, Rogosch, & Cicchetti, 2015). For example, physically, maltreated children can experience malnutrition and failure to thrive, as well as disabilities due to injuries or burns (Block & Krebs, 2005). There may also be abnormalities in both the structure and functioning of key brain areas related to cognition, memory, emotion, and sensory integration (Kim & Cicchetti, 2010; Shonkoff, 2012). Socioemotionally, children may develop problems in emotion regulation, which can lead to depression, anxiety, suicidality, or externalizing behavior problems (Cicchetti, 2016). Cognitively, children often face learning challenges, cognitive delays, and the inability to concentrate in school (Gould et al., 2012). With such wide-ranging difficulties, child maltreatment has been characterized as a global health epidemic.

Due to the devastating impacts of child maltreatment for both families and societies, it is crucial that we develop standardized child abuse prevention programs and evaluate their effectiveness in real world contexts. Varying research quality, sample heterogeneity, and questionable measurement techniques are common in parenting program evaluations; however, across dozens of extant studies, there is consistent evidence that parents from both developed and developing nations can learn nurturing skills and can reduce harsh and coercive discipline practices, thereby preventing child maltreatment (e.g., Chen & Chan, 2015; Knerr, Gardner, & Kluver, 2013).

Low- and middle-income countries

Low- and middle-income countries (LMIC) tend to experience higher rates of all forms of trauma, including child abuse and neglect, than wealthier nations, and mounting evidence confirms that parenting interventions can be equally effective in developed and under-resourced countries. Unfortunately, many LMICs have yet to even gather statistics regarding child maltreatment rates, let alone implement evidence-based practices with families. Officials in developing countries often report that they have few well-trained practitioners to implement programs, as well as limited access to facilities and materials (Mikton, Power, Raleva, & Almuneef, 2013).

Due to high rates of child maltreatment and limited resources, practitioners in LMICs cannot hazard to implement novel programs or those which have never been evaluated. They need good training and support to implement evidence-based practices so their populations are not used as 'guinea pigs' for new fads or untested ideas. Scholars increasingly argue for implementing well-established and tested parenting programs using a public health model (e.g., Ward, Sanders, Gardner, Mikton, & Dawes, 2015). This approach makes programs available to all families at a low cost to the country. Moreover, any given program must be effective at reducing risk factors, increasing protective factors, and it must be flexible enough to be implemented in often stressful or impoverished environments (Ward et al., 2015).

ACT Raising Safe Kids

The *ACT Raising Safe Kids Program* was developed by the American Psychological Association's (APA) Office of Violence Prevention to fill a void in child maltreatment prevention efforts. Several evidence-based parenting programs existed at the time ACT was developed (circa 2005), but they were costly to implement, with expensive required materials, and they were not easily portable to isolated, nonwestern, or difficult contexts. In contrast, ACT is a not-for-profit universal program that can be implemented for the cost of materials in virtually any setting (Weymouth & Howe, 2011).

The ACT curriculum was designed for caregivers of children zero to 8 years of age. Its goals include preventing child abuse, increasing positive parent–child relationships, and optimizing children's developmental outcomes (Silva, 2009). It uses an interactive, strengths-based format where parents build a supportive community with each other and learn how to reduce coercive punishment practices. Parents spend 8 weeks learning about the ages and stages of development, strategies for emotion regulation, the effects of media violence on children, and positive communication and problem solving techniques. ACT has been recognized as an effective parenting program by the World Health Organization, The California Evidence-Based Clearinghouse for Child Welfare, Crime Solutions, and The Office of Head Start. It is currently being implemented in 80 communities across the United States and in Brazil, Colombia, Peru, Greece, Turkey, Croatia, Bosnia and Herzegovina, Romania, Portugal, Taiwan, and Japan.

