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Child Forensic Interview Structure, National Children's Advocacy Center

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Do you have a training model of what constitutes a competent or "good enough" child forensic interview? What are its components and its characteristics?

The National Children's Advocacy Center (NCAC) has developed a model for the forensic interview of a child. Its flexible structure honors both the "forensic" and the "child" aspects of this conversation and encourages the interviewer to engage in a decision-making process throughout the interview. We regularly introduce this model through a one-week training, which may be provided to professionally and regionally mixed groups from across the country or to more homogenous groups within a community. Logistically, this one-week format allows us to participate in training the large number of professionals needed to interview children, but it is necessarily simplified. We recommend that to produce a skilled and effective interviewer, attendance of a one-week training be followed by (a) supervised interview experience with a variety of children, (b) ongoing training, and (c) peer review.

Engaging children in conversation about their life experiences is a weighty and complex undertaking. Interviewers need a structure to anchor and guide the conversation, but must also be receptive to guidance from the child's internal structure and meaning. Consequently, we are concerned that a "cookbook" approach, which albeit may be simplified and more easily taught, may not provide the best format in which individual children can share their information. We introduce the concept of a "good enough interview," drawing the comparison to Dr. D. W. Winnicott's description of a "good enough mother."

In the NCAC training, the introduction of our interview process is preceded by the review of a number of the currently recognized interview models and schools, along with the acknowledgement that these models possess many more similarities than differences. Philosophically, we know that professionals have not reached a complete understanding of the complex task of questioning children about their memories of unique life experiences and that we are indebted to the contributions and strengths of other models. Our approach is to be inclusive and collaborative, proceeding with an open and inquisitive mind that would incorporate new knowledge (research and practice) in our model.

We do not assume that the work of child abuse investigation is done in exactly the same way in all communities. Many factors influence the investigation, including population characteristics, specialization within professions, cultural demands, resources, and standard of practice within courts with jurisdiction over criminal and child protection decisions. The presence or absence of multidisciplinary teams and child advocacy centers also affects interviews and investigations. We have attempted to reach a balance between providing a clear structure and acknowledging that the interviewers must adapt the structure to their professional background, tasks, state statutes, and community practices. Although we attempt to educate trainees about recommended best practice, we know that interviewers are often not the final decision makers within their community and that limits to their work are established by outside influences.

As with all interview-training curricula, the stages of our model are presented in a linear fashion, but conversation with a child is seldom linear. We address the different approaches and skills that may be required by the child in active disclosure and by the nondisclosing child. We emphasize the importance of using the rapport-building/developmental-screening portion of the interview to learn about this individual child and to guide the rest of the interview.

The following are the stages of the NCAC model:

- Introductions
- Rapport building/developmental screening
- Guidelines for the interview
- Transition questions
- Abuse-specific inquiry, which proceeds differently with a child who is in
  (1) active disclosure (2) tentative disclosure (3) denial
- Gathering details of any disclosure by the use of narrative/open-ended inquiries, follow-up detail questions, and the use of tools for clarification (if needed)
- Closure

Most models include the instruction to avoid leading questions. What is your operational definition of a leading question?

Our definition of a leading question would be "a direct question that also indicates a preference for a particular response." In other words, it asks the question and implies the answer. However, to merely instruct the trainee to avoid the use of leading questions is limiting and not helpful.

Focused questions are often necessary to explore the many areas of concern and to assist children in recalling stored information about a topic already under discussion. Repetition of a particular question is less desirable than approaching the topic of concern from a new direction. This avoids the possibility of pressuring the child to change or give a response, but also offers an opportunity to pose another question that may make more sense to the child.

We teach the use of a continuum of questions: narrative invitations, focused narrative requests, direct questions, multiple-choice questions, and yes-no questions. We also introduce suggestive and coercive questions, but discourage their use. Along with internalizing the flexible structure of the interview, our procedures focus on assisting trainees in learning to recognize and use the question styles throughout the interview. Learning about the child's ability to make use of various types of questions is a goal of the rapport-building/developmental screening portion of the interview. Attempts to bring children to their optimal level of providing narrative responses to questions should be encouraged.

Trainees are introduced to two primary ways of using the continuum of questions. One format follows the work and directive of Michael Lamb and colleagues and can be effective with a highly narrative child. Dr. Lamb recommends that the interviewer exhaust the use of focused narrative requests as the means of gaining information

from the child, before moving to more direct questioning and techniques for clarification. The other primary questioning format is well represented by the work of Dr. Kathleen Faller and recommends that the interviewer move up and down the continuum of questions to assist the less narrative, younger, or more reticent child in relating stored information. In this approach, the interviewer may introduce a new topic with a direct or a multiple-choice question, then follow up with an invitation to tell more or explain the previous answer. We discuss the benefits and limitations of each format and provide practice.

What is the history of the NCAC Child Forensic Interview model?

The NCAC Forensic Interviewing Academy was established in 1999. For the initial academy, curriculum planners reviewed other training models and incorporated many of their strengths. We introduced our model at that time and have developed and refined it through subsequent classes.

Whom do you train? Rationale?

There are no limits, other than legitimate need and professional status, to those who may register and attend our training. Individuals or small groups from the same community attend. We hold classes in our training facility in Huntsville, Alabama, approximately six times a year with a regional and professional cross section of trainees. Additionally, we conduct customized forensic interview trainings for homogenous groups from a single community or region or representing a particular profession or group.

Our typical classes provide variety among professionals (law enforcement, social workers, interview specialists, doctors, nurse practitioners, and prosecutors) as well as community types (urban, rural, tribal, and international.) The discussion around different needs, points of view, resources, and job descriptions stimulates interest and participation. We encourage trainees to maintain contact with NCAC and with each other following this training experience.

Is the questioning focused on child sexual abuse only? Do your guidelines routinely include questions about physical abuse, neglect, domestic violence, substance abuse, and felony animal abuse? Rational?

Our goal was to develop a model that could be effectively adapted to children experiencing all forms of maltreatment as well as to those who are witnesses to acts of violence. We also wanted a model that would be flexible enough to adapt to children from different cultural and socioeconomic backgrounds.

Maltreatment in a child's life is complex; obtaining facts about an isolated incident seldom tells the story. Acts of physical and sexual abuse are often not exclusive; rather, abusive acts, maltreatment, and inappropriate caretaker behavior are dynamic and interactive. For children who are able to provide information in a narrative format, we have the possibility of a much fuller description of their experiences. Without initially focusing on isolated incidents, we have the opportunity to hear a description that is much closer to the child's experience. This approach does not preclude our returning to target incidents to ask about specific details. The approach may help us understand more fully this child's dilemma and may suggest other areas of the child's life that should be explored and addressed.

For less verbal children, this inclusive description may not be possible, and it may be of benefit to question the child about other areas where there is concern. However, this multitopic approach may be difficult for young children, who often have trouble making use of direct questions about events that are not salient or connected to the moment. Young children also are unable to group individual incidents into a "type" of experience.

Do you see your interview protocol or guidelines as prosecution-focused or protection-focused? Do you see conflicts between these goals?

Our training format is equally useful for prosecution-focused and protection-focused questioning. A holistic approach to questioning can elicit the most complete information about the child's situation. For trainees who may be working in prosecution-driven arenas, we offer the suggestion of addressing prosecution concerns earlier in the conversation and moving to protection issues or more direct questioning as the interview progresses. This may serve to protect the forensic integrity of earlier statements, and yet not exclude the possibility of protection where prosecution does not seem to be an option.

As for the second question, standard practice varies greatly from community to community. Therefore, we believe that it is impossible to provide definitive answers to issues such as these. Decisions concerning the focus of interviewing must be made at the community level and be consistent with the community's intentions. Our goal is to present and support best practice, as we in the field know it, and to empower the individual interviewer to work with other professionals and institutions in their community to best serve children.

Do you teach structured protocol, semi-structured protocol, or flexible guidelines?

The NCAC Child Forensic Interview guidelines would best be described as flexible. Children differ remarkably in how they encode and retrieve memories of experienced events. These differences are the result of their developmental characteristics, inherent and developed cognitive abilities, the impact of family and culture on language as an expression of meaning and understanding, temperament, coping strategies, and experiences with unfamiliar adults. While this conversation or interview must be given a recognizable form and should be guided by forensic principles, a protocol that is highly structured cannot be responsive to the traits of the individual child.

Our training approach is to present an outline of the structure with the rationale and intended goals for each stage of the interview. We follow with suggestions and a discussion of various ways that the stage might proceed. The option to omit or return to any stage for a particular child is offered. For example, preschool children may not be able to make use of the guidelines for the interview and so this stage may be omitted.

Particularly with children who are making a tentative disclosure or are denying any knowledge of why they are being interviewed, a

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variety of approaches may be appropriate. A strict directive to use a particular technique at any critical juncture of the interview disregards the interviewer's understanding of the child's emotional and cognitive needs. Communicative competency (which considers both the competence of the child and the interviewer to engage in this conversation) calls for a wide range of skills, interest in and knowledge of children, and awareness of the cultural, community, and family context of the children one is interviewing.

How do you build rapport? How do you initiate the questions to move to the topic of concern or the abuse allegation?

In their hurry to get to the "real" conversation, interviewers often hurry past rapport building with a few peremptory questions. We see rapport building and developmental screening as an essential, integrated process. Rapport building may be strictly conversational or may incorporate the use of materials such as markers and paper for drawing, Play-doh, simple puzzles, or other activities to engage and relax the child. One can only build rapport in a manner that fits the child. Consequently, the building of rapport can be a difficult skill to teach, as it should engage the interviewer in an active and a receptive way. The interviewer is encouraged to pay attention to the child's verbal and nonverbal responses and to engage the child in conversation in which he or she has interest and knowledge. This kind of conversation allows for the best assessment of the child's language and narrative abilities as well as the opportunity for the interviewer to encourage full description and explanation. We recommend a relaxed conversational style and the avoidance of techniques that appear to be "testing" skills and knowledge.

The introduction of guidelines for the interview can assist latency age and adolescent children in understanding that this is a specific kind of conversation, but this will only be effective if the guidelines govern the interaction from its beginning. Different questioning styles may be used during this phase, which can be instructive in selecting questioning strategies for more difficult portions of the interview. We have found that this approach provides children with the opportunity to develop confidence and some degree of comfort with the interview process. For younger, shyer, more anxious, and less flexible children, this stage may need to be extended.

Children who know why they are being interviewed may initiate the topic of concern at the point where they feel comfortable. If this does not happen, transitional questions, such as "Who told you that you were coming here today? What did they tell you about coming here? What are you here to talk about?" can be used to invite the child to move into the allegation-specific portion of the interview.

A strength of our model is that the trainee or interviewer is offered different options for proceeding, based on the child's response to transition questions. Children's responses may indicate that they are in active disclosure, in tentative disclosure, or in denial of any problem. Each type of response is discussed separately, and we instruct our trainees on effective strategies for each kind of response.

Does your protocol vary according to the developmental level of the child being interviewed? Rationale?

The structure of the protocol remains basically the same with all developmental levels, with the exception that some stages may be eliminated for preschoolers (e.g., guidelines, competency assessment more open-ended approaches to abuse-specific topics, use of toolswhere representational skills are not developed). Each stage can be developed differently in response to the child's developmental level, interest, personality, cultural group, or mental health characteristics. Interviewers are encouraged to gather information beforehand, which can serve to instruct their thinking about the best approaches for each child. That vision, of course, may change in response to a child's behavior, demeanor, or statements during the early stages of the interview.

