Volume 16 Number 4, Fall 2004
Volume 17 Number 1, Winter 2005

APSAC ADVISOR

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

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The Contribution of Decision Theory to Promoting Child Safety

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Child welfare practice is, first and foremost, about making effective decisions that promote outcomes of safety, permanence, and well-being for abused and neglected children. Further, the accurate and timely identification of children at high risk of maltreatment, either imminently or at some time in the future, is a prerequisite to making the most effective decisions to assure their safety.

In spite of this, many traditional strategies for assessing safety and estimating the risk of future maltreatment can result in decisions that compromise children's safety rather than assure it (Rycus & Hughes, 2003; Gambrill & Shlonsky, 2000). Historically, child welfare workers have used the case study method to identify children who are "unsafe" and to estimate the likelihood of future maltreatment. They have relied on individualized case assessments, clinical experience, professional judgment, and sometimes intuition to make these determinations. However, even the most experienced and capable social workers may find it difficult to accurately estimate the level of risk in each case situation (Macdonald, 2001; Gambrill & Shlonsky, 2000). This is the epicenter of the child protection crisis in America. Child welfare decisions are made daily by thousands of individuals with different levels of education, training, and experience, who apply different criteria and thresholds to determinations of safety and risk. This has resulted in widely disparate decisions, even among persons considered to be experts in the field (Rossi, Schuerman, & Budde, 1996).

The child welfare profession has an ethical responsibility to use decision-making tools that promote accurate and equitable protective decisions for maltreated children and their families. Further, because of the potentially devastating consequences of bad decisions, we must assure that our decision-making tools have the most rigorous scientific support possible.

In a system that must assure efficient, effective, and equitable decisions on behalf of maltreated children and their families, this can create significant problems. Children who are unsafe or at high risk of future harm may remain in high-risk situations, while low-risk children may be subjected to intrusive intervention, including out-of-home placement. The serious negative consequences of inappropriate case decisions on outcomes of child safety, permanence, and well-being contributed to the recent federal emphasis on system accountability for achievement of these fundamental outcomes.

To address disparities in decision making, many child welfare organizations have implemented standardized decision-making models, protocols, and instruments. However, the use of such models has been inconsistent and their effectiveness has been compromised by a variety of factors (Rycus & Hughes, 2003; DePanfilis, 1996; Curran, 1995). There has been a lack of uniform, relevant, well-articulated criteria on which to base decisions (Lyons, Doueck, & Wodarski, 1996; Cicchinelli & Keller, 1990). Tools and protocols used to guide these decisions often demonstrate poor reliability and validity or have simply never been researched (Gambrill & Shlonsky, 2000; Pecora, Whittaker, Maluccio, & Barth, 2000; Johnson, 1996; McDonald & Marks, 1991). There are wide disparities in criteria and tools designed to achieve the same objectives, and there is a lack of consistency among workers in their decision-making methods and processes (Gambrill & Shlonsky, 2000; Cicchinelli, 1995). Many child welfare systems have failed to fully and properly implement decision-making protocols (Ruscio, 1998; English & Pecora, 1994). And, staff using these protocols have often not been properly trained in their use (Rycus & Hughes, 2003; Pecora et al., 2000; Curran, 1995).

The child welfare profession has an ethical responsibility to use decision-making tools that promote accurate and equitable protective decisions for maltreated children and their families. Further, because of the potentially devastating consequences of bad decisions, we must assure that our decision-making tools have the most rigorous scientific support possible. This adherence to a more standardized and rigorous approach to decision making is consistent with the child welfare field's recent commitment to evidence-based practice. Not only must we seek strong empirical support for our activities and interventions, but we must also apply this "evidence" in structured and systematic ways to assure that the most relevant and appropriate decisions are made using this information.

Decision theory provides a conceptual framework and a variety of reliable, valid, and easy-to-implement technologies that can help child welfare practitioners make effective decisions in a variety of decision-making contexts and environments. This article introduces some of the fundamental constructs of decision theory and describes how these can be used in the development of instruments and protocols to guide critical child welfare decisions. Research will be reviewed that demonstrates the validity of protocols developed in accordance with tenets of decision theory. Finally, recommendations will be offered for a concise, logical framework for improved decision making in child welfare.

Decision Theory –Tenets and Models

Decision theory can be defined as "a body of knowledge and related analytical techniques of different degrees of formality designed to help a decision maker choose among a set of alternatives in light of their possible consequences" (*Web Dictionary of Cybernetics and Systems*, 2004). Tenets of decision theory form the foundation of economic theory and have also profoundly influenced other disciplines, such as psychology, philosophy, evolutionary biology, and political science.

To be precise, decision theory is not a single theory. Rather, it is an amalgam of constructs, technologies, and decision-making models

designed to maximize utility while concurrently minimizing risk. Decision theory attempts to reduce uncertainty in decision making by establishing priorities, increasing consistency and accuracy, and optimizing the use of resources. These objectives are all critical to child welfare decision making. It is therefore not surprising that many of the decision-making models that emanate from decision theory can be easily applied to child welfare decisions.

Many of life's most important decisions require an ability to analyze, weigh, and synthesize a large body of information, and to use this information to guide actions toward achievement of a predetermined goal. Some decisions require an estimation of the likelihood of a future event. These can vary in both importance and complexity, from estimating the probability of rain (to decide whether to carry an umbrella) to estimating the probability of future serious illness (to decide whether to undertake preventive medical measures). Further, the degree of certainty in the environment in which the decision is made can vary dramatically from substantially certain, to probable, to equivocal, to completely uncertain. Complex decisions are made even more complex when the decision-making environment is highly uncertain—that is, when essential information is unavailable or of questionable accuracy; when the decision maker has little knowledge about the topic being considered; or when there is insufficient time to fully analyze and assimilate the variables to be considered. Clearly, the higher the degree of uncertainty, the greater the potential for error.

Child welfare decisions are inherently complex, largely because so little is certain about human behavior. This is especially evident when assessing child safety, which requires identifying the unique contributors to child maltreatment in a family and the contribution of factors in the physical and social environments, as well as the impact of strengths or protective factors in mitigating maltreatment. Moreover, in child welfare, the decision-making environment is frequently enigmatic and opaque, since vital information may not be readily available, and decisions must often be made in truncated time frames. Child welfare decisions, especially those requiring estimates of the likelihood of future maltreatment, are rarely certain. Yet, when children's safety and well-being are in question, we are compelled to strive for the greatest degree of certainty possible when making decisions, and we need decision-making strategies and tools that increase both the reliability (consistency) and validity (accuracy) of these decisions.

The complexity and uncertainty that characterize child welfare decisions compel us to seek the clarity, simplicity, and utility of well-designed decision protocols. Decision theory can provide technologies and tools to help accomplish this.

The complexity and uncertainty that characterize child welfare decisions compel us to seek the clarity, simplicity, and utility of well-designed decision protocols. Decision theory can provide technologies and tools to help accomplish this. While the constructs of decision theory are often complex, protocols based on its tenets are generally conceptually simple and often elegant.

In an essay on the technology of decision making, Dawes (1993) referenced the need to "break down a problem into its components" to enhance the effectiveness of decisions. This recommendation is central to improving decision making in child welfare. Making decisions to assure children's safety and well-being is an iterative process, requiring a series of separate assessments and actions, often in a prescribed order, throughout the life of the case. Consider, for example, the decisions that must be made during the first few days and weeks following receipt of a report of child maltreatment. Should the agency accept a referral for investigation or divert the family to other community providers? How quickly must the agency respond to the referral? Are any of the children currently unsafe and in need of immediate protection? Can a child be left in the home while the investigating worker gathers more complete information? What immediate interventions are necessary to protect the child? Does a child need to be placed into substitute care to assure his or her safety? What is the likelihood that the child will be harmed in the future? Should the case be opened for ongoing services? What kind of services will be necessary to promote safety, assure the child a permanent family, and promote the child's well-being?

While all decisions must be based on the most relevant and critical information available, we must also recognize that the accuracy of any decision will be affected by the amount of information that can be reliably gathered at each decision point. For example, what is known from an initial phone referral will be less than what is known after completion of an on-site assessment, and both will provide less information than a thorough investigation. Yet, each decision must be as accurate as possible and must be made in a timely and efficient manner. There are obvious benefits to decision-making tools that prioritize collection of the most essential and most available information for the decision at hand; that structure the collection and analysis of this information; and that guide the decision maker to a presumptive decision. In essence, an overarching goal of child safety is achieved by implementing a structured series of subdecisions, each one appropriate for a particular stage in the case history, which when taken together comprise a decision-making strategy to provide the best possible safety decisions for a child through the life of the case.

Decision theory addresses a second, but related, issue. In child welfare, as in other human service disciplines, there is a natural tendency to gather as much information as possible about a family, an individual, or an event. However, too much data can itself create an information overload that reduces both the efficiency and quality of decisions. Proponents of decision theory divide data into two categories, "information" and "noise." Information reduces uncertainty; noise is superfluous information not directly relevant to the problem being addressed. When noise is mistaken for relevant information, it supports ineffective and inappropriate decisions. The most problematic "noise" is that which appears intuitively relevant but which does not substantially affect the decision-making process. Decision theory uses research to isolate and quantify the type of information that is most relevant to a particular decision and then incorporates only the most relevant information into the decision-making model, essentially separating information from noise. Resulting decision-making protocols focus attention on only those factors with the greatest relevance to the circumstances being as-

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sessed. This not only enhances the quality of the decision but often reduces the amount of time necessary to reach it.