The American Psychological Association's Office of Violence Prevention (OVP) plays a centralized role in training and supporting program sites through the use of master trainers who provide 2-day trainings for service providers. Master trainers and the OVP continuously support and consult with practitioners to allay fears and provide recruitment, implementation, and evaluation guidance. ACT also has a research advisory team that conducts research at US sites and regularly confers with researchers from international sites to help them design, implement, and evaluate their programs.

Each country has differing levels of access to professionals with research expertise; thus, evaluations vary widely, from qualitative and descriptive work on small samples of parents, to larger randomized, controlled trials. All domestic and international sites conducting program evaluations receive IRB approval from an affiliated university. This paper will present evaluations from several countries so that practitioners may gain insights regarding how to begin small scale program implementations and evaluations, as well as how to then envision those efforts growing and becoming more rigorous over time.

Method

This section provides an overview of the evaluations completed in the United States. It serves as a framework for developing an understanding of the results presented below, which stem from diverse implementation strategies and program evaluations completed in LMICs.

Program evaluations in the United States

Program evaluations in the United States have shown that ACT is low cost yet its outcomes evidence similar effect sizes to those found in expensive, well-known parenting interventions (Knox, Burkhart, & Hunter, 2010; Weymouth & Howe, 2011). This is of vital importance because developing manualized evidence-informed programs is necessary, yet many programs cannot be adapted to low-income communities or may not be received positively by parents in diverse cultures. In contrast, the ACT program is uniformly embraced by parents around the world, regardless of cultural context or presence of historic trauma or other stressors.

Having well-trained facilitators from their own communities implement the program is extremely helpful for parents who may fear outsiders or be shy about participating in active learning exercises due to language or cultural barriers. In one evaluation study, Spanish speaking parents in the United States improved even more than English-speaking parents, suggesting that when programs are delivered in one's native language by culturally competent facilitators, results for outcomes like knowledge of child development, monitoring violent media, and reducing coercive parenting can be improved, with medium to large effect sizes (Weymouth & Howe, 2011).

Program evaluations in the United States have been conducted with approximately 1500 parents and caregivers across approximately 30 sites, with both voluntary and court-mandated parents, in Spanish and English. Programs were implemented with groups of 5–25 parents per 8-week session, with classes taking place in community centers, churches, prisons, health care centers, psychiatric facilities, and social service agencies. Facilitators included social workers, therapists, counselors, psychologists, and other professionals. Evaluations included within-group pre–post-designs, waitlist control/treatment group comparisons, and randomized controlled trials with pre–post and 3-month follow-ups.

Many evaluations used the ACT Evaluation Measure designed by the OVP to quickly and easily assess knowledge and application of the learning modules in the curriculum. However, evaluations have also used psychometrically sound established measures, such as the Child Behavior Checklist (Achenbach & Edelbrock, 1983), the Parenting Stress Index (Abidin, 1995), The Strengths and Difficulties Questionnaire (Goodman, 2001), the Behavioral Assessment Scale for Children (Reynolds & Kamphaus, 2004), and the Family Environment Scale (Moos & Moos, 1984). See individual evaluation studies for more information on study designs, measures used, and detailed results (Burkhart, Knox, & Brockmyer, 2013; Knox & Burkhart, 2014; Knox, Burkhart, & Cromley, 2013; Knox, Burkhart, & Howe, 2011; Knox et al., 2010; Porter & Howe, 2008; Portwood, Lambert, Abrams, & Nelson, 2011; Weymouth & Howe, 2011).

Across every evaluation in the United States, regardless of methodology or sample composition, consistent results included a reduction in coercive, aggressive, harsh, and negative parenting practices, an increase in positive, nurturing parenting practices, and internalization of the program messages in the ACT curriculum. When child behavior was assessed, children's aggressive, externalizing, and bullying behaviors decreased significantly. Moreover, individual studies found reductions in spanking, increased monitoring of violent media, reductions in hostile attributions and negative beliefs about children, increased understanding of children's development, and increased perceptions of social support.