As already discussed, we view the rapport-building/developmental-screening phase as an opportunity to place the child with regard to language, narrative ability, self-knowledge, expressive skills, and response to question styles. This knowledge should guide the interviewer in both questioning strategies and expectations of the child in the abuse-specific portion of the interview.

What do you teach about the use of interview aids? Rationale?

Children vary in their verbal ability, comfort level, and communication style. Although great emphasis is placed on verbal description and consistency for forensic purposes, some children struggle with providing verbal descriptions of complicated, embarrassing, and confusing acts. Interview aids can offer children the opportunity to demonstrate what they cannot explain. Further, aids may assist children in initiating verbal description or responding to questions.

We teach trainees how to use a number of interview aids, such as drawings, anatomical drawings, anatomical dolls, and touch inquiries. None of those interview aids are indicated as a standard part of the interview, but rather are to be used to assist certain children in providing verbal disclosures or in the clarification of a disclosure. The child's performance and preferences during rapport building guide the interviewer in determining what, if any, aids may be helpful or risky with this child.

To facilitate or clarify the verbal disclosures of less verbal or reticent children, we provide trainees with a simplified structure for using anatomical dolls. Additionally, we supply them with a number of articles, a bibliography, and the recommendation that they pursue additional training, practice, and supervision in the use of dolls.

We offer trainees two models for the use of anatomical drawings: the introduction of drawings to facilitate, elaborate, or clarify a disclosure that is already in progress, and the introduction of anatomical drawings as part of anatomy identification and touch inquiry. However, we do not recommend that drawings be used in all interviews or in the same manner with all children. Again, additional reading material is provided.

We also introduce trainees to Dr. Sandra Hewitt's touch inquiry and refer them to her book, *Assessing Allegations of Sexual Abuse in Preschool Children: Understanding Small Voices* (1999, Sage), for further explanation and rationale.

What do you teach about questioning reticent (nondisclosing) children?

In considering children's responses to the demands of the interview, we have identified three groups: (1) children in active disclosure, (2) children who are making tentative disclosures, and (3) children

in denial. For each group we explore the dynamics and child characteristics that might impact the disclosure process. We provide a structure for questioning children who are able and willing to disclose (active disclosure group); this structure may be followed with less forthcoming children once a topic of concern has been brought forth.

Tentative or reticent children may be willing to admit that there is a problem, but then employ various tactics (i.e., distraction, forgetting, minimization, avoidance, empowerment) for a variety of reasons. We encourage interviewers to think strategically about the source of the blocks for the individual child. We then explore and practice strategies that may be used with these children.

The same process is repeated for children who are in denial, including the added consideration that a portion of these children may truly not have anything to tell. We repeat the process of exploring a variety of approaches. Even though we focus on each category separately, some strategies may be appropriate for both groups and some are more helpful with one or the other.

We introduce trainees to the "process of disclosure." We also encourage them to consider (with their communities) alternative responses to children who experience great difficulty with the traditional one-interview model, such as additional interview sessions, extended forensic evaluation, or therapy.

How are diversity issues integrated into your guidelines or protocol?

The flexibility of the interview structure encourages the interviewer to adapt each stage to the needs of the child. Those needs may be the result of developmental, linguistic, or cognitive issues, temperament and trauma characteristics of the child, as well as ethnic and cultural backgrounds. It is impossible to provide training in all of these specific considerations; however, it is crucial that we acknowledge the need for adaptations to fit the child.

Cultural and historical variables in the lives of children, families, and groups influence their behavior, language, and communication styles, as well as the meaning they make of life experiences. We raise these issues at all points of the training and provide some direction and suggestions for steps that trainees might take to sensitize themselves to the worldview of other groups.

We use a variety of examples. Addressing such variables by changing "surface structure" components (e.g., environment, appropriate forms, bilingual interviewers) may be the place where we all begin. But this still does not address "deep structure" aspects of this type of conversation for children and families from groups that may have suffered intergenerational trauma, cultural shame, and disenfranchised grief. We raise the questions; nevertheless, we do not yet have all of the answers. NCAC is actively engaged in developing training programs for interviewers who serve identified cultural and ethnic groups.

What do you teach about interviewing with the intent to obtain corroborative evidence, so that the child's interview need not stand alone?

It is crucial that interviewers (especially those who are not from a law enforcement background) be trained to interview children toward a goal of obtaining information that can be corroborated. Children bear an unfair burden when asked to carry the proof of the case with their statements alone. We encourage a multidisciplinary approach, which increases the possibility that this type of information will be gathered and noted.

When children are able to both provide narrative descriptions and respond to follow-up questions, we have the possibility to gain the greatest amount of detailed information. That is, we address the topic from the child's point of view, and we pursue the investigator's concerns. Further, we encourage documentation through videotaping, which creates the most complete record of the child's statement. Nonetheless, we recognize that such an option is not allowable in all communities. The question of corroboration is only partially addressed by developing good interviewing techniques; it is also greatly influenced by thorough and timely investigations.

Have you measured training or protocol outcomes, and if so, how? What have you found?

NCAC is actively developing a practical and scientifically valid method to measure training and protocol outcomes. The research consists of a quasi-experimental survey design and makes use of repeated measures. Specifically, we will collect information concerning trainees' knowledge and skill level as well as information concerning their practice context, prior to the training. We will then administer a knowledge and skills assessment survey immediately after the training, to determine the internalization of the content material.

We will also conduct two waves of follow-up surveys, at 6 and 12 months after the trainees' return to their community. In each wave, we will collect information concerning their retention of knowledge, application of skills and practices, and both the barriers and facilitators that they have experienced in applying the interview model. We will also inquire about any additional peer review, mentoring, or other professional support they have received since the initial training, as well as needs for further training for themselves or other professionals in their community.

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Patterns of Designating Special Needs in Maltreated Children by CPS Caseworkers: A Secondary Data Analysis of a Nationally Representative Data Set

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Introduction

The risk for maltreatment of children with special needs or disabilities has long been of concern to both health care and child protection professionals (Garbarino, Brookhouser, & Authier, 1987; Balderian, 1991; Ammerman, 1998; Goldson, 1998; Botash, 1999). A growing professional literature supports the clinical observation that children with disabilities are at increased risk for child maltreatment (Glaser & Bentovim, 1979; Diamond & Jaudes, 1983; White, Benedict, Wulff, & Kelley, 1987; Sullivan, Brookhouser, Scanlan, Knutson, & Schulte, 1991). In an effort to better understand the epidemiology of this problem, the U.S. Congress commissioned a nationwide study to examine the incidence of maltreatment among children with disabilities (USDHHS, 1993).

In response to the Congressional commission, the National Center on Child Abuse and Neglect (NCCAN) conducted a study using a nationally representative sample of caseworkers from 36 Child Protective Service (CPS) agencies that provided information regarding all reports of maltreatment investigated and substantiated during a 6-week period in the Spring of 1991. Results of the incidence study were published in *A Report on the Maltreatment of Children With Disabilities* (referred to as the disability/child maltreatment incidence study) (USDHHS, 1993). During the study period, 1,249 substantiated cases of maltreatment were identified, representing a total of 1,834 children.

Children With Disabilities at Higher Risk for Child Maltreatment

Approximately 14% of the children either had or were suspected of having one or more disabilities, according to the Americans With Disabilities Act (ADA) definition of *disability*. The study concluded that children with known or suspected disabling conditions were 1.67 times more likely to have substantiated reports of maltreatment than children without such conditions, using an estimate of 9% for the overall estimate of children in the general population meeting a similar definition of *disability* (USDHHS, 1993). Moreover, children meeting this definition of *disability* had a 2.09 times higher risk for physical abuse, a 1.75 times higher risk for sexual abuse, and a 1.60 times higher risk for physical neglect when compared with the general population of children.

Meeting Needs for Children With Disabilities

Over the past several decades, professionals in the child development field have called attention to two issues of central importance to the care of children with disabilities who may have been maltreated. The first issue deals with the need for early identification and early provision of services for children with disabilities or special needs, and the second deals with the prevalence of unmet needs among children who enter the CPS system.

Improved developmental outcomes are clearly associated with the earliest possible identification of the disability along with early and intensive provision of appropriate services (Shonkoff & Hauser-Cram, 1987; Martin, Ramey, & Ramey, 1990; Wasik, Ramey, Bryant,& Sparling, 1990; Ramey & Ramey, 1992; Campbell & Ramey, 1994). Comprehensive review of 38 studies examining the long-term effects of early childhood education programs found those programs to produce persistent effects on achievement and academic success that was sustained over years (Barnett, 1998).

Children who become involved in the child welfare or CPS system have a high prevalence of unmet medical, dental, developmental, and mental health/behavioral needs (Chernoff, Combs-Orme, Risley-Curtiss, & Heisler, 1994; Halfon, Mendonca, & Berkowitz, 1995; Klee, Krondstadt, & Zlotnick, 1997; Simms, 1989; Takayama, Wolfe, & Coulter, 1998). Depending on the study, anywhere from 44% to 92% of children entering foster care have at least one unmet health care need (Chernoff, et al., 1994). In addition to physical health issues, developmental delays appear to be common, and developmental delays may be identified in up to two-thirds of children entering foster care when appropriate assessment tools are used (Simms, 1989). These statistics did not markedly improve over the decade of the 1990s, and more recent studies still showed approximately 60% of children entering foster care with unmet medical problems and 57% with various developmental delays (Silver, et al., 1999a; Takayama, et al., 1998). A concerning number of children in CPS also had behavioral and mental health issues, ranging from 35% to 85%, depending on the study (Simms, 1989; Dubowitz, Zuravin, Starr, Feigelman, & Harrington, 1993; Halfon, Berkowitz, & Klee, 1992; Halfon, et al., 1995; Harman, Childs, & Kellehare, 2000). Identification of emotional and behavioral problems varied by the type of evaluation. Mental and behavioral health problems were identified in 37% of children evaluated by a multidisciplinary team of pediatric foster care specialists. In contrast, there was identification in 13.8% of children when evaluated by a routine community-based health care provider (Horowitz, Owens, & Simms, 2000).

The importance of high-quality screening and assessment services to ensure that children's needs are identified and subsequently met cannot be overstated when dealing with maltreatment concerns of children in foster care (Diamond, 1992; Halfon, et al., 1995; Silver, Haecker, & Forkey, 1999). Even with enhanced efforts at accurate identification, the challenges are substantial as Silver and colleagues (1999a) have demonstrated, showing that only half of the children in foster care who were identified as having a need go on to receive that health care-related service.

Study Questions

Understanding the relationship between a child's disability status and child maltreatment remains an essential first step to the effective development of prevention, evaluation, and treatment strategies (Elvik & Berkowitz, 1990; Valentine, 1990; Hudson & Giardino, 1996). To this end, the NCCAN disability/child maltreatment incidence study recommended that CPS caseworkers receive education about identifying disabilities, the relationship between maltreatment and disabilities, and making appropriate refer-

rals on behalf of children with disabilities (USDHHS, 1993). This secondary analysis seeks to shed further light on this important issue.

Given the fact that children with disabilities are at increased risk for maltreatment and the demonstrated benefit of early assessment and intervention services tailored to meet the needs of these children, this study sought to answer the following three questions using data from the disability/child maltreatment incidence study (USDHHS, 1993) provided by the National Data Archive on Child Abuse and Neglect (NDACAN).

Question 1: What are the primary sources that CPS caseworkers rely on to obtain information regarding a child's known or suspected disability?

Question 2: Does the information source have (a) sufficient contact with a child? (b) the professional knowledge to provide information regarding his or her condition? and, (c) Does the reliability of information used to make a disability designation vary by type of condition?