In spite of the apparent value of decision theory for the child welfare field, its use may meet with considerable resistance. At first glance, decision theory and social work could appear incompatible. Decision theory is most often expressed in the language of mathematics, using terms such as probability, odds ratios, and decision trees. Nothing appears more antithetical to many social workers than the impersonal nature of these constructs. Social workers are taught to work within the context of an established interpersonal relationship, to take a humanistic view of issues, to consider all perspectives equally, and to individualize their approaches to each family. Social work typically focuses on individual entities (i.e., a child, a family, an organization), while decision theory focuses on the collective, drawing inferences for the individual from the combined experiences of many. Further, some practitioners equate any form of standardization as a rigid mandate that undermines individuality, responsiveness to clients, and creative use of "self" in addressing client needs and problems (Rycus & Hughes, 2003). Training and supervisory support will be necessary to help staff understand that using standardized protocols in no way undermines social work values and methods and, in fact, will support fundamental social work values by promoting equity and justice to families and children.

Defining Decision-Making Models

Decision-making models are formal frameworks designed to help promote decisions that achieve predetermined objectives. Effective decision-making models and tools not only guide the decision maker in gathering the most relevant information, but in many cases, the tools also direct and standardize the methodology for analyzing and synthesizing the information to promote the most appropriate conclusions from the analysis. Decision-making models structure the steps in the decision-making process in the following manner:

1) They formalize the collection, recording, and analysis of specific information that is most relevant to the decision at hand by incorporating predetermined and carefully defined questions, items, or measures in the protocol;

2) They often structure the sequence in which the information should be considered, thereby promoting the most logical analysis and synthesis of the information;

3) They may assign a level of priority or a weight to each piece of information, based on the relative importance of the information to the desired conclusion or decision; and,

4) They guide the decision-maker to arrive at the most accurate and relevant conclusion based on the answers or responses to the questions or items in the model.

Good decision-making models must have certain characteristics. First, they must be easy to understand and to use without oversimplifying either the criteria or the methods of analysis to the point that conclusions are either inaccurate or ambiguous. Second, the questions, criteria, or measures in a tool must be defined clearly enough to be recognized and understood by a variety of users, thereby promoting consistency (sometimes referred to as inter-rater reliability) in the use of the protocol. Third, the criteria or items in a model must actually measure what they are intended to measure. There must be a relationship of each measure to the specific outcome we are seeking to impact. Tools must be subjected to scientific assessment to establish their reliability and validity, thus assuring they perform in the intended manner. Finally, the type of tool must always be appropriate to achieve the tool's stated objective. Thus, as the decision-making goal or objective changes, both the criteria incorporated in the tool and the methodology needed to arrive at a decision may also change.

Two decision-making models are particularly useful in structuring decisions related to child safety. One model is called a decision tree. A decision tree provides a logical framework for decision making by identifying, articulating, and prioritizing very specific criteria needed to reach a decision, and then sequencing the assessment of these criteria in a predetermined order. In its most basic form, the criteria in a decision tree are presented as questions that can be answered either "yes" or "no." Depending on the answer, the decision maker is directed to consider the next relevant question, until, at the end of a line of inquiry (i.e., the end of a "branch" of the tree), a specific presumptive decision is provided. Decision tree technology forms the framework for two types of safety-related decisions: establishing priorities for agency response at the time of referral and assessing child safety.

A second type of tool, sometimes referred to as an additive index, is better suited to translate research results into simple decision tools. One application of this technology is an actuarial risk assessment, in which the decision maker must assign a level of potential risk to families based on the likelihood of a future occurrence of child maltreatment in the family. Actuarial risk assessments are based on rigorous, structured research that establishes statistical associations between certain predetermined criteria and a specific outcome of interest—in this case, the probability of future maltreatment. The characteristics of actuarial risk assessment are described more fully below.

These decision-making tools exemplify several concepts of decision theory. The "child safety decision" is broken down into its component parts, specifying what decisions must be made at each stage of intervention, and applying criteria and models that are most appropriate for each individual decision. By simplifying and structuring the decision making process, these tools also increase both effectiveness and efficiency by helping to eliminate "noise" and enhance the consistency (i.e., reliability) of the resulting decisions.

Applying Decision-Making Models to Child Safety

Child safety, the underlying purpose of child protective services, must be assured throughout the life of each case. This requires continuous and vigilant attention to identifying circumstances that place children at high risk of maltreatment, and acting in ways to reduce this risk while simultaneously promoting permanence and well-being. However, as indicated earlier, the specific approach to assuring child safety will differ depending on the particular stage of intervention and the nature of the task at hand. For example, identifying children at risk of imminent harm requires a different scope and type of information than that needed to choose the most relevant services to strengthen a family and prevent future maltreatment.

To improve the accuracy and relevance of each decision on the child safety continuum, four steps must be implemented when developing decision-making systems and protocols:

- Identify precisely what problem needs to be addressed at each decision point in the continuum, and specify what decision must be made to effectively resolve this problem (e.g., whether and how quickly the agency should investigate a referral; whether a child can remain safely at home while the investigation proceeds; or what services should be provided to reduce the likelihood of future harm);

- Determine the type, scope, and depth of information that is most relevant and most critical to each decision on the continuum;

- Determine what information is most likely to be available or can be reliably obtained at each decision point, considering the length of agency involvement and the number and extent of case and collateral contacts;

- Determine the stakes involved, the barriers that increase the potential for error, and the possible consequences of error.

This process can be used to develop three decision-making protocols to guide decisions related to child safety:

1) A priority response tool, which uses a decision tree model to screen referrals at intake and to determine which children appear to be at sufficient risk of imminent harm to warrant an immediate, face-to-face contact with an investigation caseworker;

2) A safety assessment protocol, using a modified decision tree model, to confirm whether a child is currently unsafe or is likely to sustain harm in the imminent future, and to guide actions to assure the child's protection while a more thorough assessment is completed;

3) An actuarial risk assessment tool, which estimates the probability of future maltreatment and categorizes families into groups by risk level, to inform case disposition decisions—that is, whether to open a case for child protective services, to refer a family to other providers for case management and supportive social services, or to close the referral at the intake level.

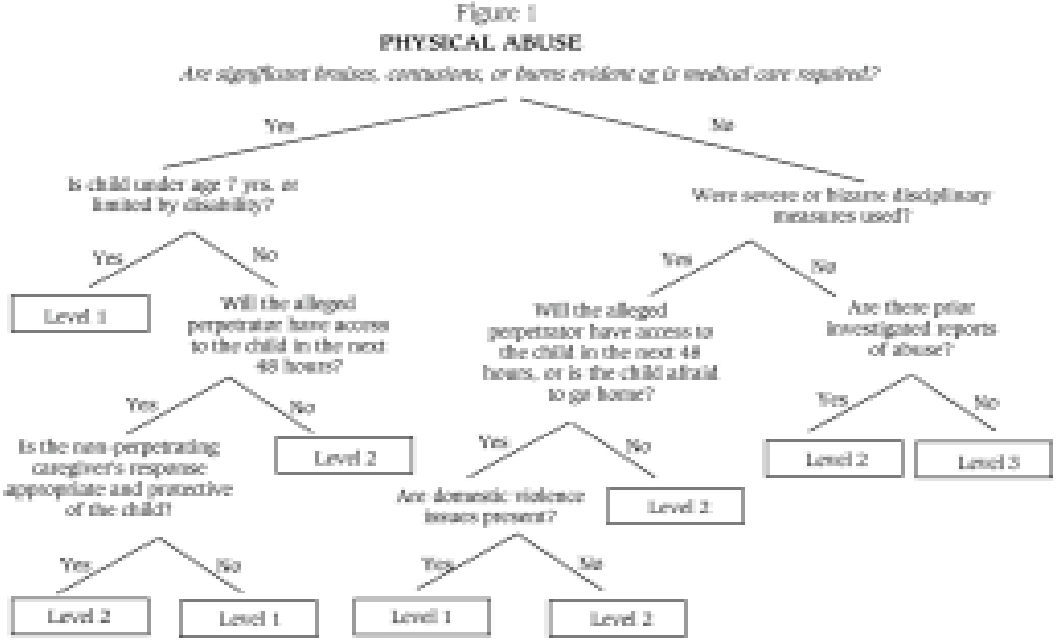
All three decisions have a significant effect on children's safety, albeit at different times in the case planning process and with different purposes. The tools to guide these decisions incorporate different criteria and measures and require different technologies of information assessment and synthesis. Other tools will be needed later in the casework process to gather assessment data for service planning purposes, to reassess risk, and to guide reunification planning. Because of space limitations, we will focus here on the three tools described above. These tools are more fully described next, followed by a review of the research that has established their validity and effectiveness in achieving their intended purpose.

Priority Response

The first point at which child safety is addressed is at the time of intake, when an allegation of child maltreatment is received. The criteria used to establish response times should be based on a few essential facts that can be reliably obtained without a face-to-face contact. The goal should be a simple, straightforward approach that promotes consistency and accuracy in making intake decisions.

An example of a response priority decision system to evaluate physical abuse is shown in Figure 1. This decision tree approach incorporates and prioritizes critical risk factors to be considered in the proper order to lead the decision maker directly to a presumptive decision

Figure 1



Source: Children's Research Center, 2002

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regarding the speed of the response.