Facilitators who convene at the OVP during the ACT Annual Leadership Conference report that parents feel heard, welcomed, and supported when attending the ACT program. Program facilitators are, of course, mandated reporters of concurrent child abuse; however, they stress to parents that facilitators are not part of the child welfare system or any court proceedings, and that what is discussed in sessions is confidential. Thus, parent safety and comfort in discussing and trying out new approaches to parenting are increased. Parents support each other in learning and implementing their new skills and at many sites around the world, facilitators report that parents request to take the class again after they have completed it.

Based on these results, the current authors felt it prudent to share program successes and challenges with mental health providers so that more families may be served by ACT or other evidence-informed programs, hopefully on a global scale, and especially in LMICs. The following presentation of evaluation results illustrates the widely varying methods practitioners can use for implementation and evaluation. Ultimately, it should become apparent that manualized curricula can be flexibly implemented and modified to fit diverse contexts. Moreover, it is emphasized that evaluations *of some kind* must be conducted so that programs can be continuously improved, because practice-based evidence is equally as important as evidence-based practice.

Results

Cultures, contexts, and participants

There are two key sites in Brazil. In the first, a sample of 139 low- and middle-income caregivers was recruited from public family health centers and private and public schools in the city of Riberao Preto, in the State of Sao Paulo. Successful strategies for recruitment included home visiting by primary health agents, lectures about the program, and testimonies of ex-participants from the ACT program. The second site is in Curitiba, where ACT was implemented with incarcerated women. There are few interventions available for this population, and the majority is coordinated by religious institutions (Camargo, 2016; Durigan, 2015; Ormeño & Williams, 2013). The program was implemented in a maximum-security prison in Curitiba, Parana State, with 23 incarcerated mothers, 20–45 years old. In terms of crimes committed, 82.6% were incarcerated for drug trafficking, 8.6% for homicide, and 8.6% for robbery. All were from low-income communities.

In Japan, the focus was mainly on Fukushima. After the earthquake and tsunami of 2011, child abuse and domestic violence reports increased dramatically in areas affected by the disaster (Japanese Ministry of Labor and Welfare, 2012; Tsushin, 2013). Participants from Fukushima and Tokyo were recruited to examine differing community needs. In Fukushima, parents are raising children suffering from chronic anxiety and fear about the impact of radiation, as well as coping with the complex impacts of societal judgment and stigma against those exposed to radiation. In Tokyo, ACT was implemented in six typical middle-class communities.

In Taipei City, Taiwan, parents were recruited from university-affiliated elementary schools and preschools.

Finally, in Lisbon, Portugal, a pilot sample included five mothers and one father, 36–52 years of age. All participants had a college degree and belonged to a two-parent household.

Cultural modifications and fidelity assurance

In Riberao Preto, the Brazilian Portuguese version of ACT (Silva, 2011) was used with minor adaptations,

adding new videos adapted to the cultural context. Attrition prevention included providing child care, calling and texting class reminders, giving gifts (e.g., toys and books), offering snacks, and giving a certificate to participants. Brazilian caregivers readily accepted the program and reported that positive aspects included facilitators' explanations, group discussions, and dynamic activities. The ACT program demonstrated validity and efficacy for both low- and middle-income parents but attrition varied. Only 51% of low SES caregivers and 61% of middle-class parents completed the program (vs. 79% of higher income parents). However, completion rates were similar to the 56%–74% in US samples (Knox & Burkhart, 2014; Knox et al., 2011, 2013).

In the prison sample in Curitiba, challenges included an extremely low social-educational level among participants, a coercive environment, and restrictions related to the penitentiary. All of the participants came from families with multiple traumas and risk factors, which required the team to reframe the explanations about topics such as the impact of violence. For example, much of the violence the women had committed was not considered by them to be violent, but normative events. Thus, defining violence occurred more methodically, with more time allowed to reflect and think about new worldviews. Moreover, the group had difficulty recognizing and describing emotions, which led the facilitator to extend emotion-related sessions, and spend more time with activities, such as role-playing. With more time and additional materials, the women could interact better with others and with the research team, strengthening rapport.