Question 3: To what extent do differences exist in caseworkers' assessment of the reliability of information sources for children with primary or secondary behavioral problems compared with children who do not have primary or secondary behavioral problems?

Methods

This paper discusses a secondary analysis focused on characteristics that describe the reliability that CPS workers ascribed to the information before them when working with the case and upon which they made a disability designation of the child involved. Data files on a nationally representative sample of children who were maltreated were obtained from NDACAN. The original disability categories and types of information sources were condensed into smaller more manageable clusters via a consensus process. Descriptive and inferential statistics were then generated.

Secondary Analysis Procedures

A secondary analysis is a reanalysis of an existing data set with the goal of performing new analyses to enhance information produced from the original study. For the purpose of this analysis, eighteen disability categories (some with relatively small numbers of children) were collapsed into seven clusters using a consensus process involving child development consultants:

Disability Clusters:

- Chronic health condition
- Developmental delay (DD)
- Learning disability (LD)
- Mental retardation (MR)
- Mixed behavioral problem (behavioral problem and at least one other known/suspected disability besides MR)
- Perinatal risk factors
- Primary behavioral problem

The original "information source" categories were consolidated into five clusters as well:

Information Source Clusters:

- CPS caseworkers
- Family/friends/other
- Health care providers
- School/day care
- Social services/mental health/police, probation (SS/MH/'PP)

A "behavioral risk" variable was created, given the number of primary and secondary behavioral problems listed in the original "disability" file and the well-recognized challenges of identifying and serving children with behavioral problems among children in the CPS system. Children at least 1 year of age with the following conditions were considered to have behavioral risks: mental retardation (MR) and at least one known/suspected behavior problem, a primary behavioral problem, or a mixed behavioral problem.

Analyses

The study used descriptive and inferential analyses to answer the three research questions. The Chi-square test was used for the inferential analysis because it was based on nominal and ordinal level data.

Approximately 91%, or 274, of the 300 children in the disability file had substantiated cases of maltreatment. These children represented a total of 255 cases, as maltreatment was substantiated for more than one child with a disability in a family in some instances. Disability-related information was available for 235, or 92.2%, of the 255 cases in the electronic file provided by NDACAN. Analyses conducted to answer the first two study questions included all 235 cases. For the third study question regarding the relationship between reliability of information sources for children at least 1 year of age with and without behavioral risks, 169 cases were included in the analysis.

Results

The proportion of cases in each disability cluster is as follows: 25.5% were in perinatal risks, 18.7% were in behavioral, 15.3% were in developmental (DD), 11.1% were in chronic health, 10.6% were in mixed behavioral, 9.8% were in mental retardation (MR), and 8.9% were in learning disability (LD). Cases with perinatal risks and chronic health conditions had the lowest median ages, 0.5 and 1.0 years, respectively. The median ages for the other disability clusters were 6.0 years for DD, 8.7 years for mixed behavioral, 10.0 years for MR, and 10.8 years for LD.

The sections that follow provide results of analyses designed to answer the three study questions.

Question 1: What are the primary sources that CPS caseworkers rely on to obtain information regarding a child's known or suspected disability?

In general, the primary sources CPS caseworkers used to gather disability-related information were as follows: health care providers (39.5%), school/day care providers (23.6%), family/friends/others (15.5%), social services/mental health/police, probation (SS/MH/PP) providers (15.0%), and self (6.4%). Table 1 provides a complete breakdown of information sources by disability cluster.

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Health providers represented the primary information source for cases with perinatal risks and chronic health conditions, 96.6% and 73.1%, respectively. In contrast, the primary sources for the MR and LD clusters were school/day care providers, 52.2% and 71.4%, respectively. The top three sources for the DD cluster were school/day care providers (27.8%), CPS caseworkers (25.0%), and health providers (22.2%). Primary sources for the behavioral cluster included family/friends/others (36.4%) followed by school/day care providers (29.5%). For the mixed behavioral cluster, the two primary information sources were SS/MH/PP (37.5%) and family/friends/others (29.2%).

Question 2: Does a primary information source have (a) sufficient contact with a child and (b) the professional knowledge to provide information regarding his or her condition? And, (c) Does the reliability of information used to make a disability designation vary by type of condition?

The original data set included an item regarding the CPS caseworker's perception of the extent to which the primary source used to make a disability designation had sufficient contact with a child to provide information regarding his or her physical, developmental, and/or mental health/behavioral condition. For all disability clusters combined, 87.7% of the caseworkers thought information sources had "sufficient contact." Sufficiency of contact ranged from 69.4% for the DD cluster to 100% for the LD cluster. In respect to "professional knowledge," 74.6% of the caseworkers believed information sources had the expertise to make a disability designation. Responses to this question ranged from 52.0% for the mixed behavioral cluster to 98.3% for the perinatal risk cluster. Table 2 lists ratings for "yes" responses regarding "sufficient contact" and "professional knowledge" by disability cluster.

In addition to responding to the item about sufficiency of contact with a child, CPS caseworkers also rated the reliability of disability-related information provided by primary sources. For the entire set of disability clusters, the caseworkers rated information sources either as "very reliable," 91.5%, or "somewhat reliable," 8.5%. As Table 3 illustrates, the percentages varied by disability cluster, with "very reliable" ranging from 76.0% for cases with mixed behavioral problems to 98.3% for cases with perinatal risks.

Question 3: To what extent do differences exist in CPS caseworkers' assessment of the reliability of information sources for children with primary or secondary behavioral problems compared with children who do not have primary or secondary behavioral problems?

A Chi-square analysis was conducted to examine the relationship between reliability of information sources used to make a disability determination for children who were at least 1 year of age with a primary or secondary behavioral problem and children in this age group who did not have a primary or secondary behavioral problem. A significant difference ($C2 = 6.918$, $p < .01$) emerged for these two groups. Although 82.2% of the information sources for children with primary or secondary behavioral problems were perceived as being "very reliable," 94.8% of the sources for children without these problems were rated "very reliable."

Discussion

This secondary analysis further describes CPS caseworkers' designation of disability and special needs among a nationally representative group of maltreated children previously described in 1993. The patterns in designating disability that emerge are important to consider by health care providers and CPS officials. Specifically, understanding what underlies caseworkers' designations of disability is a fundamental first step in determining if a problem exists. This information may also suggest what types of training for CPS caseworkers may be useful in the future. Additionally, one could argue that the types of disabilities that are more readily identified, and those considered more reliably identified when compared with other types, may ultimately influence what is designated as a disability. Further, such identification may also determine what set of services is necessary to serve a given population of children and families. The sets of services and programs that CPS agencies feel a need to prioritize and support may be materially impacted by the perceived need for such services, based on how prevalent various disabilities are thought to be within a given group of children.

It appears that the more obvious physical disabilities and special needs included in the DD and perinatal risk factors categories, which could be potentially easy to identify by caseworkers on their own, are ascribed more reliability than the less obvious cognitive and behavioral health-related disabilities, such as LD, MR, and primary behavioral and mixed behavioral problem categories. Health care professional sources most frequently provide the information upon which the chronic disease and perinatal risk factors disability cluster designation is made, whereas in the primary behavioral problem category, a high number of family and friends provide the caseworker with information used for the designation. Not surprisingly then, the information sources for primary behavioral and mixed behavioral problems are seen as less reliable when compared with other categories. This category has the lowest rated information sources in terms of the caseworker's perception of professional knowledge and opportunity to assess the actual child in question. The children with behavioral disabilities may be at a particular disadvantage as far as identification and access to services, owing to these patterns of perceived reliability and competence on the part of the information sources used to identify them. Additional research will need to be conducted to confirm this, however.

The identification of developmental and mental health/behavioral problems in the foster care population is generally not an easy task and, in fact, is a complex endeavor. Relatively recent program evaluations have demonstrated that the types of screening tools used materially affect the identification of a developmental disability, as do the skill and awareness levels of the evaluator (Horwitz, Owens, & Simms, 2000; Blatt, et al., 1997). Therefore, the idea that CPS case workers may designate a disability on the basis of a heterogeneous collection of information drawn from a variety of sources is of great concern. This argues for increased professional screening and evaluation to ferret out the existence of physical as well as developmental and behavioral problems and to ensure that attention is paid to the need for services in all these areas. Accurate identification of the true prevalence of the child's unmet needs would then contribute substantively to the planning of necessary services. The most sensitive evaluation would require CPS to obtain a complete medical, developmental, and mental health assessment at the time of entry into the system (Silver, 1999). Such timely and professionally competent evaluations would have the highest likelihood of identifying the child's needs early on and would promote the early provision of necessary services.

With regard to behavioral health problems, mental health/behavioral services for children have historically been difficult to find (Steinberg, Gadomski, & Wilson, 1999). If one recognizes that CPS

workers may not receive what they see as reliable information from which to identify behaviorally related disabilities, as compared with medically oriented conditions, then the formulation and delivery of behavioral and developmentally oriented services may be even less likely to occur.

Limitations

A study such as this, based on secondary data analysis, has a number of limitations. Despite the nationally representative sample, it relies on data collected by others for purposes of the original study. The investigators may only analyze what has already been collected and must of necessity work with the data that are available. There is no opportunity for the researchers to go back and collect additional information from the original study participants. This is a well-recognized shortcoming of many secondary analyses (Moriarty, Deatrick, Mahon, Feetham, Carroll, Shepard, & Orsi 1999; Shepard, Carroll, Mahon, Moriarty, Feetham, Deatrick, & Orsi, 1999; Huston & Naylor, 2000). The assessment and designation of a disability in the children were made by caseworkers who may not have had sufficient training, which calls into question the accuracy of the data. Additionally, many of the children had suspected disabilities, not verified conditions. However, previously cited literature supports the high prevalence of similar problems in the children who come into the CPS system. Finally, disabilities related to perinatal risk factors may be overrepresented in this data set, which could skew the results as well.

Summary

In conclusion, CPS workers face many challenges as they work to serve children who are maltreated (Dubowitz & Depanfilis, 2000). These challenges are magnified when the child who has been maltreated also has special needs (Hudson & Giardino, 1996). This analysis demonstrates that for some disability types, the information used by CPS workers is viewed as very reliable by them and allows for a confident designation of a child as having a special need. However, for other types of special needs, the often less obvious behaviorally oriented type, the designation is seen as less reliable and is made relying on information that is perceived as more suspect. The disparity among disability types needs further exploration to determine if the ambiguity surrounding disability designation actually affects identification and referral for appropriate services in a timely manner. A prospective study that uses medical, child development, and mental health professionals performing complete evaluations on children immediately upon entry into the CPS system would be best able to provide a definitive response to these concerns.

Table 1. Information Source by Disability Cluster (n = 233)

Disability Cluster	"SS/MH/PP"	"School"	"Health"	"Family"	"Worker"
MR	21.7%	52.2%	4.3%	13.0%	8.7%
DD	13.9	27.8	22.2	11.1	25.0
Chronic health	-	3.8	73.1	19.2	3.8
LD	19.0	71.4	4.8	4.8	-
Behavioral	22.7	29.5	9.1	36.4	2.3
Mixed behavioral	37.5	16.7	8.3	29.2	8.3
Perinatal risks	3.4	-	96.6	-	-

Table 2. Sufficiency of Contact and Professional Knowledge by Disability Cluster

Disability Cluster	Had Sufficient Contact	Had Professional Knowledge
MR	91.3%	69.6%
DD	69.4	61.1
Chronic health	84.6	73.1
LD	100.0	85.7
Behavioral	93.2	63.6
Mixed behavioral	80.0	52.0
Perinatal risks	93.3	93.3

Table 3. Reliability of Information Source by Disability Cluster (n = 235)

Disability Cluster	Very Reliable	Somewhat Reliable
MR	95.7%	4.3%
DD	97.2	2.8
Chronic health	92.3	7.7
LD	90.5	9.5
Behavioral	84.1	15.9
Mixed behavioral	76.0	24.0
Perinatal risks	98.3	1.7

NDACAN Database Description

NDACAN maintains electronic data files from the disability/child maltreatment incidence study, which are available to researchers interested in conducting secondary data analyses. Of the five files, one contains case-level information on all study cases (n = 1,249), a second has information regarding children with known or suspected disabilities (n = 300), and a third file contains information regarding adults suspected of having substance abuse problems (n = 635). The fourth file contains information regarding all children in a family in which at least one child had a substantiated incident of abuse or neglect (n = 2,662). The fifth file contains case information regarding all adults involved in substantiated cases (n = 2,305).