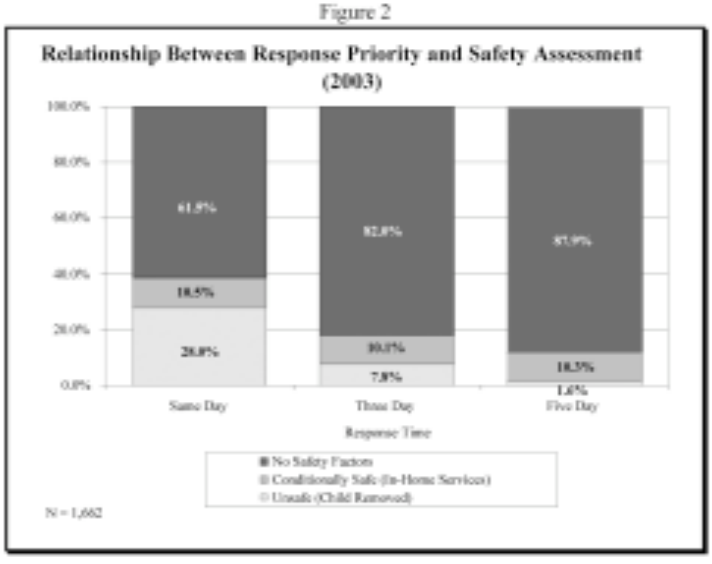
As the example illustrates, the speed of agency response to an allegation of physical abuse depends on the seriousness of the alleged maltreatment and the level of vulnerability of the child. Each type of allegation (e.g., abuse, neglect, medical neglect, sexual abuse) uses a different set of criteria to determine a presumptive course of action. Although additional information would certainly be useful, agencies are generally constrained by how little reliable information can be obtained from a phone conversation with the person making the referral.

Research on Priority Response Tools

If the response times established by these protocols are appropriate, research should be able to demonstrate a strong relationship between the identified response priority and both subsequent assessments of safety and agency actions taken to ensure safety. In other words, a far higher proportion of cases identified by the response priority tool as needing an immediate response should (1) have safety factors identified during the intake assessment or investigation, and/or (2) have children removed from their homes to assure their protection at the time of intake. Tracking these relationships over time provides measures of concurrent validity for the priority response tool and also gives agencies data to identify and correct weaknesses in the system.

Data are available from a wide variety of agencies across the nation using structured response priority tools. The priority ratings assigned to reports of abuse/neglect were highly correlated with safety issues identified at the first face-to-face contact (Baird, 2004). Figure 2 further delineates this relationship.

Figure 2



Safety Assessment

One of the most critical decisions facing intake caseworkers is how to recognize and protect children at high risk of imminent maltreatment when very little is known about the child and family. This decision usually involves considering whether to leave children at home while conducting further assessment and service planning. The "place or not place" decision has major implications not only for children's safety but also for the long-term detrimental consequences of traumatic separation on children's development, family functioning, and agency liability and credibility. In 1996, a major study by Rossi and colleagues found little agreement among child welfare workers or experts about the specific conditions that warranted removal of a child from the home. They concluded that "a family's chances of having a child taken into custody varies widely according to the person who is assigned to investigate that case" (Rossi et al., 1996, p.3).

This challenge prompted the development of a variety of decision-making protocols, called "safety assessments," to standardize the collection of information and to help workers balance the potential for imminent harm against the availability of factors to mitigate such harm. These safety assessment tools were intended to guide decisions to protect children in the least traumatic, least intrusive manner possible (DePanfilis & Scannapieco, 1994). A modified decision tree format is generally used to guide this decision process.

Items on safety assessments routinely probe for information about existing unsafe environmental conditions, a recent history of serious maltreatment, negligent or abusive parenting practices, and family or environmental conditions that currently compromise a child's health or well-being. Identifying the presence of any one of these conditions is sufficient to register a potential safety concern. The decision tree model, in effect, directs the assessor to consider three standardized questions, in the following order, to reach a decision about whether the child can be protected at home or will need to be removed and placed to assure their safety.

> The first question is, Does the identified condition represent a high likelihood of serious harm, either currently or in the immediate future? If the answer is "yes," indicating there is a high potential for serious imminent harm, the agency has two choices–but "not acting" is not one of them.
>
> One option is to protect the child at home; the second is to protect the child through out-of-home placement. To make this decision, a second question must be asked. Do protective factors exist in the family, extended family, and immediate environment that could mitigate the safety concerns and reduce the safety threat? If sufficient protective factors can be identified and mobilized to protect the child at home, the trauma of out-of-home care can be prevented, often without extensive or costly agency intervention. However, if the answer is "no," indicating that sufficient protective factors do not exist within the family system, the worker must ask, Can the agency apply interventions that can protect the child at home while the investigation and assessment can be completed? Such interventions might include homemaker services, protective day care, crisis intervention, and other concrete services to stabilize family situations. If agency interventions cannot protect the child, then the final option, removal and placement, is considered.

By standardizing these questions in the proper sequence, the decision to remove and place a child in out-of-home care is made only after the child has clearly been identified as "unsafe" and all other options to protect the child at home have been exhausted. Thus,

structuring the assessment process in a predetermined order helps establish safeguards that help deter inappropriate placement decisions.

Information gathered during safety assessments is typically formalized into safety plans, which guide casework activities during the initial phases of case contact until a more in-depth assessment and individualized service plan can be completed.

Research on Safety Assessment

The most extensive studies of safety assessment have been conducted in Illinois (Fluke, Edwards, Bussey, Wells, & Johnson, 2001; Fuller, Wells, & Cotton, 2001) and in Michigan (Wagner, Johnson, & Caskey, 1999). Both Illinois studies analyzed the impact of a safety protocol, the Child Endangerment Risk Assessment Protocol (CERAP), on child safety. The second study of CERAP also attempted to measure the relationship between individual safety factors and case outcomes. The CERAP studies were important because researchers did observe a significant reduction in short-term recurrence of child maltreatment when the CERAP had been implemented. While the researchers could not state with certainty that this reduction was due to use of the safety assessment, this finding remains positive. Less success was attained in establishing relationships between individual safety factors in the protocol and maltreatment recurrence. Because safety assessments typically gauge whether children may be harmed in the imminent future (generally within the 30-day time frame allocated for most investigations), safety assessment research is compromised by the typically low rates of recurrence within this short period of time. Recurrence rates are further reduced by the fact that many children judged to be "unsafe" are removed from their homes, often for the entire follow-up period.

The Michigan research did establish some significant relationships between individual safety factors and recurrence of maltreatment, but the follow-up analysis period was expanded to 6 months before these relationships proved significant.

Large databases from several states also provide other means of judging the efficacy of safety assessments. Safety assessments have demonstrated reasonably high correlations with valid risk assessment instruments as well as response priority tools, and these, at least, provide a measure of concurrent validity (Baird, 2004).

Risk Assessment

The unique role of risk assessment in the larger context of child protection is to classify families accurately into groups based on their likelihood of future maltreatment, thereby enabling agencies to decide which families to serve and monitor within the child protection system. This allows agencies to divert families with low probability of future maltreatment to other community providers and to target the most intensive services to the children and families most likely to experience maltreatment.

The benefit of applying actuarial technologies to risk assessment is that it promotes greater consistency and accuracy of these assessments and. hence, greater fairness to families (Rycus & Hughes, 2003). Because actuarial decision-making models use standardized statistical procedures to identify the specific criteria, and their combined effects, that have the greatest power to discriminate between groups of people regarding the future occurrence of a particular outcome, actuarial risk assessments typically have a higher degree of both reliability and validity than consensus-based or matrix tools (Baird & Wagner, 2000).

In contrast to safety assessment, for which research data are limited, a great deal is known about the efficacy of risk assessment, particularly actuarial risk assessment protocols. For example, in the past two decades, the Children's Research Center of the National Council on Crime and Delinquency has conducted 16 individual studies to develop and revalidate actuarial risk assessment tools for child welfare (Baird, 2004). Additional comprehensive validation studies of actuarial risk assessment instruments have been completed in California and New York (Johnson, 2004; Mitchell-Herzfeld & Ruppel, 2004). The data from these studies represent more than 38,000 families from 13 widely dispersed geographic areas. In most of these studies, samples were selected from cases that had been previously investigated for abuse and neglect, regardless of whether they had been substantiated. Follow-up periods ranged from 12 to 24 months. Six of these studies, including the two largest, were prospective validation studies. The availability of computerized databases has facilitated the use of very large samples in these studies, further strengthening confidence in the study conclusions.

When data from all these studies are combined, they demonstrate the effectiveness of actuarial risk assessment models in correctly estimating three different outcomes in child welfare populations: the likelihood of a future recurrence of child maltreatment, the likelihood of serious injury to a child, and the likelihood of out-of-home placement (Baird, 2004). This research has demonstrated that families rated at moderate risk are about twice as likely as low-risk families to maltreat their children; high-risk families are four times more likely to maltreat their children when compared with low risk families; and families rated very high risk are seven times as likely as low risk families to maltreat their children. The capacity of these instruments to discriminate among families on outcomes of child injury and out-of-home placement exceeds the level attained for general recurrence of child maltreatment (Baird, 2004).