The coercive nature of the prison environment and the negative leadership required adaptation to the program's rules. For example, freedom of thought and speech were established as the participants' human rights during ACT meetings even if not experienced in general. The greatest challenge for this group was that children only visited their mothers once a month. Therefore, the instructions for homework were adapted to fit future possible interactions with their children. Participants were encouraged to practice their recently learned abilities when interacting with fellow inmates and correctional agents. This was vital for the success of the program, because it allowed the mothers to practice and feel the effects of nonviolent behavior.

In order to comply with the prison environment and this population, the program was delivered mostly orally instead of using written materials. This included all of the pre- and postprogram assessments and session activities. Speaking and drawing activities substituted for the written assignments. Also, many activities had to be adapted due to lack of technology (e.g., no Power Points or videos). Information was presented in printed form and on a flip-chart. These adaptations did not compromise fidelity to the curriculum. All required sessions and activities were delivered.

In stark contrast to the prison sample, the Lisbon, Portugal team utilized a highly educated, middle-class sample. They also used the Brazilian Portuguese version of the curriculum but it was adapted to reflect the Portuguese spoken in Portugal and checked for linguistic and cultural appropriateness. A pilot study assessed feasibility and cultural acceptability. The study was announced through social media and flyers posted in kindergartens and child psychology clinics. The program was delivered by a Ph.D. student and a master's level psychologist. The ACT program checklist (Silva, 2011) was completed by facilitators to ensure fidelity to program components. Weekly meetings were conducted to discuss the previous session and prepare for the next. Sessions were videotaped, enabling further study of the implementation. All program topics were presented, with little evidence of dilution of core program elements.

In Japan, marketing posed a challenge as psychotherapy and counseling are still uncommon, but 'classroom style activities' are socially accepted. Thus, ACT provides a culturally congruent way for parents to reflect on their parenting practices without shame. A Japanese facilitator manual and program materials were developed by translating the original curriculum, conducting two pilot programs, and applying cultural adaptations to the manuals. To maintain program fidelity, facilitators conferred with APA's OVP regarding small changes.

The most notable modification was reordering the sessions. Due to cultural differences in group processes (e.g., how trust and relationships develop; how to share feelings), the session addressing the effects of violence on children was moved to later in the program, after the group developed enough trust to feel safe sharing feelings. They added some preparation activities before emotional content and spent more time reflecting on participants' experiences of each exercise. They also gave more support for experiential exercises, such as facilitators modeling the role plays first.

The Taiwan group translated the materials to Chinese Mandarin and minor cultural adaptations were made in the wording, examples, pictures, and videos in order to engage and retain Taiwanese participants. Fidelity checks were conducted to ensure there were no modifications of the main program components, timing, or overall structure.

Evaluation designs and outcomes

In the most rigorous evaluation performed outside of the United States, the Riberao Preto group in Brazil conducted two pre–post intervention comparison studies (Altafim, Pedro, & Linhares 2016; Pedro, Altafim, & Linhares, 2016), and one randomized, controlled trial (RCT; Altafim & Linhares, 2017). In the pre–post evaluations, parenting practices were assessed by the ACT Evaluation Measure with psychometric validation on the Brazilian sample (Altafim & Linhares, 2017; Altafim, McCoy, & Linhares, 2017). Also, child behavior was evaluated by two main caregivers of each child, using the Strengths and Difficulties Questionnaire (SDQ). The Curitiba prison study examined qualitative behavioral change from pre- to postintervention, as well as orally administering the ACT Evaluation Measure to twelve mothers.

In Japan, 120 facilitators were trained on the ACT program, spanning 15 communities. The researchers developed a pilot questionnaire to assess cultural appropriateness and parental perceptions of program effectiveness in both Fukushima and Tokyo.