This analysis used two national study files: the first contains disability-related information and the other contains child-related information. The file on children with known or suspected disabilities includes variables such as disability/condition categories, sources used to obtain information regarding disabilities/conditions, and caseworker assessment of information source reliability. The child-based file includes demographic data and information regarding relationships among children and adults involved in a case as well as timing and type of maltreatment.

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2) The study was presented in part at Pediatric Academic Societies/ American Academy of Pediatrics Joint Meeting, Boston, Massachusetts, May 2000; and, Society for Research in Child Development, Albuquerque, New Mexico, April 1999.

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Resources Sidebar

In 2001, the American Association of University Women (AAUW) education foundation published the results and recommendations of a report, based on a Harris Interactive survey, conducted with 2,064 public school students in eighth through eleventh grade. The report, *Hostile Hallways: Bullying, Teasing, and Sexual Harassment in School*, can be ordered by calling 207-728-7602 or at www.aauw.org.

As another outcome of the study, the AAUW prepared (2002) a guide, "Harassment-Free Hallways: How to Stop Sexual Harassment in Schools," for students, parents, and educators (www.aauw.org/ef/harass).

The Center for Sex Offender Management has many articles available online, including "Understanding Juvenile Sexual Offending Behavior: Emerging Research, Treatment Approaches, and Management Practices" (www.csom.org, Dec 1999).

Last summer, the Nevada Coalition Against Sexual Violence published some of its findings in an article, titled "Educator Sexual Abuse Statistics." (www.ncasv.org/educator_sexual_statistics.htm). S.E.S.A.M.E. (see following) Board President Terri Miller gathered the information.

The S.E.S.A.M.E. (Survivors of Educator Sexual Abuse and Misconduct Emerge) web site provides survivor stories and links. S.E.S.A.M.E. believes "the power imbalance between a teacher and student (of any age) creates a climate that can facilitate sexual exploitation behavior by the teacher, behavior that is psychologically equivalent to incest" (www.ncweb.com/org/rapecrisis/sesamehome.html, downloaded Sept 2002).

What Teachers Can Do to Prevent Sexual Abuse in Schools

Pegi Taylor, free-lance writer

*[Because this article by Pegi Taylor (*APSAC Advisor, *Summer 2003) contained printing errors that rendered portions of it illegible, we are reprinting the entire article in this issue. - Erna Olafson, Editor-in-Chief]*

Is there anything that makes a teacher's skin crawl more than reading in the paper or seeing on TV a story about a school employee committing a sex crime against a student? Yet, this is only one of the four types of sexual misconduct that occurs in schools. The other three happen when students sexually abuse other students, students sexually assault staff, and staff sexually assaults other school personnel. This article focuses on contact that includes minors, so it will not address the category of sex crimes against coworkers within schools.

Teachers can do a great deal to prevent sexual abuse of students. But first, just what does the term sexual abuse encompass? For the purposes of this article, sexual abuse does not include verbal sexual harassment. STOP IT NOW! (a national organization dedicated to ending the sexual abuse of children) uses a definition of sexual abuse that includes both contact behaviors, such as touching a child's genitals or forcing a child to touch a teacher's genitals, and noncontact behaviors, such as exhibitionism or watching a child undress.

Robert J. Shoop, a professor of education law at Kansas State University, has testified in over thirty court cases involving sexual abuse or harassment in schools. Every week he gets calls from school districts about everything from a teacher having sex with a student in a classroom in front of 30 pupils to multiple teachers having sex with the same student.

Shoop understands how distressing it is for teachers to consider such situations. "There is this thinking that everyone knows a teacher shouldn't have sex with a student," he said during a recent phone interview (October 2002). "It's embarrassing and demeaning to talk about it." Shoop urges teachers to get beyond their discomfort because, as far as he can determine, 5% to 10% of students will be sexually abused by a staff person between kindergarten and twelfth grade. He believes this is a conservative figure due to underreporting when older teenagers are involved.

Some simple rules Shoop advocates can go a long way to protect both students and teachers:
—"Teachers shouldn't meet students outside of school. If you choose to be in an unsupervised relationship with a student, you are doing so at your own peril.
— "No room should be without visible access from the outside. Don't cover the windows with artwork.
—"Don't transport students in your own vehicle." Like all rules, this one has exceptions. "If I were driving home in a sleet storm and saw a 15-year-old student without a coat, I would take her home," says Shoop. "But I would immediately call my principal and let him or her know what I had done."

Teachers can work with administrators to make sure schools do not become sexualized environments. A sexually charged climate can start without a teacher having any intent to harm a student. For example, a student might confide in a favorite teacher and talk about having sexual struggles. This teacher, rather than refer the student to the school nurse or counselor, might get drawn into a discussion and relate stories about his or her own sexual behavior. There are two dangers to this sort of conversation. The student might misinterpret the teacher's motives, and teachers who sexually abuse students use these sorts of situations to initiate contact.

Sexual misconduct often starts with the teacher talking about sex or brushing up against a student's genitals. "If students don't understand that this is inappropriate behavior they should report," says Shoop, "then how can the school expect students to come forward after a serious incident has happened?" By this point, students will often feel responsible and guilty for their own compliance and may be infatuated with the perpetrator.

Teachers can ask school districts to identify a specific staff person to handle complaints about sexual abuse and harassment. Shoop suggests that if a school has a counselor or social worker, this is the best person for the job. All teachers can keep an eye on the staff.

STOP IT NOW!'s web site lists a number of warning signs that might indicate improper conduct. Teachers should report staff, including administrators, librarians, bus drivers, or custodians, who spend time alone with a student, buy gifts for a particular student, or repeatedly talk about a student's developing body. Teachers who coach extracurricular sports, music, and drama have the opportunity to get particularly close to students. A study conducted by *Education Week* reported that in 244 nationwide active cases (from Mar-Aug 1998), in which staff sexually abused students, at least one-third of the teachers were leaders of extracurricular activities. Instructors can ask for more oversight of after school teacher-student interactions.[1]

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To have school personnel monitoring each other is risky, however. No one wants to create a "Big Brother Is Watching" atmosphere. "You have a double-edged sword," Shoop adds. "By heightening people's awareness, you can make people believe every teacher is a bad person, and that clearly is wrong. But by pretending it doesn't happen, you create conditions that allow it to keep happening."

Another risk of vigilance is teachers staying at arm's length from students. Nan Stein, a senior research assistant at the Center for Research on Women at Wellesley College, said in an interview for the *Harvard Education Letter*: "I'm in favor of teachers being able to have appropriate physical contact with kids." She has extensively studied and written about sexual contact in schools and believes touch is especially important in elementary school. "I only have two rules about touch," says Stein. "Don't put any kid on your lap, and don't give neck rubs and back massages." Rather than having young students sit on their laps, teachers can have affectionate boys and girls sit beside them.[2]

As instructors and supervisors, teachers can also do a huge amount to prevent students from sexually abusing other students. Most people are unaware of the extent of sex crimes perpetrated by children. The Center for Sex Offender Management published an article (Dec 1999) that estimated the following: "Juveniles account for up to one-fifth of all rapes and almost one-half of all cases of child molestation committed each year." Some of these crimes happen at school.[3]

David Prescott has assessed and treated adolescents with sexual behavior problems in Vermont for 15 years. In a phone interview (Sep 2002), he suggested that teachers can play a significant role in teaching students to plan and manage their behavior and thus help reduce sexual abuse by juveniles—both inside and outside of school.

First, teachers can address students' "callous sexual attitudes." For example, Prescott says male athletes may express sexual entitlement and assume, "I'm a basketball player, and if I want to have sex with a girl she should be willing and grateful." Second, instructors can help curb impulsivity, another common feature of youths who commit sexual offenses. Such students tend to be poor problem solvers and don't understand that actions have consequences. Third, and likely most important, teachers can help students develop positive self-esteem. Juveniles who don't feel adequate can become emotionally detached to the point that they will say, "What do you mean I sexually abused her? She was drunk at a party and was unconscious, so I had sex with her. What's the big deal?"

Sex education is another vehicle that can help prevent juveniles, both male and female, from becoming sexual abusers. "Kids need an owner's manual to their own bodies," says Prescott. Gail Ryan, director of the Perpetration Prevention Program at the Kempe Children's Center in Denver, Colorado, agrees wholeheartedly. In a SIECUS (Sexuality Information and Education Council of the United States) report (Vol. 29/1, 2000), "Perpetration Prevention: The Forgotten Frontier in Sexuality Education and Research," she argues, "The child's risk of sexually abusing other children has been largely ignored in sexuality education and sexual abuse prevention programs." She believes "children need to be given permission to talk about sexuality and to learn to define all types of abusive behaviors." Teachers and conservative parents might agree on sex education programming if they knew it deterred sexual abuse.

The most complicated and least discussed type of sexual abuse in schools is the situation of students assaulting teachers. In Milwaukee, Melissa Bittner, convicted in 2002 of having sexual contact with a 16-year-old student at a private high school, claimed the student had assaulted her. Bittner, a first-year teacher who had attended college in Ohio, insisted she received no training about sexual abuse issues during college or when she started teaching.[4]

She might have had more of a chance to support her claim if she had worked in a public school. In a July 2002 interview, Sam Carmen, executive director of the Milwaukee Teachers Education Association, detailed what would have happened if Bittner had taught in a Milwaukee Public School. After the youth accused Bittner, the principal would have notified the Milwaukee Public Schools Central Administration. The central administration would have called the MTEA, generally within an hour or so, and the MTEA would have immediately sent a lawyer to meet with Bittner to clarify the facts in the case and make sure Bittner's rights were protected. MPS would have removed Bittner from the school during an investigation. When the district attorney charged her with committing a crime, the MTEA's role would have ended.

Perhaps the first step for teachers to take is to demand training. As *Education Week* recommended, "Districts should consider training for educators in how to respond when sexual abuse is suspected, disclosed, witnessed, or actually experienced."[5]

Resources Sidebar

A three-part series with twelve articles about child sexual abuse by school employees appeared in *Education Week* in December 1998. (To access other recent *Education Week* articles related to sexual abuse in schools, search "sexual abuse" in the archive at: www.edweek.org. The series is available at www.edweek.org/sreports/abuse98.htm.)

Robert J. Shoop, a professor of education law at Kansas State University, has a forthcoming book, S*exual Abuse in Schools* (Corwin Press, 2004). He has written other books and numerous articles and has developed a number of videos. Two sources that teachers might find most pertinent are *Preventing Sexual Harassment in the High School* (Shoop and Debra Edwards, 1995, Sunburst Publications, Pleasantville, NY) and *Sexual Harassment: It's Hurting People* (Shoop and Edwards, 1994, National Middle School Association, Columbus, OH).

STOP IT NOW!, a national organization dedicated to ending the sexual abuse of children, has a web page on "Warning Signs About Child Sexual Abuse" (www.stopitnow.org/warnings.html).