Recent studies have also demonstrated that actuarial instruments used in child welfare are quite robust: they perform as well or nearly as well when applied to populations other than the sample population on which they were developed (i.e., the construction sample). Well-validated risk assessment instruments have also proved to be transferable among jurisdictions–actuarial risk assessments developed in Michigan and California have been found to provide valid estimates of risk in several other jurisdictions as well (Baird & Wagner, 2000).

Validity also appears to remain intact over time. The risk assessment instrument developed on a population randomly sampled from seven California counties in 1995 performed about as well on an investigation cohort of cases from 2001 (Wagner & Johnson, 2003). Similar instruments used in the field of corrections have been found to remain valid over a span of nearly three decades (Wagner, Quigley, & Ehrlich, 1998).

Still, continuing research, particularly revalidation research, can improve the validity of these instruments even further. In New York, a revalidation study led to revisions in the protocol that produced a higher level of discrimination than that produced by the 1997 study (Mitchell-Herzfeld & Ruppel, 2004).

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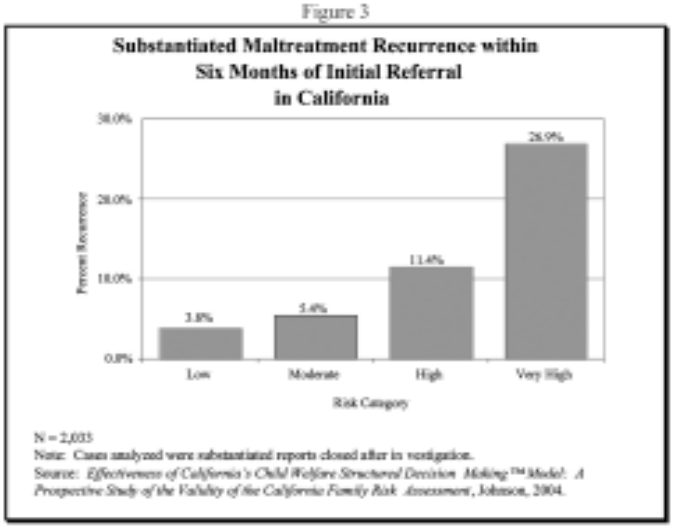
Risk Assessment and Federal Performance Outcomes

Under federal child safety outcome requirements, states are expected to reduce the rate of maltreatment recurrence to 6.1% or less at 6 months from the date of the initial substantiation, measured by numbers of newly substantiated reports. To comply with these standards, it would be helpful if states could identify families at the highest risk of maltreating a child within the 6-month time frame. The following graph (see Figure 3) illustrates that actuarial risk assessment provides such capability (Johnson, 2004).

Figure 3



Johnson (2004) found that families at the two lowest risk levels had recurrence rates below the 6.1% federal threshold, even without CPS intervention, while families ranked high and very high risk had recurrence rates that were substantially higher than 6.1%. Successful intervention with the higher risk families could, therefore, help agencies meet the federal standards. Such findings have profound implications for targeting services to higher-risk cases.

Promoting Equity in Risk Assessment

A frequently heard and sometimes legitimate criticism of risk assessment protocols is that they promote bias in child welfare decisions. Given the level of disproportionate representation of African American and other children of color in the nation's child welfare system, it is incumbent on agencies to ensure that their decision-making systems are free from ethnic and racial bias. Thus, all assessment protocols should be tested for equity.

Criteria developed by the American Educational Research Association can be used to judge the equity of assessment procedures. They suggest that equity is attained when

> Examinees of equal standing with respect to the construct the test is intended to measure should, on average, earn the same test score, irrespective of group membership. (American Psychological Association, American Educational Research Association, National Council on Measurements in Education, 1999, p. 17)

When applied to risk assessment, this means that maltreatment recurrence rates observed at each level of risk (very high, high, moderate, low) should be approximately the same for each racial and ethnic group served in the CPS population. Agencies must avoid situations in which, for example, African American families are rated to be high risk when they have recurrence rates similar to other racial groups who are rated as moderate risk. Such a circumstance can lead to differential treatment of groups whose actual probability of continued maltreatment is, in fact, essentially equal. Moreover, if recurrence rates are approximately equal across racial and ethnic groups, agencies should expect approximately equal proportions of each group to be classified in each risk level.

Because actuarial systems are based on research, it is easy to evaluate the equity of these protocols during their development. Unfortunately, few consensus-based systems have been tested for their capacity to assure equity. Wherever study sample size permits, all risk assessment models should be independently tested on each racial and ethnic group in the construction sample. This helps determine if there are significant differences among subgroups in recurrence rates at each risk level and also allows developers to make adjustments in the instrument's items, item weights, or cut-off scores to achieve equity. The level of equity actually attained by the instrument can then be validated using a prospective evaluation on a different data set. An example of this process being applied can be seen in California, where a comprehensive evaluation of that state's actuarial risk assessment concluded the following:

> Collectively, the findings reported here support two hypotheses: (1) That the California Family Risk Assessment (CFRA) is a fair and equitable means of assessing the likelihood of future maltreatment when used with major U.S. population subgroups—African Americans, Hispanics, and Whites, and (2) That use of the CFRA will reduce disproportionate representation of minorities including African Americans relative to Whites in the child welfare population. (Johnson, 2004, p. 44)

The state of Michigan also applied these equity measures to their actuarial risk assessment. Table 1 presents data illustrating that nearly equal proportions of African Americans and Whites are classified at each level of risk. Data presented in Table 2 more directly address the equity criterion listed above: There were no significant differences in subsequent rates of substantiation between African Americans and Whites at each risk level in Michigan (Baird & Wagner, 2004).

Table 1

Michigan Percentage of Families at Each Risk Level

Risk Level	Whites (N = 6,651)	African Americans (N = 5,296)
Low	10.5%	11.3%
Moderate	30.7%	30.0%
High	45.1%	46.0%
Very High	13.7%	12.7%

Source: Michigan Family Independence Agency, 2002.

Table 2

Michigan Substantiation Rates at 12 Months (by Race)
1995

Risk Level	African Americans	Whites
Low/Moderate*	6.0%	5.0%
High	15.0%	12.0%
Very High	28.0%	30.0%

* Because of the small number of cases rated low risk (when the sample is divided by race), the low- and moderate-risk categories have been combined.
Source: Michigan Family Independence Agency, 2002.

Safety Assessment and Risk Assessment: A Note of Caution

There are proponents who maintain that safety assessment is the "instrument of choice" in assuring child safety, even to the point of excluding risk assessment and other decision-making protocols. However, research has demonstrated that safety assessment technology is limited in its utility, and there is little evidence that safety assessments alone can effectively gauge the potential for harm over a more protracted future (Johnson, 2004; Baird, 2004). Data also indicate that even when the follow-up period is limited to 30 days, risk assessment actually outperforms safety assessment in identifying families most likely to maltreat their children (Baird, 2004). Thus, when safety assessment is used to identify more than imminent harm, it is venturing into an arena better left to risk assessment. With considerable available research demonstrating that actuarial risk assessment effectively identifies families where children are most at risk of future serious harm (and future placement), utilizing safety assessment beyond this limited purpose seems an unwise proposition. Still, safety assessment plays a vital part in CPS decision making, and when combined with response priority, risk assessment, family assessment for service planning, and reassessment protocols, it completes a comprehensive system that can help attain child safety at all decision points and contribute to preventing subsequent maltreatment of children.

Conclusions

Combining the basic tenets of decision theory with what is known about CPS assessments and child safety creates an excellent framework for case decision making. Assessing child safety throughout the life of a case is an iterative process. Decisions should be based on what information is essential at each decision point and what can be reliably gathered at that point. What can and should be considered when a referral is received is different from what can be assessed when a worker actually arrives on site. This, in turn, is far less than what is known at the end of an investigation and development of a social history. Each decision must be made in a manner to ensure that agencies use their resources most effectively to protect children. The key to improving child welfare is the development and use of a logical framework for decision making followed up with continuing research to validate and further refine the structure and tools that can best help us achieve our outcomes.

Utilizing decision theory and the existing safety and risk assessment research, we make the following recommendations to promote evidence-based decision making in child protective services:

1. Decision-making protocols should be as concise and easy to implement as possible.

2. Decision-making tools should include only those criteria that can be assessed with some degree of reliability and accuracy at the point in time each decision is made, and these criteria should relate specifically to the decision at hand.

3. Decision tools and their criteria should be clearly articulated to promote understanding not only by the staff who must use them, but also by the judiciary, other professional partnering organizations, and the community at large.

4. Decision-making tools should lead directly to presumptive decisions. This requires the structure of an additive index, a decision tree or, at a minimum, clearly delineated rules on the role of each factor in reaching each decision.

5. Decision tools, regardless of their type (i.e., research-based, consensus-based, or clinically-based) should be tested for reliability, equity, and efficacy. Evidence regarding the effectiveness of each decision tool should be routinely collected, analyzed, and reported back to staff and administrators.

6. Neither safety assessment nor risk assessment alone can provide sufficient information on which to make effective safety decisions for children throughout the life of the case. Both are essential components of a comprehensive decision-making system for child welfare.

7. Actuarial risk assessments do not have to be lengthy to be valid. Generally, accurate estimates of risk can be attained by combining ratings from 9 to 12 items, selected on the basis of research specifically designed for the purpose of instrument development.

8. Risk of abuse and neglect are best assessed separately. Although some measures of past behavior and some family characteristics relate to both types of maltreatment, there are also different family dynamics that relate to each.