In Taiwan, 15 participants were randomly assigned to the intervention and 17 to the waitlist control group. Groups were assessed using the ACT Evaluation Measure. The intervention group was assessed at 3-month follow-up. Parents completed the Conflict Scale of the Family Environment Scale (Moos & Moos,

1984). Qualitative data were also collected to gain an understanding of parents' thoughts about the ACT program.

In the pilot feasibility study in Lisbon, Portugal, parents were asked weekly to complete evaluations regarding their experiences in the program. In the last session, participants also completed a satisfaction questionnaire (Silva, 2011), and 4 weeks after completion, parents were interviewed regarding any potential changes in their parenting.

Parent outcomes

In Riberao Preto, mixed model ANOVAs showed that parenting practices improved significantly, with increased positive and decreased negative practices, as well as improved electronic media monitoring, all with large effect sizes. Additionally, the findings of the RCT revealed that mothers' parenting practices (positive discipline, emotional/behavior regulation, and communication) improved. Moreover, these findings where maintained at 3–4-month follow-up, while the control group did not change.

In the Curitiba prison sample, qualitative analysis of survey answers revealed an increase in parenting knowledge in 100% of the participants. Also, 82.6% exhibited observable behavioral changes during the program. For example, when the program began, women were often negative, hostile, and rude toward each other and the facilitators. As they improved their skills in the program, the facilitators noted an improved atmosphere in the classes. Mothers became kind and helpful toward each other. Additionally, 100% of the participants rated the program and the team as 'excellent,' without reservation.

Twelve mothers completed pre- and postprogram assessments and results demonstrated that over half of the mothers increased the number of answers they gave that illustrated excellent parenting techniques and 64% decreased the number of responses considered harmful parenting. The program also changed the women's relationships with each other. Before the intervention, none of the following behaviors were observed by facilitators, but occurred frequently after the program: offering other mothers a place to sit, saying please and thank you to others, praising other participants, choosing not to be a bully, respecting others' time to speak, and respecting others' opinions, even if they were different from their own.

In Japan, parental responses to the pilot questionnaires showed that ACT helped parents understand their negative reactions to their children's behaviors (Nishizawa, 2014). According to the ACT model, this awareness marks the beginning of the parents' process of gaining control over their anger and choosing positive discipline. Many parents responded that they learned effective parenting tips and understand more about their children. The responses were similar for participants in the both Fukushima and Tokyo. The pilot study showed that the majority of parents spanked less at the end of the program, liked the program, and would recommend it to others. Specifically, approximately 45% of parents in Fukushima had hit, slapped, or spanked their children at pretest, and 80% of those parents decreased the frequency of corporal punishment by the end of the program.

About 91% of Japanese parents would recommend this program to others and 70% reported learning helpful parenting tips and tools which would improve their parenting. Parents felt the most helpful activities were small group discussions and role plays. Many participants stated that they learned a lot about their children and about their anger, and that they yelled or got angry at their children less after the program. The results were similar in Tokyo and Fukushima, except that 91% of participants in Fukushima said they wanted to remain in contact with the other parents, while 60% in Tokyo did. This may be due to the isolation many parents in Fukushima feel, or due to the faster paced life found in Tokyo.

In Taiwan, mixed model ANOVAs indicated significant improvement in parent–child interactions, child development knowledge, and family conflict, with no significant changes in media literacy or overall violence prevention knowledge. These preliminary results suggest that the ACT program is adaptable to Taiwanese/Chinese cultural contexts. The ACT program shows initial promise in increasing positive parenting knowledge and skills and decreasing family conflict in Taiwanese parents, which may prevent child maltreatment and domestic violence.