Notes:

1. www.edweek.org/ew/vol-18/14abuse.h18, in Caroline Hendrie, "Sex With Students: When Employees Cross the Line"

2. www.edletter.org/past/issues/2000-jf/stein.shtml, *Research Online*, Jan-Feb 2000, p. 2

3. www.csom.org/pubs/juvbrf10.pdf, in John Hunter et al., "Understanding Juvenile Sexual Offending Behavior"

4. www.milwaukeemagazine.com/112002/darkness.html; Pegi Taylor with Stanley Mallach, "The Other Side of Darkness," *Milwaukee Magazine*, Nov 2002, pp. 58-63

5. www.edweek.org/ew/vol-18/16syst.h18, in Caroline Hendrie, "'Zero Tolerance' of Sex Abuse Proves Elusive," Dec 16, 1998.

11th Annual APSAC Colloquium

Over 600 child abuse professionals attended the 11th Annual APSAC Colloquium in Orlando, Florida, on July 23–26, 2003. The attendees represented a variety of professions, including medicine, law, social work, mental health, administration, advocacy, and law enforcement. Over the course of the 4-day conference, attendees had the opportunity to participate in workshops provided by over 175 experts in the field.

Wednesday, July 23, was an all-day advanced training focusing on cultural issues. Approximately 150 persons attended this unique event. The day started with a panel, titled "Sexual Abuse in the Catholic Church: What It Means to Us." This was followed by three sets of 1-hour workshops that focused on a variety of topics, including working with Hispanic, African American, Muslim, and Vietnamese families.

In addition, the Department of Children and Families Professional Development Center for the state of Florida sponsored two all-day special institutes focusing on child welfare issues. The topics for the institutes included "Decision Making and Critical Thinking in Child Assessments" and "Mental Health Issues in Child Protection."

On Thursday, the official opening of the Colloquium, Carole Jenny, MD, delivered the keynote address, titled "New Medical Developments in the Diagnosis and Treatment of Child Abuse." Dr. Jenny gave a fascinating account of recent progress in the field of medicine, including up-to-the-minute advances in the area of shaken baby and head trauma. Nine sets of 1-hour to 6-hour workshops were provided over the course of the rest of the conference. There were 14 workshops during each time slot with focused tracks offered on advocacy, interdisciplinary concerns, law, law enforcement, research, mental health, medicine and nursing, prevention, cultural diversity, and child protective services.

The opening reception/silent auction was an opportunity for fun and networking. There was intense bidding on some exceptional items donated to the auction, including honorariums for several nationally recognized speakers as well as hotel rooms at the Renaissance Hotel (location of the 2004 Colloquium) in Hollywood, California. A special note of thanks to Bente' Hess and her coworkers at the Southwest Mississippi Child Advocacy Center for their organization of the silent auction. As at the New Orleans Colloquium last year, this event was both enjoyable and successful due to their hard work, and we look forward to working with them again next year. Who knows what they will come up with for the Hollywood Colloquium–-maybe tickets to the Academy Awards, dinner with a movie star, an old Oscar–—after all, it will take place in the heart of Hollywood!

Overall, the 11th Annual APSAC Colloquium was a definite success, which was confirmed by the positive evaluations from attendees. We are now planning the same high quality training at the 12th Annual Colloquium, scheduled for August 4–7, 2004, in Hollywood, California, at the beautiful, new Renaissance Hotel. To obtain information about the 2004 Colloquium, please contact Tricia Williams, JD, at 405-271-8202.

SAVE THESE DATES!!!!

APSAC'S 12TH ANNUAL NATIONAL COLLOQUIUM
AUGUST 4–7, 2004
RENAISSANCE HOTEL HOLLYWOOD, CA!

Join your colleagues and bring your family to glamorous, exciting Hollywood for the most energizing professional training of your career!

Explore a star-studded setting, located directly off Hollywood Boulevard and the Hollywood walk of fame, in the shopping-dining complex with the Kodak Theater, and minutes away from the Pantages theater, Griffith Park, the famous Hollywood Bowl, and Universal Studios as well as many other Hollywood attractions.

Enjoy convenient shuttles from nearby Burbank airport or slightly more distant Los Angeles International Airport, inexpensive and fast subway service from Los Angeles Union Station for those arriving by train, and underground parking for those who drive.

11th Annual APSAC Membership Luncheon and Awards Presentation

Dr. Jon Conte, President of APSAC, served as the Master of Ceremonies for this eleventh annual event. The purpose of the luncheon is to provide an annual meeting for APSAC members and to recognize and celebrate the hard work and dedication of various professionals in the field of child abuse and neglect. The following recipients were recognized during the awards ceremony:

Outstanding Professional Award

This award recognizes a member who has made outstanding contributions to the field of child maltreatment and to the advancement of APSAC's goals.

Martin Finkel, MD (Center for Children's Support, School of Osteopathic Medicine, University of Medicine and Dentistry of New Jersey)

Outstanding Service Award

This award recognizes a member who has made substantial contributions to APSAC through leadership and service to the Society.

Nancy Lamb, JD (District Attorney's Office; Elizabeth City, NC)

Research Career Achievement Award

This award recognizes an APSAC member who has made repeated, significant, and outstanding contributions to research on child maltreatment over his or her career.

Karen Saywitz, PhD (Department of Child and Adolescent Psychiatry, UCLA Medical Center)

Outstanding Advancement of Cultural Competency in Child Maltreatment Prevention and Intervention

This new award recognizes an individual or agency that has made outstanding contributions to the advancement of cultural competency in child maltreatment prevention and intervention.

Children's Advocacy Center of SW Florida, Inc.

Outstanding Front-Line Professional Award

Recognizing a front-line professional (e.g., child protection worker, law enforcement personnel, mental health counselor, or medical professional) who demonstrates extraordinary dedication and skill in his or her direct care efforts on behalf of children and families.

Alice J. Lindner, RN, BSN (Scott and White Memorial Hospital and Clinic; Temple, TX)

Outstanding Doctoral Dissertation

This award recognizes the doctoral dissertation completed within the last calendar year that made the most outstanding contribution to research on child maltreatment.

Karen Stubenbort, PhD (Family Resources, University of Pittsburg)

Outstanding Media Coverage

This award recognizes a reporter or team of reporters in print or electronic media whose coverage of child maltreatment issues in the previous calendar year shows exceptional knowledge, insight, and sensitivity.

Karen Grau and Bill Hussing (Calamari Productions, MSNBC Special – "In a Child's Best Interest"; April 12, 2002)

Outstanding Research Article Award

This award recognizes the author(s) of a research article or book published during the calendar year 2002 judged to be the most significant contribution to the field of child maltreatment during that year.

"Adjustment Following Sexual Abuse Discovery: The Role of Shame and Attributional Style," *Developmental Psychology*, *38*, 79-92 (2002).
Candice Feiring, Lynn Taska, and Michael Lewis

Outstanding *Child Maltreatment* Article of 2002 Award

This award recognizes the most important article published in the APSAC journal during the prior calendar year, as judged by the Editorial Board of the journal.

"Trying to Understand Why Horrible Things Happen: Attribution, Shame, and Symptom Development Following Sexual Abuse," *Child Maltreatment*, *7*(1) (February 2002).
Candice Feiring, Lynn Taska, and Keven Chen

2nd Annual Past-President's State Chapter Challenge

To recognize state participation at our annual colloquium, the Past Presidents of APSAC created an award to recognize the state chapters for the following accomplishments: state with the highest percentage of people attending compared with the number of members in the chapter; the state with the largest overall attendance; and the state that had the highest number of new APSAC members. The monetary feature of this award is comprised solely from the generous donations of APSAC's past presidents.

Florida State Chapter (winning all three categories)

2001 President's Honor Roll

This honor acknowledges APSAC members whose exceptional support and contributions have gone far beyond the call of duty.

Bette Bottoms, PhD – Chicago, IL
Susan Esquilin, PhD – Monclair, NJ
Christine Baker, PhD – West Orange, NJ
Melissa Runyen, PhD
Anita Sampson – Ann Arbor, MI
Robert Sanoshy – Ann Arbor, MI
Wanda Sanchez-Morales – Puerto Rico
Martiza Rivera-Valcarcel – Puerto Rico
Yanira Carmona – Puerto Rico
Mary Elizabeth Briscoe – Hyannis, MA
Diane Moore – Santa Fe, NM
Michael Nover, PhD – Freehold, NJ
Marsha Heiman, PhD – Metuchen, NJ
Julie Lippman, PsyD – Stratford, NJ
Janell Clarke – Ann Arbor, MI
Jennifer Overton – Ann Arbor, MI
Sarah Visger – Ann Arbor, MI
Elizabeth Laraciente-Camacho– Puerto Rico
Roshcen Underwood-Toro – Puerto Rico
Jordan Abbott, MEd – Springfield, MA
Diane Cooper – Hyannis, MA

Hooray for Hollywood!!!

Entertainment Weekly called it "Magnificent." *Los Angeles Times Magazine* proclaimed, "Every inch now sparkles."

The Pantages Theater, recently restored to its art deco grandeur, has firmly established its position as the premier theatrical venue in Southern California. The home of blockbusters such as *The Lion King* and *The Producers*, the Pantages provides visitors not only the finest Broadway shows available, but also the most luxurious and opulent surroundings imaginable in easy walking distance of the Hollywood Renaissance Hotel, the site of the 2004 APSAC Colloquium.

During the 2004 Colloquium in August 2004, the Pantages will be presenting *Hairspray*, Broadway's big musical comedy hit. The winner of 8 Tony Awards, including Best Musical, *Hairspray* is piled bouffant-high with laughter and romance, and enough deliriously tuneful new songs to fill a nonstop platter party.

Ticket information will be included in the Spring 2004 issue of the *Advisor*. Plan now to attend the 2004 APSAC Colloquium in Hollywood, California. And plan to see *Hairspray* at the beautiful Pantages Theater on a free evening or on Saturday afternoon.

In Memorium
Robert H. Kirschner, MD

Bob Kirschner was internationally recognized, respected, and honored. But his greatest accolade will be the memories he leaves with professionals and families the world over. Some of the memories involve intensely serious and tragic situations he explored and about which he exposed truths that are horrific and bizarre. Other memories focus on his lightheartedness, including my memory of a snowball fight with Bob at a Helfer Society meeting in Utah where we were surprised by an early snowfall. His premature death at age 61, from complications of cancer, leaves a void that is not easily filled. Dr. Kirschner died on September 15, 2002. As we reflect on his life during the one-year anniversary of his death, we are reminded that "there is no pain so great as the memory of joy in present grief." Bob would ask us to have memories of joy.

Bob was of a member of the International Advisory Board of the National Center on Shaken Baby Syndrome and a member of the Board of Directors of APSAC. He was a member of, and has been honored by, the Ray Helfer Society. His expertise extended far beyond child abuse to include forensic pathology, human rights, police brutality, and torture situations. Undoubtedly one of the world's most expert pathologists in the field of child abuse, Bob shared his wisdom with dignity and his opinions with passion. He was a founder of the child death and serious injury review team for Cook County and worked for many years with the Cook County Medical Examiner's Office.

As physicians across the country, and the world, become increasingly specialized in the field of child abuse, all have read Bob's scholarly works, and many have been fortunate to know him personally. He impressed many of us by always, always having time to answer individual questions in spite of a hectic, full schedule. As expressed by Alex Levin, MD, "Bob was there with compassion, scientific inquiry, and enthusiastic support."