9. Overrides to decision-making tools can be allowed, but the reasons for these should be clearly articulated and documented, approved by a supervisor, and monitored to determine their accuracy over the longer term.

10. Finally, the child protection field must recognize it is not enough to simply identify factors that have a demonstrated relationship to risk and allow these factors to be applied in different ways by different staff members at each decision point. A high level of *structure* is required to ensure that staff make consistent and appropriate decisions to expedite the safety and well-being of children.

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The Parenting Patterns of Men Who Batter

Lundy Bancroft
Jay G. Silverman, PhD

The lives of women and children can be torn apart by the violent and intimidating behavior of men who batter. Three million or more children are exposed to acts of domestic violence each year (Fantuzzo & Mohr, 1999). The great majority of children who live with a batterer see or hear one or more acts of violence (Kolbo, Blakely, & Engleman, 1996), and a substantial number witness sexual assaults against their mother (Wolak & Finkelhor, 1998). These children show higher rates of aggression and other behavioral and adjustment problems (Graham-Bermann, 1998), including hyperactivity, anxiety, withdrawal, and learning difficulties (Gleason, 1995).

However, efforts to intervene on behalf of children of battered women must be well considered and nuanced because actions by social workers and court personnel can have unintended and harmful consequences (Whitney & Davis, 1999). The need for increased sophistication in the professional response to children who witness battering has been underlined by recent federal and state court rulings in New York, which forbid child protective services to punish mothers for the behavior of their violent partners and which demand that social workers offer appropriate support and services to battered mothers (Kaufman, 2004).

One critical route to improved interventions is increased knowledge and training on the parenting dynamics of men who batter, including the profile and tactics of the perpetrators, their impact on the parenting of battered women, and the unhealthy family dynamics they can engender. This knowledge base needs also to include an understanding of how batterers create entrapment for battered women, and how batterers can sometimes continue to endanger children even in cases where the mother is fully cooperative and takes all the steps demanded of her by public institutions (Bancroft, 2004; Bancroft & Silverman, 2002).

One critical route to improved interventions is increased knowledge and training on the parenting dynamics of men who batter, including the profile and tactics of the perpetrators, their impact on the parenting of battered women, and the unhealthy family dynamics they can engender.

The Batterer Profile: Implications for Their Children

Prevalent attitudes and interpersonal dynamics of men who batter can have profound significance for their children's emotional experience, physical and sexual safety, and healthy development. Learning to recognize these dynamics and to assess their impact on family functioning can make the difference between a failed intervention and a successful one. Some typical characteristics of batterers include the following:

Control: Coerciveness is a primary characteristic of men who batter (Lloyd & Emery, 2000), and parenting is one sphere of the battered woman's life that is subject to heavy control by the batterer. The batterer may overrule her parenting decisions and may physically assault her if she does not cede to his directives regarding the children (Ptacek, 1999). It is not surprising that battered women are far more likely than other women to feel obligated to alter their parenting styles when their partners are present (Holden & Ritchie, 1991). Evaluators must be cautious when assessing the parenting of a battered mother, since she may be using a style imposed upon her by the batterer's violence and threats.

Entitlement: Batterers typically believe they are entitled to use violence toward female partners when they deem it necessary (Silverman & Williamson, 1997), and they tend to claim a superior status in this relationship, expecting catering and deference (Edleson & Tolman, 1992). The batterer may, for example, demand that the mother neglect the children's needs in order to focus on his, and he may treat the mother like a servant in front of the children, which can condition them to disrespect and defy her, resulting in her appearing to be an inept parent.

Manipulation: It is common for batterers to be manipulative of family members and of professionals, using such tactics as dishonesty, false promises, and creating divisiveness to increase power and to escape accountability (Bancroft & Silverman, 2002). Batterers also tend to project a public image of generosity and kindness in order to escape accountability (Bancroft, 2002). In this context, children may blame themselves or their mothers for the violence, and they may make contradictory or victim-blaming statements to professionals due to their confusion.

Possessiveness: It is common for men who batter to perceive their partners as owned objects (Bancroft, 2002), an outlook that often extends to their children. For example, batterers have been found to seek custody of their children after separation at higher rates than do nonbattering fathers (APA, 1996). Parents who perceive their children as possessions show increased rates of child abuse (Ayoub, Grace, Paradise, & Newberger, 1991), including incest perpetration (Hanson, Gizzarelli, & Scott, 1994).

Batterers and Child Abuse

Various published studies of physical abuse of children by batterers indicate that roughly half of batterers repeatedly assault children in the home, a rate about 700% that of nonbattering men (e.g., Straus, 1990; Suh & Abel, 1990). A substantial body of research finds batterers to be four to six times more likely than other men to sexually abuse children. Exposure to domestic violence is one of the top risk factors for incest victimization (e.g., McCloskey, Figueredo, & Koss, 1995; Paveza, 1988; Sirles & Franke, 1989). The literature on incest perpetrators describes a profile that is consistent with the profile of batterers including the following: the need for high levels

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of control, feelings of entitlement, manipulativeness, cultivation of a positive public image, and a tendency to view children as owned objects (e.g., Leberg, 1997; Salter, 1995). Batterers tend to use authoritarian and verbally abusive approaches to child rearing and, at the same time, to be neglectful and irresponsible parents (Margolin, John, Ghosh, & Gordis, 1996). Therefore, any time professionals become aware that children in a home are being abused or neglected, an assessment should be made for the possibility that their mother is also being battered by her partner.

The Batterer as a Role Model

Boys who are exposed to domestic violence show dramatically elevated rates of battering their own partners as adolescents or adults (Silverman & Williamson, 1997). Research suggests that this connection is a product of the values and attitudes that boys learn from witnessing battering behavior (Markowitz, 2001; Silverman & Williamson, 1997). Daughters of battered women show increased difficulty in escaping partner abuse in their adult relationships (Doyne et al., 1999). Both boys and girls have been observed to adopt various aspects of the batterer's belief-system (Hurley & Jaffe, 1990), including the view that victims of violence are to blame, that males are superior to females, and that the use of violence against women by men is justifiable (Bancroft & Silverman, 2002). Unfortunately, the batterer's influence as a role model is rarely taken into account in professional interventions, particularly those affecting custody and visitation plans.

Impact on Family Dynamics

A batterer's actions provide a model of aggressive behavior and contempt for women that can contribute to increased rates of violence in children and disobedience toward their mothers (Jaffe & Geffner, 1998). These destructive behaviors by children are aggravated in many cases by the batterer's deliberate weakening of the mother's ability to set limits (Bancroft & Silverman, 2002), which may be accompanied by violence toward her regarding issues about the children (Ptacek, 1999).

Many other commonly observed behaviors in batterers can distort family functioning. Examples include the following:

Undermining the mother's authority: Domestic violence inherently undermines maternal authority because the batterer's conduct demonstrates to children that verbal abuse, disrespect, and ignoring the mother's wishes are appropriate behaviors. In addition, a substantial portion of men who batter deliberately undercut the mother's position by overruling her, engaging the children in activities that she forbids, and rewarding the children for defying their mother. These tactics may become more pronounced in the postseparation context, as the abuser feels his power over the woman slipping and seeks to regain it (Bancroft & Silverman, 2002).

Interfering with the mother's parenting*:* Many battered women report being prevented by their partners from picking up a crying infant, assisting a frightened or injured child, feeding children when they are hungry, or taking children to medical appointments (Bancroft & Silverman, 2002). The trauma the mother experiences as a result of domestic violence can also make it more difficult for her to be fully attentive to her children (Levendosky & Graham-Bermann, 2000).

Creating divisions within the family: Batterers commonly use favoritism in their parenting. The favored child is likely to be a boy, and the batterer may bond with him partly through encouraging a sense of superiority to females (Johnston & Campbell, 1993). Batterers may also sow divisions through the deliberate creation or support of familial tensions. High rates of intersibling conflict and violence are present in families where battering of the mother occurs (Hurley & Jaffe, 1990). We have also observed that some batterers try to drive children away from their mothers by shaming them for being close to her.

Use of the children as weapons: Many batterers use children as a vehicle to harm or control the mother (Erickson & Henderson, 1998) through such tactics as destroying the children's belongings to punish the mother, requiring the children to report on their mother's activities, or threatening to kidnap or take custody of the children. During postseparation, many batterers use unsupervised visitation as an opportunity to abuse the mother through the children by alienating them from the mother, encouraging them to behave in destructive or defiant ways when they return home, or by returning them dirty, unfed, or sleep-deprived (Bancroft & Silverman, 2002).

A mother may be assaulted or intimidated if she attempts to prevent the batterer from mistreating the children, or she may find that he retaliates by harming them even more severely (Bancroft & Silverman, 2002).

Retaliation for the mother's efforts to protect the children: A mother may be assaulted or intimidated if she attempts to prevent the batterer from mistreating the children, or she may find that he retaliates by harming them even more severely (Bancroft & Silverman, 2002). Cruelty or intimidation of this kind can force a mother to stop intervening on her children's behalf, which can result in her appearing to be an irresponsible parent.

These various forms of disruption to family functioning need to be taken into account in assessing the parenting of a battered mother, as she may appear to have poorer parenting abilities than she actually does. The repressive and controlling environment may prevent her from demonstrating her parenting strengths and can concurrently weaken her relationships with her children.