In the pilot program in Lisbon, Portugal, data from weekly reports showed that parents experienced high levels of satisfaction with the program sessions and the facilitators' skills. In general, all sessions received high scores. Worth noting were the lower mean scores for the second session (Young Children's Exposure to Violence), probably due to the higher education and economic status of these parents, as well as the safety of Portugal, a country with low crime rates. When asked about what they would change, all parents wanted to increase the duration of the program (increasing session length/adding sessions). Parents reported that difficult child behavior was the primary reason for enrollment and the majority of parents reported that they had been introduced to new and helpful strategies that they continued to apply at home. The results of this study will enable further improvement, with the next step being a randomized, controlled trial (RCT).

Child outcomes

Outside of the United States, only the Riberao Preto group in Brazil has so far assessed changes in child behavior. Mothers and the other primary caregivers both reported significant decreases in child behavior problems and improved prosocial behavior, regardless of socioeconomic status. There was an overall decrease in externalizing behaviors, with medium to large effect sizes.

Discussion

The above results suggest that the ACT program provides an effective model for implementing western-developed evidence-informed programs in contexts as diverse as women's prisons, natural disaster sites, schools, and child psychology clinics. Parents from all cultures reported liking the program and gaining essential knowledge and skills necessary for nonviolent parenting. Those sites using the ACT Evaluation Measure and other empirically validated measures found significant improvement in key program-targeted behaviors, such as monitoring electronic media, using age-appropriate

discipline, and regulating emotions. The most consistent finding across all cultures is a reduction in harsh, coercive, and punitive parenting practices. Being able to reduce coercive parenting is one essential component of child abuse prevention programming in both developed and developing nations.

Adverse childhood experiences such as child abuse and neglect are linked to leading causes of death such as heart disease, hypertension, cancer, obesity, and smoking, as well as to psychological and behavioral problems, ranging from internalizing to externalizing disorders (Murphy et al., 2016). One key mediator potentially linking child maltreatment to multidimensional problems later in life is the parent–child attachment relationship (Berzenski, Yates, & Egeland, 2013). Thus, prevention programs should focus on building secure attachments between caregivers and children. This includes reducing hostility, anger, and physical punishment, and increasing nurturing behaviors and knowledge of child development.

This review has suggested that the decades of knowledge we have gained from western family science can be effectively applied in both developed and developing nations. The *ACT Raising Safe Kids Program* is one program that can be used across cultures to begin approaching child maltreatment prevention from a public health perspective: making programs universally available, affordable, flexible, portable, and culturally respectful. The international evaluations discussed herein have illustrated that there are many ways that evidence-informed programs can be implemented both flexibly and with fidelity to a manualized curriculum, meeting the needs of diverse families.

Several steps must be taken to ensure successful implementation of such programming. First, frontline professionals must not only be trained by highly skilled program purveyors, but they must be continuously mentored, supported, and provided with free or low-cost continuing education. Second, their efforts must be periodically monitored by program purveyors for adherence to program content as well as the level of rapport they have with parents. Third, parents should be surveyed regarding their perceptions of program content and staff, including their views regarding cultural appropriateness of the curriculum. In this regard, all programs should be flexible enough to respond to local cultural and contextual demands. This final point is not to be confused with the need to create separate programs for every culture, especially because there are innumerable subcultures within each culture and many dialects within each language. Cultural appropriateness includes changing images, examples, names in stories, and video content to reflect the experiences of local families. It also requires presenting sensitive material in ways that will be accepted by local parents, even if they still find the material challenging to their worldview (such as the ACT program's focus on not spanking children). For more on best practices in program development, implementation, and evaluation in light of cultural and contextual diversity, please see Van Ryzin, Kumpfer, Fosco, and Greenberg (2015).

To assist private practitioners in moving toward similar efforts as those described above for larger program implementers, there are excellent guides written for service providers to help transform their work into evidence-based practices (e.g., Hamer & Collinson, 2005). Future clinical work with families should include programs like ACT, which decrease risk factors, increase protective factors, and serve as the foundation for child abuse prevention and family mental health promotion.

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