Bob leaves a legacy of professionals taught by him to question, explore, research, compare, discuss, and always insist on the best science. To his wife, Barbara Kirschner, MD, and to other surviving family members, we would say that Bob touched many corners of the world. His work will continue to inform and inspire for generations to come.

Robert W. Block, MD
September 12, 2003

Robert W. Block, MD, FAAP
Professor and Daniel C. Plunket Chair, Pediatrics
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robert-block@ouhsc.edu
FAX: 918-660-3410 or Phone: 918-660-3400

CALL FOR NOMINATIONS
EDITOR-IN-CHIEF OF *CHILD MALTREATMENT*

Child Maltreatment: The Journal of the American Professional Society on the Abuse of Children is seeking nominations for editor-in-chief (EIC) of the journal, beginning in early to mid-2004. The EIC serves a 5-year term and may serve up to two consecutive terms. The EIC is responsible for all decisions involving the review process and content of the journal, including selecting reviewers, working with authors, making final decisions about publication, planning and approving the content of special issues and focus sections, and selecting commentaries and letters to the editor for publication. The EIC chairs biannual Editorial Board meetings and reports to the APSAC Board of Directors and the APSAC Publications Committee about the journal. The EIC also is responsible for appointing Editorial Board members, setting the overall direction of the journal, coordinating manuscript flow, and working with the journal's publisher, Sage Publications, to ensure that the journal's mission is accomplished.

Nominees must be members in good standing of APSAC. The EIC must be intimately familiar with the field of child abuse and neglect and its related scientific, professional and policy literatures. Expertise in scientific research methods, cultural diversity, and public policy and practice issues is important. It is critical that the EIC is committed to scientific rigor and appreciates the multidisciplinary and multicultural facets of child abuse and neglect. Financial support for operating a small editorial office at the EIC's institution is included with the position. The exact terms of this arrangement are negotiated among the EIC, the EIC's parent institution, and APSAC.

Nominations should include a vita and a cover letter describing the following:

1. The nominee's vision for the journal and a description of how the nominee would lead the journal to attain that vision.
2. The nominee's membership status in APSAC and history of work within the organization.
3. A description of the applicant's career accomplishments to date in research, practice, and public policy related to child maltreatment.
4. If the nominee is housed at an institution, university, or agency, a letter from the nominee's division head (e.g., department chair or agency director) documenting institutional support for the nominee's application to serve as EIC. This should indicate an understanding of the time and resource needs involved in serving as EIC and a commitment to support the nominee's needs in these areas.
5. Up to three letters of support may be included, but are not required.

Questions about the EIC position should be directed to the current EIC, Mark Chaffin, at 405-271-8858 or e-mail: mark-chaffin@ouhsc.edu.

Nominations must be received by December 15, 2003.

Please send the nomination packet by either regular mail or e-mail to **Terry Hendrix, Search Committee Chair**
c/o Tricia Williams, Operations Manager, APSAC
OUHSC Center on Child Abuse and Neglect
P. O. Box 26901; CHO 3406
Oklahoma City, OK 73092
e-mail: tricia-williams@ouhsc.edu
405-271-8858, fax 405-271-2931

National Survey of Child and Adolescent Well-Being

Special Research Meeting June 2-6, 2004, Cornell University, Ithaca, NY

The National Data Archive on Child Abuse and Neglect at Cornell University is sponsoring a Special Research Meeting for users of data from the National Survey of Child and Adolescent Well-Being (NSCAW). Applicants will be selected based on the quality of their research plan and demonstrated experience using the NSCAW data (available from the Archive).

Visit our web site, www.ndacan.cornell.edu, or e-mail NDACAN@cornell.edu for an application and additional information.

The application deadline is January 15, 2004.

National Data Archive on Child Abuse and Neglect

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN (APSAC)
ADVANCED TRAINING INSTITUTES

HUNTSVILLE HILTON – HUNTSVILLE, ALABAMA
TUESDAY, MARCH 16 9:00 AM to 4:00 PM

APSAC Members save $50 off the registration fee!

APSAC's Advanced Training Institutes offer in-depth training on selected topics. Taught by nationally recognized leaders in the field of child maltreatment, these seminars offer hands-on, skills-based training grounded in the latest empirical research. Participants are invited to take part by asking questions and providing examples from their own experience. Take home in-depth knowledge you can use immediately by signing up for the APSAC Institute of your choice.

Join APSAC and realize the benefits of membership today! When you register and select the membership option on the Institute registration form, you are immediately eligible for the member discount on the Institute registration fee. Please make your check for registration and/or membership payable to APSAC, and return your registration to APSAC. This option is available for new members only. *Please do not renew your membership through this form*.
About APSAC APSAC is a nonprofit, interdisciplinary membership organization incorporated in 1987. Thousands of professionals from all over the world—attorneys, child protective services workers, law enforcement personnel, nurses, physicians, researchers, teachers, psychologists, clergy, and administrators—have joined APSAC's effort to ensure that everyone affected by child maltreatment receives the best possible professional response. Visit our website at www.apsac.org.

PROGRAM

I. Doing Real Justice for Children - Critical Issues in the Investigation of Child Sexual Abuse Cases
Detective Rick Cage (Ret.) & Brian Holmgren, JD

This intensive training seminar will focus on the requirements for successful investigation of sexual abuse cases from both law enforcement and prosecutorial perspectives. Emphasis will be placed on the use of a wide variety of investigative techniques designed to corroborate the child's allegations of abuse. Through the use of several varied mock fact scenarios drawn from actual cases, participants will brainstorm investigative strategies and techniques designed to develop the case from the child's initial disclosures through the preindictment phase of the case. Topics will include evidentiary requirements for preservation and admission of the child's disclosures, crime scene investigation, suspect interviewing, effective use of search warrants, and the development of "other acts" evidence. A variety of audiovisual aides will be used throughout the presentation as well as examples from actual cases.

II. Children With Sexual Behavior Problems
Jane Silovsky, PhD

This seminar will provide information on the identification, assessment, and treatment of preschool and school-age children with sexual behavior problems. Part one will include an overview of normal and problematic sexual behavior in children and assessment measures and procedures. Part two will cover treatment of sexual behavior problems. Specific cognitive behavioral techniques used in individual and group treatment to reduce inappropriate or aggressive sexual behavior will be discussed.

III. Triple Jeopardy: Substance Abuse, Domestic Violence, and Child Maltreatment
Ronald E. Zuskin, LCSW-C, LCADC

These three issues are intercorrelated. They present a triple threat to the children in these families and pose triple jeopardy to the practitioner responding to the family's service needs. This workshop will review the intercorrelations, the impact of domestic violence on children, and the effect of substance involvement on parenting. An array of strategic service interventions designed to promote child safety and well-being will be offered, along with specific protocols for the professional to use in assessing and managing the challenges of intervening with these families to promote safety, reasonable permanence, and child well-being.

HUNTSVILLE ADVANCED TRAINING INSTITUTES: REGISTRATION FORM

First name | Middle initial | Last name | Degree

Agency name

Address/Street | City | State | Zip

Work phone | Home phone | Fax

E-mail

Participants receive Continuing Education verifying six (6) contact hours for submission to appropriate entities.

Please circle the appropriate amount and indicate your first and second choice Institute to attend below:

Institute Registration Fee	Through 1/09/04	After 1/09/04	
Nonmembers	$125	$150	1st Choice Institute # _____
APSAC members (savings of $50)	$75	$100	2nd Choice Institute # _____
Membership			
Join APSAC now & register for an Institute at discounted rate	$175	$200	
Join APSAC as a new member only	$100	$100	Total $: _____

Group rates are available. Call APSAC's Training Department at 405-271-8202 for details.

Enclosed is: Check_____or Purchase order _____ or payment by

Credit card: MasterCard_____VISA_____AMEX _____Discover_____

Card #_____Expiration date _____/_____

Signature_____

Please return this form with payment for the APSAC Institutes and/or New Membership to:
APSAC, PO Box 26901, CHO 3B-3406, Oklahoma City, OK 73190. To register by **Fax: 405-271-2931**.

- Cancellations received prior to 1/09/04 are refundable, less a $50 administrative fee. Cancellations not accepted after 1/09/04. Substitutions may be made at any time for no cost.
- Confirmation of registration will be e-mailed.
- For more information about membership or APSAC's other training programs, call 405-271-8202, e-mail: tricia-williams@ouhsc.edu, or visit www.apsac.org.

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

[Office Use Only:] **Date to SChap** _____ **Today's date**

Membership Application

First name | Middle initial | Last name

Degree | Job title | Referred by

PLEASE INDICATE (X) YOUR PREFERRED MAILING ADDRESS FOR BUSINESS CORRESPONDENCE

_____Work address

Agency

Street

City | State | Zip

____Home address

Street

Apartment #

City | State | Zip

Office phone | **Home phone** | **Fax** | **E-mail address**

APSAC membership includes State Chapter membership. In what State Chapter do you want membeship?_____

FIELD OF PRACTICE

We realize that many of our members perform multiple functions across disciplinary lines. To assist us in compiling a useful profile of our members' activities, **please mark no more than two items** in each column to indicate the best description of your work.

DISCIPLINE	FUNCTION	AREA OF EXPERTISE	POPULATION SERVED
__Child Protective Services	__Administrator	__Neglect	__Child Victims
__Education	__Child Interviewer	__Physical Abuse	__Adolescent Victims
__Law	__CPS Worker	__Prevention	__Adult Survivors
__Law Enforcement	__Clinician	__Sexual Abuse	__Offenders
__Medicine	__Defense Counsel	__Psychological Maltreatment	__Families
__Ministry	__Investigator		__Other_____
__Nursing	__Judge		
__Psychiatry	__Probation Officer		
__Psychology	__Prosecutor		
__Social Work	__Researcher		
__Sociology	__Therapist		
__Other_____	__Victim-Witness Advocate		

CULTURAL GROUP IDENTIFICATION

__African American __Asian American __Native American __Caucasian/European American __Latino/Hispanic __Other _____

HOW DID YOU HEAR ABOUT APSAC? __Word of mouth __Advertisement __Conference __ Mailing __Other_____

MEMBERSHIP OPTIONS: Please check below to indicate your membership selection*

Individual Member Salary Range	One-Year Membership (check one)
Above annual income of $50,000	__$125.00
$30,000 to $50,000 annual income	__$100.00
Below $30,000 annual income	__$75.00
+Student Membership	__$65.00 (+Verification of full-time student status is required.)

***Group Membership: A 10% discount is offered for each NEW membership fee when from five to nine individuals from one agency join at the same time. A 20% discount is offered for each NEW membership fee when ten or more individuals from one agency join at the same time. Membership includes all benefits, including subscriptions to *Child Maltreatment*, APSAC's quarterly journal, and the *APSAC Advisor*.**

Payment: All payments must be made in U.S. funds. Charge payments can be faxed to 843-225-2779.

Applicants outside the United States, please add $20.00 (U.S.) to annual membership dues to cover extra postage costs.

$_____ is enclosed for membership dues

$_____ is enclosed for a hard copy of the journal, *Child Maltreatment* **($20 is required to receive a hard copy of the journal; if not included, an electronic version will be provided via e-mail)**

$_____ is enclosed as a voluntary, tax-deductible gift to support special APSAC projects.

$_____ ($20 for additional postage fee) is enclosed for applicants living outside the United States

$_____ **TOTAL AMOUNT ENCLOSED** **Circle Method of Payment:** Check#_____ Cash Visa Mastercard AMEX Discover

Card number:_____Expires_____/_____

Signature_____

Please note: In applying for membership, professionals certify compliance with the APSAC code of ethics as well as the professional and ethical standards of and all laws and regulations relating to their respective profession or field. Membership in APSAC does not certify professional competence.