Postseparation Implications

Child protective services personnel sometimes believe that children's interests and safety are best promoted by pressuring mothers to leave their battering partners. Yet, batterers are at their greatest risk of committing homicide during and after the break-up of the relationship with the mother (Websdale, 1999). There are many other ways in which the behavior of batterers creates worse rather than better conditions after separation, through stalking the family, kidnapping children, exposing the children to severe assaults against the mother, causing homelessness, or obtaining unsupervised contact with the children through a family court order (Bancroft, 2004).

It is therefore essential for professionals to strategize for long-term empowerment and safety for families, rather than to seek simple solutions, which may actually increase the danger to the children.

Professionals involved with custody and visitation determinations need to be aware of the destructive parenting behaviors exhibited by many batterers and the ways in which many batterers use custody litigation as a form of ongoing abuse of mothers and children (APA, 1996; Bancroft & Silverman, 2002). Batterers commonly use their postseparation contact with children to damage mother-child and sibling relationships, yet those relationships have been found to be critical to children's healing from exposure to battering (Heller, Larrieu, D'Imperio, & Boris, 1998; Graham-Bermann, 1998). Children's level of attachment to their battering fathers may be due at least in part to traumatic bonding (see James, 1994). Some factors that can help identify a batterer who may be a high risk to children during visitation include a history of using the children as a weapon against the mother, the batterer's belief that his children are his personal possessions, his excessive control and feelings of entitlement, his history of boundary violations toward the children, and the escalation of his violence or cruelty toward the mother. Common errors in custody visitation assessment include dismissing domestic violence allegations without proper investigation, or inappropriately attributing children's anxieties about visitation to their mother's influence.

Children's safety and healing postseparation can be fostered by expanding the use of professionally supervised visitation, keeping any unsupervised visits relatively short in duration, and in most cases, avoiding the use of overnight stays. Additionally, family courts should increase their use of state-certified batterer intervention programs as a condition of visitation for men who batter, given recent research showing that such programs are more effective than was previously believed (Gondolf, 2001).

Conclusion

Children who are exposed to domestic violence may experience multiple types of emotional and physical injury as a result of the batterer's behavior, well beyond the trauma from simply witnessing assaults on the mother. Further, an abused mother faces many obstacles in attempting to protect her children from a batterer. Professionals can increase the quality of their interventions on behalf of children by deepening their understanding of the common patterns of parenting of men who batter, including ways in which a batterer may damage mother-child and sibling relationships and make it difficult for a mother to parent her children. A focus on fostering maternal and child safety, and on empowerment of the battered mother, shows the most promise for positive results in the long term (Bancroft, 2004; Whitney & Davis, 1999).

NOTE:
A detailed guide to performing custody and visitation evaluations in the context of domestic violence allegations can be found in *The Batterer as Parent* by Lundy Bancroft and Jay G. Silverman, published by Sage in 2002. This article is a synopsis of this book, which was a winner of the 2004 Pro Humanitate Literary Award.

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An Assessment of the Privatization of Child Welfare Services

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Public child welfare agencies are increasingly contracting with agencies in the private sector to provide a variety of services to children that were previously provided almost exclusively by public agencies. Based on the assumption that market competition produces greater economy and effectiveness, privatization has been embraced as a strategy for providing higher quality services at a lower cost. Although the history of privatization is more extensive in the areas of child support enforcement and the administration of welfare benefits, the privatization of child welfare services in Kansas in 1996 ushered in an era of heightened interest in privatizing family preservation, foster care, and adoption services. In the past, noncompetitive quasi-grant arrangements typified the relationships between public and not-for-profit agencies. Now, public human service responsibilities are increasingly being privatized through a variety of contractual arrangements that place considerable program responsibility with private agencies in both the not-for-profit and the for-profit sectors. Practice, policy, and fiscal considerations have together set the stage for the increase of privatization in human services, including child welfare. The benefit of privatizing child welfare services continues to be debated, however.

The principal arguments for and against privatizing child welfare services have centered on the extent to which such efforts result in higher quality of services, greater efficiency, and cost savings. Proponents of privatization embrace a market economy rationale, arguing that privatization results in significant cost savings while, concurrently, maximizing efficiency. Opponents of privatization contend that the private sector is not as economical as might be assumed. They argue that the competitive marketplaces that exist in other service areas do not typically exist in the social service environment, and as a result, privatization may not work. Additionally, they cite both the initial cost investments private entities must make to offer services already offered by public agencies, as well as the new costs generated by privatization itself. Opponents also question whether state and local governments have either the resources or the expertise to design, implement, and oversee privatization efforts.

A Survey of Privatization Efforts

These arguments not withstanding, there has been a clear trend toward the privatization of child welfare services since the mid-1990s. The Cornell University Department of City and Regional Planning has noted, for example, that "although empirical studies do not provide clear evidence on the costs and benefits of privatization, public perception and pressure for improved government efficiency will keep privatization on the government agenda" (Cornell University, 2000.)

Our case study on privatization examined the privatization of child welfare services taking place in six communities. The initiatives studied were as follows:

(1) Kansas: The statewide privatization of family preservation, foster care, and adoption services by the Kansas Department of Social and Rehabilitative Services. This effort was initiated by the governor of the state and was quickly implemented through contracts with private agencies through a statewide contract for adoption services and by regional contracts with a number of providers for family preservation and foster care services.

(2) Florida: The statewide privatization of child welfare and related services, with the exception of protective service investigations, through an effort called "Community-Based Care." This case study focused on the privatization of child welfare service in Sarasota County, the site of the longest-standing privatization effort in the state.

(3) Missouri: A privatization effort, entitled The Interdepartmental Initiative for Children With Severe Needs and Their Families, a collaborative effort between the State Departments of Social Services and Mental Health. The initiative focused on serving children and youth with severe emotional disturbance.

(4) Hamilton County, Ohio: A county-based privatization effort, entitled Creative Connections, involving child welfare, mental health, substance abuse, mental retardation, developmental disabilities, the juvenile court, and a private not-for-profit lead agency. The initiative was designed to provide services for children and youth with multisystem needs.

(5) Michigan: A pilot privatization effort, called the Foster Care Permanency Initiative, based in Wayne County, including Detroit, which was designed to promote more timely achievement of permanency for more children in the foster care system.

(6) Maine: A statewide privatization initiative, entitled the Community Intervention Program, which provided assessment and intervention services to families at low to moderate risk of child abuse and neglect.

Because of space limitations, two of these efforts are briefly summarized here to illustrate some of the directions taken in the course of child welfare privatization. They include the initiatives implemented in Missouri and Hamilton County, Ohio.

Missouri: The Interdepartmental Initiative for Children With Severe Needs and Their Families

This initiative, still in operation in 2004, was developed through a collaboration of the Missouri Department of Social Services and the Missouri Department of Mental Health in an effort to develop services for children with serious emotional disturbances and their families. It was designed so families could access these services without having to meet categorized program eligibility requirements. The resources of the two state departments were combined to create programs designed to reduce the number of children in residential care by making it possible for these children to be moved into community-based settings. The two departments entered into a contract with the Missouri Alliance for Children, a newly established for-profit entity formed by the owners and chief executives of major social services agencies in the state. Among the key fea-

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tures of this initiative were the following:

- a lead agency model
- a case rate fiscal methodology based on data related to historical expenditures for children in residential care
- a plan to provide a full array of services for children
- locally organized systems of services and supports
- penalties and incentive payments related to the stability of children's placements after their discharge from the program
- initially, an intermediary that served as monitor of the lead agency's performance and assessed outcomes
- outcomes that focused on moving children to community-based care and sustaining those care arrangements

Hamilton County, Ohio: Creative Connections

This initiative originally targeted children with multisystem needs and included a service cap of 286 children at any time. The initiative was the product of intersystem collaboration and pooled funding by five county agencies: child welfare, the juvenile court, the mental health board, the alcohol and drug addiction services board, and the mental retardation/developmental disabilities board. The lead agency, Beech Acres, a private child welfare agency in Cincinnati, assumed responsibility for developing and managing a range of services to meet the needs of children enrolled in the initiative. Each of the five participating county agencies was assigned a designated number of slots and was permitted to develop the criteria for referral for children served in its system. Among the key features of this initiative were the following:

- a lead agency model
- an extensive provider network with a focus on expanding local services
- clearly defined outcomes with documentation of improved quality of care
- a case rate that was significantly subsidized by Beech Acres' endowment
- an intermediary between the lead agency and the public agencies, which was assigned responsibility for program evaluation

This initiative was redesigned and considerably revised in 2003, and a new contractor assumed responsibility for the initiative. The multisystem coordination and pooled funding arrangements continue.

Lessons Learned

The experiences of the six jurisdictions studied provide data from which to draw some initial conclusions about current privatization efforts in child welfare. While it cannot be said that these six jurisdictions are representative of all privatization efforts, they did demonstrate sufficient similarity to allow certain observations to be made. The following discussion synthesizes some of the major findings from this study.

1. Neither cost savings nor greater efficiency was a common outcome of these privatization efforts.
The experiences of the jurisdictions examined in this study suggested that communities embarking on privatization initiatives should not expect to save money, and while they may reasonably anticipate some improvements in efficiency, they generally should not expect dramatic gains. In fact, none of the studied jurisdictions saved money, and there were significant concerns in all jurisdictions about the efficiency of the newly designed systems.