PLEASE RETURN COMPLETED APPLICATION WITH APPROPRIATE PAYMENT TO:

APSAC, P.O. BOX 30669, CHARLESTON, SC 29417 OR FAX 843-225-2779,
PHONE 843-225-2772, E-MAIL: APSAC@KNOLOGY.NET, OR VISIT: WWW.APSAC.ORG

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

APSAC is a nonprofit, interdisciplinary membership organization incorporated in 1987. Thousands of professionals from all over the world—attorneys, child protective services workers, law enforcement officers, nurses, physicians, researchers, teachers, psychologists, counselors, clergy, administrators and allies—have joined APSAC's effort to ensure that everyone affected by child maltreatment receives the best possible professional response.

MISSION

- Providing professional education that promotes effective, culturally sensitive, and interdisciplinary approaches to the identification, intervention, treatment, and prevention of child abuse and neglect.
- Promoting research and guidelines to inform professional practice.
- Educating the public about child abuse and neglect.
- Ensuring that America's public policy concerning child maltreatment is well informed and constructive.

MEMBERSHIP BENEFITS

- The *APSAC Advisor*, a hands-on style periodic publication that brings you the latest news in practice, research, legislation, publications, and events in the field of child maltreatment.
- An electronic version of *Child Maltreatment*, the distinguished, quarterly peer-reviewed journal designed expressly to bring APSAC's members the latest research, policy, and practice information in clear language and an immediately usable form.
- Discounts on APSAC's annual Colloquium, other conferences across the United States, and educational publications and audiotapes on a wide range of topics.
- A state chapter network through which members can form vital partnerships with other professionals in their states.
- The opportunity to participate in national task forces, establishing best practice guidelines in many critical areas.
- The opportunity to collaborate through APSAC's members and other professional peers around the country who are working to educate local, state, and federal legislators to better protect children.
- A national voice that works to influence public awareness and media representation of the complex problem of child maltreatment.
- A voice on Capitol Hill to ensure that federal policies and programs affecting child abuse and neglect are well informed and effective.
- An interdisciplinary professional network of thousands of colleagues.

JOIN APSAC TODAY

WASHINGTON UPDATE

Thomas Birch, JD, PhD

PRESIDENT BUSH SIGNS CAPTA LAW

At a small ceremony with a handful of advocates and Republican Congressional leaders present in the White House's Oval Office, President Bush signed into law on June 25 the Keeping Children and Families Safe Act of 2003, reauthorizing the Child Abuse Prevention and Treatment Act (CAPTA) for 5 more years as Public Law 108-36.

Bush signed the official copy of the legislation witnessed by a few of those who had worked on advocating for the legislation, as well as HHS Secretary Tommy Thompson, Sen. Judd Gregg (R-NH), chair of the Senate HELP Committee; Rep. Peter Hoekstra (R-MI), author of the House CAPTA reauthorizing bill; Rep. John Boehner (R-OH), chair of the House Committee on Education and the Workforce; and Rep. Tom DeLay (R-TX), House Majority Leader. Bush thanked those attending the signing ceremony for their work on behalf of children and gave credit to the Congressional leaders for shepherding the measure through Congress.

The new CAPTA law includes slight increases in authorized funding levels over the amounts set in current law and well above appropriations in 2003: CAPTA basic state grants and discretionary grants would have a combined authorization at $120 million (FY03 appropriations equal $56 million); CAPTA Title II Community-Based Grants would be authorized at $80 million (FY03 appropriation is $33 million.)

As always, the challenge for advocates for protecting children and preventing child maltreatment is to secure sufficient funding to realize fully the potential of the policies embodied in CAPTA. Successive administrations have not seen fit to invest their budget priorities in CAPTA at levels anywhere near the authorized spending ceilings.

The final CAPTA legislation continues the theme, proposed by the National Child Abuse Coalition, of developing andexpanding collaboration between child protective services and health, mental health, and developmental services to benefit children who come to the attention of the child welfare system.

The measure also pays attention to analyzing the redundancies and gaps in use of resources to prevent child abuse and neglect, with special attention to how CAPTA funds are used in connection with other federal support to address the prevention and treatment of child abuse and neglect.

Recruitment, training, supervision, and retention of child welfare workers are also highlighted in the final bill. In response to home schooling representatives, who pushed for a requirement that caseworkers reveal the allegations made against an individual "at the initial point of contact," a particular aspect of training for caseworkers would address duties to protect the rights and safety of children and their families from initial contact at investigation through treatment.

CAPTA's Title II, formerly the Community-Based Family Resource and Support program, is now called the Community-Based Grants for the Prevention of Child Abuse and Neglect, with the focus of the Title II grants clearly on supporting programs for the prevention of child maltreatment. The bill also adds home visiting to a list of services deserving attention and includes parents with disabilities among those to be served.

Finally, the so-called Greenwood amendment is aimed at preventing harm to infants born drug-exposed. The bill attempts a compromise, which requires procedures ("including appropriate referrals" to CPS) to address needs of infants born "affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure." It includes development of a plan of "safe care" for the infant and a requirement that hospitals notify CPS, with the caveat that notification does not establish a definition under federal law of what constitutes child abuse nor require "prosecution for any illegal action."

SENATE APPROVES ADDITIONAL CAPTA FUNDING

On September 10, the Senate added $2.5 million in funding for the Child Abuse Prevention and Treatment Act (CAPTA) in the FY 2004 Labor, HHS, Education Appropriations Bill. The legislation, readied for floor action by the Senate Appropriations Committee, had held CAPTA's state grants and community-based prevention grants at the 2003 levels and cut $7.5 million in earmarked funding from the discretionary grants.

Sen. Lamar Alexander (R-TN) offered the CAPTA money amendment, originally introduced by Sen. Christopher Dodd (D-CT), with the co-sponsorship of Sens. Edward M. Kennedy (D-MA) and Patty Murray (D-WA), bringing appropriations for CAPTA's basic state grants and Title II community-based prevention grants up to the level of funding approved by the House and adding $2.1 million in new funding for discretionary grants in research and program innovations.

The House passed its bill in July, increasing CAPTA state grants and prevention grants by $355,000 and eliminating the $7.5 million in earmarks from the discretionary grants, all in accord with the President's budget proposal. The HHS money bill next goes to a House-Senate conference committee. The only difference between the two bills on CAPTA funding is the additional $2.1 million in discretionary funds in the Senate's version. If that amount holds through to final passage, CAPTA's competitive R&D funding will reach a new high of $28.4 million.

House action on appropriations closely follows President Bush's budget proposal with slightly less than 1% in additional funding for most child welfare and children's services, including child care and the Promoting Safe and Stable Families program. The Senate's version of the bill takes a different approach to spending for child welfare programs, leaving money for most activities at the lower 2003 level without adding in the slight increases proposed by the President and approved by the House. However, in a significant departure from the House funding bill, the Senate measure includes $33.779 million—the same as 2003—for the Early Learning program, which was zeroed out in the President's budget and in the House bill.

SCANT ACCOUNTING OF CHILD WELFARE FUNDS, GAO REPORTS

The federal government has "limited knowledge" about how states spend their child welfare services funding under Title IV-B(1), it collects no data on expenditures, and little attention is paid to statutory limits on using child welfare IV-B(1) funding for foster care maintenance and adoption assistance payments, according to a September 12, 2003, report from the U.S. General Accounting Office (GAO).

What's more, GAO reported that 9 of the 10 regional offices of the U.S. Department of Health and Human Services (HHS) do not monitor states' compliance with the spending limits. As a result, GAO found that HHS approved 2002 spending plans for 15 states that reported spending amounts on foster care and adoption subsidies that exceeded the limits by a total of over $30 million.

In analyzing how states spend their IV-B(1) child welfare services funding, GAO found that salaries of child welfare agency staff—primarily for social workers conducting CPS investigations, recruiting foster parents, and referring families for services—accounted for 28% of the money. The next three largest spending categories—administration, including rent and utilities, CPS services, and foster care maintenance—claimed 43% of the federal funds used by states.

As for Title IV-B(2)-–the Promoting Safe and Stable Families program, which is more restrictive in its uses—GAO found that states spent over 80% of their dollars on the four mandated service categories: family support, family preservation, family reunification, and adoption promotion and support services.

cont'd on page 24

GAO recommends in its report that HHS ensure that its regional offices are conducting appropriate oversight on the uses of Title IV-B(1) funds; that HHS collect data on state spending of Title IV-B funding to facilitate oversight; and that HHS use the information gained through enhanced oversight to inform its design of the child welfare service option being proposed by the Bush administration to allow states to use Title IV-E foster care funding for the same range of services allowed under IV-B.

The response from Wade Horn, HHS Assistant Secretary for Children and Families, agreed to provide guidance to regional offices in monitoring the states' use of child welfare funds, but disputed the usefulness of the statutory limits on the uses of IV-B(1) funds. HHS disagreed with the recommendation for collecting data on state spending, asserting that HHS' oversight efforts were focused through the ongoing Child and Family Service Reviews. As for waiting to collect IV-B spending data to inform the design of its child welfare option, HHS had no comment.

Title IV-B is the primary source of federal funds for child welfare services available for preventing child maltreatment and protecting the victims of child abuse and neglect. In 2003, appropriations were $292 million for IV-B(1) and $405 million for IV-B(2).

The full GAO report, "Enhanced Federal Oversight of Title IV-B Could Provide States Additional Information to Improve Services," which was requested by Rep. Wally Herger (R-CA), chair of the House Ways and Means Subcommittee on Human Resources, is available on the GAO web site at www.gao.gov/ or linked directly at GAO-03-956.

HEAD START BILL NARROWLY PASSES HOUSE; SENATE NEXT

On July 25, the House of Representatives barely passed by the margin of one vote (217–216) legislation to reauthorize the Head Start program through 2008. The School Readiness Act of 2003 (H.R. 2210) embodies the Bush administration's proposal to allow a limited number of states to fold Head Start into their own early childhood education programs. In addition, the House bill puts increased emphasis on the development of language and reading skills in the Head Start program, reflecting the policy directions enacted 2 years ago in the Bush administration's education bill.

Head Start advocates have warned that the House bill threatens the future of Head Start with its proposal to dismantle the current operations of the Head Start program by turning the funds over to the states without explicitly guaranteeing the application of federal performance standards. Concerns raised by the Head Start bill passed in the House include establishing a set of new goals for Head Start programs without providing the funding needed to meet the goals; reducing the federal commitment to training and technical assistance; allowing religious discrimination by faith-based providers receiving Head Start funds; and giving eight states the option to receive a block grant without adequate accountability or full application of the current Head Start Performance Standards.

Head Start has operated since its inception as a federal-to-local grant program for the provision of early childhood education, comprehensive services, and family support to poor preschool children and their families. Currently, only three out of five children eligible for Head Start's services are served in the program.

The measure passed by the House includes a series of non-controversial amendments proposed by the National Child Abuse Coalition to build upon the ways in which abused and neglected children and children at risk of maltreatment and in need of preventive services might benefit from Head Start and Early Head Start services. The Coalition's proposal, accepted almost in its entirety in the House bill, recognizes that ensuring that children are ready to learn means ensuring that children are safe and nurtured at home.

The amendments would build upon provisions already existing in the Head Start statute that provide for 1) home-based services to Head Start children and their families, 2) staff training in working with children who experience violence, 3) train ing to parents in parenting skills and basic child development, and 4) collaboration with other agencies and organizations involved in child and family services.

In that regard, the Coalition's amendments provide for

1) greater attention to serving children who have been maltreated or are at risk of abuse or neglect,
2) greater attention to the training needs of parents in parenting skills and basic child development (especially in Early Head Start),
3) improved coordination with existing home-based services,
4) staff training in working with children who experience violence, and
5) collaboration with other agencies and organizations involved in child and family services.

With attention to Head Start now passing to the Senate, on July 29, Sen. Christopher J. Dodd (D-CT) introduced S.1483, legislation to reauthorize the Head Start Act. The Dodd bill,

which rejects the state option included in the House measure, also calls for strengthening the academic qualifications of Head Start teachers by requiring that by 2008 all teachers—rather than just half as provided in the House—must have 4-year college degrees. All Democratic members of the Senate HELP Committee signed on as cosponsors to S. 1483.

Although the Senate committee's Republicans have not yet introduced their Head Start legislation, both Sen. Judd Gregg (R-NH), chair of the HELP Committee, and Sen. Lamar Alexander (R-TN), chair of the Subcommittee on Children and Families, have expressed little interest in developing a bill that would include the state option provisions from the H.R.2210.

In a related action, the Senate Appropriations Committee, reporting out the HHS appropriations bill, stated its position on the new directions drafted for Head Start in the House bill. The committee's report on the appropriations bill had this to say about Head Start: "The Committee cautions against anything that would detract from the comprehensive nature of the program in delivering early childhood development and family services. While school readiness is front and center in the goals of Head Start, the elements necessary to achieve that readiness range from adequate nutrition and health screening, to social and emotional development and family building, as well as the cognitive growth of young children."

WHITE HOUSE LOOKS TO FOSTER CARE FUNDING OPTION BILL

The Bush Administration hopes to have legislation introduced in Congress before the end of the year embodying its foster care funding proposal to offer states the option of receiving their foster care dollars as a block grant for a period of 5 years or to receive their foster care allocation in an entitlement as currently funded under Title IV-E. The "flexible option" is meant to give states the opportunity to develop a continuum of child welfare services using IV-E funds now available only for foster care.

The proposal does not represent an investment of any new dollars in the Title IV-E foster care subsidy program. In testimony before the House Ways and Means Subcommittee on Human Resources in June, Dr. Wade Horn, HHS Assistant Secretary for Children and Families, asserted that "the option encourages innovation and the development of cost-effective programming that over time will result in children reaching permanency more quickly and fewer children being removed from the home."

The Administration's proposal includes the following components:

- The block grant funding option would be available to support any child welfare purpose (identified as those child welfare services currently eligible for funding under Title IV-B).
- The funding option would come from dollars currently estimated for the existing Title IV-E foster care entitlement payments and associated administrative costs. States would receive up to 20% of their 5-year allocation in any one year, or states could choose to receive all of their funding—-5 years' worth-—at the outset of the program.
- Once a state has opted into the flexible grant program, it must stay in for 5 years and cannot opt out.
- The flexible option must prove to be "cost neutral" over the 5 years of the grant.
- If a state experienced an emergency with increased numbers of children placed in foster care, the state could draw on its TANF contingency fund to pay for the additional subsidies.
- The Administration's proposal would maintain all current protections under Title IV, and HHS would continue to conduct Child and Family Service Reviews.
- The plan would set aside direct foster care funding for Indian tribes.

Concerns raised by child welfare advocates include the following:

- States might very well not realize any real gains over the 5 years. Funding could be limited to current levels without any significant injection of funds to promote system improvements and meaningful prevention services, while continuing to maintain foster care subsidies.

- There is no guarantee that states would in fact use their funds for preventive services, nor is there any reporting mechanism for HHS to ascertain how states choosing the optional grant program are using their Title IV money.

- Tapping the TANF contingency fund could pit the needs of poor children against those of foster children, since the need for additional funds in both programs would likely arise under similar circumstances, i.e., economic downturn.

- Questions remain as to how much states would be required to maintain in matching funds, given that counties and localities may currently contribute to the match; and in foster care training, for example, universities often pay the matching funds, raising concerns about the future of child welfare training with the flexible funding option.

Although there is no certain date for introduction of the legislation in Congress, Congressional committee staff have already been reviewing the specifics of the Administration's proposal.

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SENATE PANEL APPROVES TANF BILL

The Senate Finance Committee on September 10 approved legislation reauthorizing the Temporary Assistance to Needy Families (TANF) program with increased work requirements for welfare recipients, child care funding considered insufficient by child advocates, and $1 billion available over the next 5 years to promote marriage as a goal for people on welfare.

The Personal Responsibility and Individual Development for Everyone (PRIDE) Act is similar to the House bill, H.R.4, which passed in February. Both would increase the number of hours recipients are required to work: 30 hours weekly under current law would go to 38 hours under the House bill and to 34 hours in the Senate measure. President Bush had asked Congress to raise the work requirement to 40 hours.

Both bills also increase the work engagement requirements for individuals receiving TANF. Under current law, at least 50% of a state's adult recipients must be engaged in work or preparing for work. Both the Senate and the House bill would increase the requirement to 70% by 2008.

Sen. Olympia Snowe (R-ME), who had previously withheld her support for the bill over inadequate provision for child care funding, voted with her fellow Finance Committee Republicans to send the measure to the Senate floor with the understanding that she would be guaranteed the ability to offer an amendment to increase child care funding. The PRIDE Act passed the committee by a party-line vote of 9-8.

NEW REPORTS FORECAST DEEPER BUDGET DEFICITS

The Congressional Budget Office (CBO) published its August "Budget and Economic Outlook" forecasting this year's federal budget deficit at $401 billion—an increase of $155 billion over the March estimate of $246 billion. The CBO now estimates that the deficit will rise to nearly $1.4 trillion by 2013.

What's more, the budget office predicts "significant strains" on Social Security and Medicare as the baby boom generation ages. Over the next 30 years, the number of retirees will grow by about 80% while the number of workers will grow by only 15%, according to the CBO report.

In a companion report, the independent Center on Budget and Policy Priorities issued its own report on federal budget deficits, projecting a 10-year deficit of $5.1 trillion. The CBPP report notes that the CBO projections don't take sufficient account of legislative changes that are "very likely to be enacted," including extension of expiring tax cuts for businesses and individuals, new Medicare prescription drug benefits, and increased military spending.

COURT EXTENDS FAMILY LEAVE TO STATE WORKERS

On May 27, the U.S. Supreme Court upheld the right of state government workers to sue their employers for violations of the Family and Medical Leave Act. In a 6-3 ruling, the court extended to almost 5 million state employees the protections of the federal leave act enjoyed by most private-sector workers already covered by the law.

The Family and Medical Leave Act, signed into law in 1993 by President Clinton, allows workers to take up to 12 weeks of unpaid leave from work to care for a newborn or adopted child or for an ill family member. In the case decided by the Supreme Court, *Nevada Department of Human Resources v. Hibbs*, William Hibbs sued the department after being fired for taking extended leave to care for his injured wife.

In the majority opinion, Chief Justice William H. Rehnquist wrote that a long history of gender discrimination by state governments justified applying the federal law to the states, contrary to the immunity from private law suits states normally enjoy under the Eleventh Amendment of the Constitution. Rehnquist called the Family and Medical Leave Act "an across-the-board, routine employment benefit for all eligible employees."

Family advocates supported the 1993 passage of the Family and Medical Leave Act legislation as an important protection to support families and to reduce the pressures of work conflicting with family responsibilities. The act had been passed earlier by Congress and twice vetoed by President George H. W. Bush. The current Bush administration filed a brief with the Court siding with Hibbs.

The Court's decision and Rehnquist's authorship of the majority opinion were noteworthy because they are counter to recent decisions in which the Court has sided with states against efforts to extend federal antidiscrimination laws to the states.

Justices Anthony M. Kennedy, Antonin Scalia, and Clarence Thomas dissented in an opinion calling the leave act a "benefit program," not a remedy for discrimination.

CONFERENCES 2003-2004

November 7-8, 2003
Children's Rights Council 14th National Conference "Effecting Positive Outcomes for Children," Hanover, MD
call 800-787-KIDS or fax 301-559-3124, or visit www.gocrc.com

November 12-14, 2003
Tools That Work, Improving Child Welfare Services Through Research, Performance Measurement, and Information Technology, Miami, FL
call 202-638-2952 or fax 202-638-4004, or visit www.cwla.org

November 19-22, 2003
55th Annual Meeting of the American Society of Criminology, Denver, CO
call 614-292-9207 or fax 614-292-6767, or e-mail: asc41@infinet.com

November 19-21, 2003
3rd Annual Partners in Prevention, Austin, TX
call 512-438-2916 or fax 512-832-2031, e-mail: Julie.martinez@tdprs.state.tx.us, or visit www.tdprs.state.tx.us/Prevention,_and_Early_intervention/Partners_In_Prevention.

November 20-23, 2003
15th Annual Conference, Federation for Children's Mental Health, Washington, DC
call 703-684-7710 or fax 703-836-1040, e-mail: ffcmh@ffcmh.org, or visit www.ffcmh.org

December 1-5, 2003
APSAC 1st Annual Child Trauma Treatment Clinic, Maui, HI
call 405-271-8202 or fax 405-271-2931, or e-mail: tricia-williams@ouhsc.edu

January 26-30, 2004
18th Annual San Diego Conference on Child and Family Maltreatment, San Diego, CA
call Linda Wilson 858-576-1700 or fax 858-966-8018, e-mail: sdconference@chsd.org, or visit www.charityadvantage.com/chadwickcenter/2004conference.asp

February 23-25, 2004
Children 2004: Vision, Action, Results, Washington, DC
call 202-638-2952 or fax 202-638-4004, or visit www.cwla.org/conferences/

March 16-19, 2004
20th National Symposium on Child Abuse, Huntsville, AL
call Darlene Woodward 256-533-0531 or fax 256-534-6883, or visit www.nationalcac.org

March 23-27, 2004
4th African Regional Conference on Child Abuse and Neglect in Africa, Child Trafficking and Child Sexual Abuse in Africa, Enugu, Nigeria
call Prof. Peter O. Ebigbo 234-4257923 or fax 234-42450112,or e-mail: pebigbo@infoweb.abs.net

April 19-23, 2004
APSAC Forensic Interview Clinic, Seattle, WA
call 405-271-8202 or fax 405-271-2931, or e-mail: tricia-williams@ouhsc.edu

May 14-19, 2004
2004 Prevent Child Abuse America National Conference, Lake Buena Vista, FL
call Ann Johnson 312-663-3520 or fax 312-939-8962, e-mail: ajohnson@preventchildabuse.org, or visit www.preventchildabuse.org/news/conf.htm

June 5-8, 2004
National CASA Conference, Washington, DC
call Tracy Flynn 800-628-3233 or fax 206-270-0078, or visit www.nationalcasa.org/casa/confer.htm

July 20-22, 2004
Advocacy in Action: Becoming a Powerful Voice for Youth! Research Triangle Park, NC
call Nancy Carter 800-820-0001 or fax 919-384-0338, e-mail: nancy.carter@ilrinc.com, or visit www.ilrinc.com/eposter/productdetail1.asp?catalogID=257

June 14-18, 2004
APSAC Forensic Interview Clinic, Norfolk, VA
call 405-271-8202 or fax 405-271-2931, or e-mail: tricia-williams@ouhsc.edu

August 4-7, 2004
APSAC 12th Annual Colloquium, Hollywood, CA
call 405-271-8202 or fax 405-271-2931, or e-mail: tricia-william@souhsc.edu

September 19-22, 2004
ISPCAN 15th International Congress on Child Abuse and Neglect, Brisbane, Australia
call 617-3844-1138 or fax 617-6844-0909, e-mail: ispcan2004@icms.com.ua, or visitwww.congress2004.com

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