2. The privatization initiatives struggled to develop and measure appropriate outcomes, indicators, and benchmarks that would allow an objective evaluation of actual performance.
Although there were exceptions, this study found that many of the initiatives struggled to articulate desired outcomes and to develop appropriate, data-based performance targets. Several problems were noted with regard to outcomes, although these problems varied from one jurisdiction to another. They included poorly defined outcomes, more identified outcomes than could possibly be monitored or measured, and variability in the outcomes used to assess performance. Even when outcomes were well developed and based on clearly defined concepts, difficulties in articulating appropriate performance targets were common. Although there was a recognition that benchmarks should be developed based on historical data and/or the experiences of comparable communities, this was most often not done.

3. Personal commitment and leadership are vital to ensuring that privatization efforts are developed and sustained.
One theme identified across all the initiatives was that the overall success of a privatization initiative was associated with the presence of strong leadership; management strategies that promoted collaboration and brought all stakeholders together; long-term commitment to the initiative; and, strong positive interpersonal relationships among public and private agency representatives as well as between agency representatives and community leaders. To the extent that the studied jurisdictions exhibited these qualities, their efforts appeared to be more effective. Nonetheless, it was common to find frequent changes in leadership and strained relationships between public and private agency representatives.

4. The roles and responsibilities of the public and private agencies must be clearly defined.
A common theme was the importance of clearly delineated roles and responsibilities between the public and private agencies, and of other players who had key roles in the initiative. Clarification of roles and responsibilities supported greater efficiency and also provided a framework for implementing and assessing the impact of the effort. Most of the studied jurisdictions, however, failed to clearly articulate roles and responsibilities, particularly for the public agencies involved in these efforts. This may not be entirely because of lack of effort or a lack of recognition of the need for such clarity. This may be because privatization of public responsibilities inherently compromises clarity of relations. Public agencies cannot give away protective responsibility though they can delegate protective function. Under such circumstances, assignment of responsibility is intrinsically difficult.

5. Attention must be given to building and funding the necessary infrastructure for any privatization effort.
The need for a well-developed infrastructure was repeatedly emphasized by individuals involved in the privatization initiatives. Such an infrastructure included a mutually shared vision for the initiative, an adequate management and staffing structure, adequate financial support during the start-up period, and strong connections with the community. Most jurisdictions, however, were unable to report full success in their efforts to develop such a supportive infrastructure for their privatization initiatives.

6. A "go slow" approach to privatization is more realistic than an "overnight" redesign of systems.
Although comprehensive planning and piloting were not used in every jurisdiction studied, to the extent that such efforts were made, they appeared to be associated with positive results. Similarly, phasing-in services as opposed to attempting to implement a comprehensive redesign was found to provide the time and pace needed to most effectively implement significant changes in service philosophy, financing, and delivery.

7. Information systems that provide relevant data are critical to effective privatization of human services.
Access to certain information was critical for determining costs and setting pricing and for developing performance-based standards. It was widely agreed that adequate data systems were essential to support the tracking of outcomes for individual children and families and to allow the aggregation of data. Most jurisdictions studied had struggled to develop adequate information systems.

8. The extent to which privatization is a viable approach depends to a large degree on service capacity.
In many of the initiatives studied, assumptions had been made about the power of new fiscal methodologies to change systems, without considering the critical role that service capacity plays in the change process. The experiences of these communities indicate that although adjusting fiscal incentives and penalties may improve certain aspects of service delivery systems, the system changes envisioned by privatization efforts cannot be made in the absence of sufficient resources to ensure development of a strong and comprehensive service capacity.

9. Monitoring tends to be overdone or underdone in many privatization initiatives.
Monitoring the performance of privatization initiatives is critical but complex. Problems often arose due to staff shortages in the government agencies responsible for monitoring, and lack of staff expertise in managing contracts and conducting audits. These issues led to inadequate monitoring in some communities. Conversely, in other communities, private agencies were so extensively and frequently monitored that considerable energy and resources had to be diverted from service delivery. Several of the communities that had initially delegated monitoring responsibility to a third party contractor subsequently reassumed this responsibility because of concerns about the effectiveness and appropriateness of delegating such an important responsibility.

10. The financial aspects of privatization are among the thorniest issues confronting privatization efforts.
The fiscal arrangements in privatization initiatives are frequently highlighted as their most innovative features. Nonetheless, the financing structure in the studied initiatives—particularly in the context of risk-sharing arrangements—presented significant challenges. Finding the "right" fiscal methodology often proved elusive. These initiatives also struggled to develop and implement mechanisms to address the potential impact of risk sharing on private agencies. Public and private contractors found it difficult to estimate both the frequency and the severity of risk variables. Without statistically valid fiscal contracting parameters, risk agreements could quickly become fiscal disasters for one party or the other. Equity in contracting proved elusive, with either public dollars being lost or private contractors finding themselves with devastating financial losses.

Recommendations

Based on the foregoing, a number of recommendations are suggested in an effort to assist communities considering privatization efforts. They include the following:

(1) When considering privatization, a community should carefully delineate the specific goals of the privatization effort and, based on those goals, clearly specify the population to be served and the privatization model to be used. If a lead agency model is selected, the types of agencies eligible to serve as lead agency should be delineated.

(2) Public agencies should not expect to save money through privatization, given the real costs of developing, implementing, and overseeing a privatization initiative and the costs associated with providing a full array of high-quality services to children and families. If a service delivery system is significantly underfunded, undertrained, and lacking in supportive resources, some small gains in efficacy through privatization should not be expected to resolve these problems. In fact, our survey found that with privatization, the contracted agencies were soon voicing the same historical concerns of public social services, i.e., lack of fiscal and supportive resources. Private agencies, however, should expect that public agencies would attempt to control costs by shifting the risk of financial loss to the private agency. For many private agencies, this has proven a Faustian bargain, as the burden of unforeseen costs and complications has proved to be unsustainable.

(3) Absent significant attention to the factors that undermine efficiency in the public sector, all parties should recognize that greater efficiency will not be achieved simply because a private agency has assumed primary responsibility for service provision.

(4) Outcomes and their associated performance targets should be few in number, should be articulated in straightforward and clearly understandable terms, and should be developed during the initial implementation stage of the privatization initiative, based on baseline preprivatization data. Fiscal incentives should be tied to a limited number of key program outcomes.

(5) Communities should recognize that privatization efforts require the commitment of high-level leadership over the long term and will require concerted efforts to develop and sustain strong interpersonal relationships among staff in public and private agencies. Absent these factors, it is unlikely that a privatization initiative can be successfully implemented or sustained. Communities should also recognize that strong, committed, and charismatic leadership could sustain problematic programs for the short run. Therefore, ultimately, program success or failure should be assessed based upon empirical data.

(6) Attention should be given to carefully delineating the roles and responsibilities of both the public agency and the private agency in a privatization initiative. This may be the most difficult task of all, as privatization efforts in child welfare can be viewed as an experiment to identify what functions, responsibilities, and activities can be most appropriately delegated to private contractors. At the very least, by clearly delineating roles and responsibilities, the field will be better able to assess both its failures and successes at this task.

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(7) A strong infrastructure, characterized by a shared vision for the initiative, an adequate management and staffing structure, financial support for start up, and strong connections with the community should be addressed early in the implementation of any privatization initiative.

(8) A "phased in" approach, in which privatization is implemented through broad-based community planning, pilot projects, and transitional contracts, will increase the likelihood of successful implementation.

(9) An assessment of existing service capacity should be a central focus in the planning and implementation of any privatization effort. The current service system and its resources should be realistically evaluated in light of clients' needs. Private agencies should receive the necessary support to develop adequate service capacity, including establishing linkages with other services systems. Service capacity should be assessed on an ongoing basis by both the public and private agencies to ensure responsiveness to changing client needs.

(10) Information management systems must have the capacity to provide data on costs, services, and outcomes at both the individual and aggregate levels. These should be developed and implemented as early and quickly as possible.

(11) Because public agencies must remain accountable when services are privatized, they should develop strong monitoring capabilities to ensure effective government oversight and contract compliance. Private agencies must be held accountable for both achievement of program outcomes and compliance with standards of quality for services. However, monitoring systems must be efficiently implemented to prevent the unnecessary overexpenditure of time and resources in monitoring activities.

(12) The funding for any privatization initiative must be at sufficient levels to achieve program outcomes. Privatization cannot be viewed as a way to provide high quality services at little cost. Reimbursement rates and schedules must be fair and equitable.

(13) At-risk contracting, which places private agencies at financial risk when the cost of services exceeds predetermined rates or payment levels, should be viewed with considerable caution. Given the current state of knowledge regarding risk shifting in privatization contracts, it is premature to utilize at-risk and/or performance-based contracting, such as case rates, capitated payments, or global budgeting. If such approaches are used, they should be subject to ongoing assessment based on the establishment of baseline costs and the assessment of outcome data and should be viewed only as "working hypotheses."

(14) When at-risk contracting is used, there should be viable protections for private agencies against excessive levels of financial loss precipitated by factors beyond private agency control. Mechanisms such as stop-loss provisions and risk pools should be carefully developed and fully implemented.

Conclusion

Privatization of child welfare services has been pursued in a variety of ways. Some of these efforts have been successful. Some jurisdictions have contributed very creatively to privatization efforts and have invested considerable resources to make these efforts powerful and valuable experiments. Some very good private agencies have provided strong and committed effort. However, in important ways, many efforts have also experienced substantial challenges that they have been unable to overcome, sometimes blocking the achievement of intended outcomes. Financial methodologies have been frequently unworkable and sometimes disastrous. Monitoring and evaluation have posed significant difficulties, both for private agencies expected to monitor and report on their achievement of program outcomes and for the public agencies attempting to undertake new monitoring and quality assurance roles. Developing and meeting outcomes and performance measures have proved to be major hurdles for most of the programs. The desired results were often not clear, and the performance targets frequently were unspecified or were developed in the absence of validating data. These barriers have made it difficult to fully evaluate the success of privatization efforts. It is clear that privatization cannot succeed by simply transferring to private agencies the problems and constraints that have characterized public agencies' service provision to children and families. Adequate support for services in the form of financial and human resources and a genuine commitment to improving outcomes are essential to any successful effort to improve the quality of child welfare services, regardless of whether the agency providing the service is a public or a private agency.

NOTE

A detailed account of this study, including supporting data, is available in *An Assessment of the Privatization of Children Services* by Madelyn Freundlich and Sarah Gerstenzang, Child Welfare League of America (2003). This article is a synopsis of the book, which was a 2004 Pro Humanitate Book Award winner.

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At Issue...

With this issue of the *Advisor*, we begin a new section, "At Issue..." Within this new venue we will attempt to identify important and timely issues and dilemmas in the field of child welfare. Between staff editorials and invited essays, our goal is to shine light on some of the problematic practice issues in child welfare in an effort to stimulate thought and discussion, and more pragmatically, to generate future articles for the *Advisor*. In this first issue, I discuss a recent experience with "evidence-based practice" that demonstrates some of the problems the child welfare field may encounter in its move toward a more empirical practice base.

I was recently involved with a state department of children's services in its effort to decide between two practice models, both of which had strong and persistent champions. A lot was at stake for this state department. As is true for many states, this state's practice models and policies would become embedded in its nascent SACWIS system—difficult to develop and even more difficult to change. So it was important to get it right the first time. Considerable time and money were to be invested. Most important, the integrity of the state's child welfare practice was hanging in the balance. The stakes were also high for the models' developers, as the contracts were long-term and had considerable remuneration.

Nowhere within social work are there calls *not* to use research in practice. Social work ethics require it. At issue... is what research should be used and how it can best be used to improve policy and practice.

To the credit of state department staff and their county colleagues, they all wanted to do the right thing. Most wanted the model with the best empirical credentials, the model that would promote best practice and the best outcomes for abused and neglected children and their families. State and county staff further recognized they needed help to make this decision. They did their homework and were able to identify a research organization with good credentials that professed a mission of helping states become more evidence-based in their child welfare practice. The state engaged this organization to do an independent evaluation of the two models and to determine which model was best supported by empirical research.

Herein begins the cautionary tale. This organization, with good credentials, personable staff, and recognized expertise, failed to disclose a long and lucrative professional relationship with a developer of one of the models. And, unfortunately, their recommendation was to adopt this model in spite of clear empirical evidence that the other model had, by far, the more substantial evidence base. The good news here is, the bias and lack of disclosure became evident. The bad news is, the state did everything right to adopt an evidence-based approach to child welfare practice and narrowly averted disaster.

Evidence-based practice originated in Toronto in the early 1990s at the McMaster University Medical School (Gilgun, 2005). By definition, evidence-based practice involves "the conscientious, explicit, and judicious application of best research evidence to" practice (Gilgun, 2005, p. 52). In the United States, evidence-based practice in social work is in its early stages, although its possibilities for improving practice have been clearly articulated (Gambrill, 1999, 2001). Nowhere within social work are there calls *not* to use research in practice. Social work ethics require it. At issue... is what research should be used and how it can best be used to improve policy and practice. There is much discussion within the profession regarding what constitutes evidence, and to what degree empirical evidence should displace other ways of knowing. Additionally, there is growing recognition of major obstacles to implementing evidence-based practice. These obstacles include the lack of relevant, high-quality research, the challenge of locating existing research, the challenge of translating research into practice, a lack of capacity or commitment of practitioners to apply research findings, and the existence of political and systemic barriers to using research findings.

In spite of these obstacles, with the support and encouragement of federal legislation, states are attempting to more systematically use empirical research to improve child welfare practice. Two strategies are being simultaneously applied. The first strategy is to turn social workers into scientists. The goal is to develop a critical mass of practitioners with the ability and commitment to locate, evaluate, and apply research to practice decisions and activities. Some say this is a daunting, even undesirable task. Critics contend it may be impossible because it asks too much of both social work educators and direct service practitioners. They also question the practical utility of applying available research to the complex realities of direct practice. They point out that in medicine, a profession with a stronger academic emphasis on research and statistics and a 15-year head start in evidence-based practice, many physicians cannot, or do not, use easily accessible evidence (Estabrooks, 2001.)

In social work, as in medicine, it is the front-line practitioners who voice these concerns most loudly. And it is these same "field ops" within social work who have begun to promote the second strategy for adopting and applying evidence-based practice: using the "Definitive Resource" to help make evidence-based practice and policy decisions. Research evidence can be contradictory, inconclusive, controversial, difficult to access, difficult to apply (Godlee, 1998; McAlister, Straus, Guyatt, & Haynes, 2000; Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000; Straus & McAlister, 2000; Gilgun, 2005) and politically discounted. Claims about the efficacy and relative merits of different assessment and treatment models can be especially confusing. Even with the unsettling experiences of some states in seeking honest brokers of knowledge and expertise, many state departments and local agencies with responsibility for child protection strongly support the development of local mechanisms, such as academic collaboratives, to serve as advisors and arbiters to promote evidence-based practice and policy decisions. They see it as a means of avoiding some of the significant

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problems associated with the first strategy of bringing all practitioners up to speed, a strategy they don't see happening any time soon.

In support of the first strategy, medicine has excelled. The medical profession has institutionalized many resources to support physicians in scientific practice, including journals and online resources, practice guidelines, research resources, and bibliographies (Bigby, 1998; Guyatt, Haynes, Jaeschke, Cook, Green, & Naylor, 2000; Slawson, Shaughnessy & Barry, 2001; Gilgun, 2005). Supporting technologies have also been developed, including large searchable databases, flow charts, decision trees, actuarial assessment tools, and systems for classifying and weighing evidence (Gilgun, 2004; Baird, 2004; Gambrill & Shlonsky, 2000). The Cochrane Collaboration has been established to provide systematic reviews of randomized controlled trials, the gold standard of evidence-based practice. Social work can and should look at medicine's efforts to support evidence-based practice as it pursues its own strategies to achieve similar ends.

However, with regard to the second strategy, establishing "Definitive Resources," social work may be unique in developing formal authorities to serve as ongoing advisors and arbiters of evidence-based practice and policy. Academic collaboratives are being developed by many states to help meet federal child welfare reform requirements and to support other evidence-based initiatives. It remains to be seen whether this new collaborative strategy between practice and academia will ever be fully implemented, tested, and vetted. In spite of the disappointment with my first encounter with one such "definitive resource," I would like to see whether well-fashioned and well-run academic collaboratives can provide fair and helpful resources for state and county agencies seeking help to make sense of research "evidence." This could become an important first step in social work's efforts to adopt evidence-based practice, as it moves along the more protracted road of identifying the parameters of evidence-based practice and improving the capacity of social workers to utilize empirical evidence to improve their practice.

In the near future, the *Advisor* will be publishing invited articles on evidence-based practice in child welfare, including a description of the work of the Social Welfare Initiatives of the Campbell Collaboration, a research organization designed to promote and disseminate systematic reviews of empirical research in the social welfare field. Modeled after medicine's Cochrane Collaboration, the Campbell Collaboration includes a focus on child welfare services. We will also publish a special edition of the *Advisor* that looks specifically at why social workers often do not use empirical evidence to support their practice, even when it is available. Authors are invited to contact me with relevant ideas or manuscripts.

Ronald C. Hughes, PhD, MScSA
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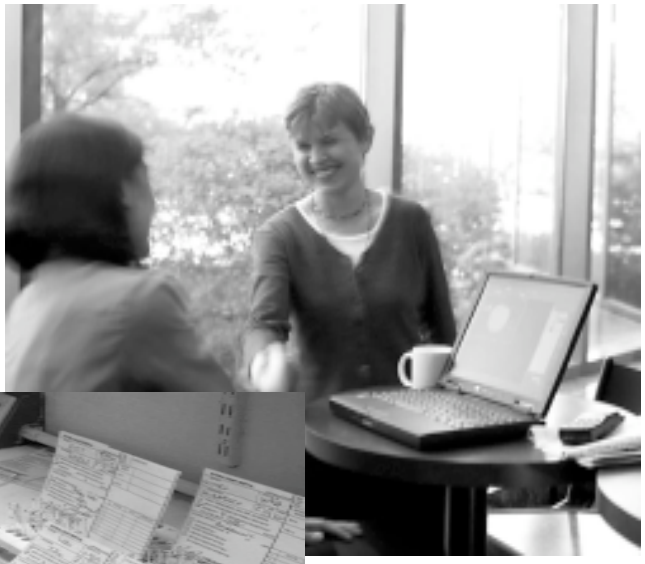

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A NEW LOCATION FOR THE APSAC OFFICE

APSAC has moved its operations from Oklahoma City to Charleston, South Carolina. This move has recentralized all functions (membership, publications, and training) in one location to facilitate providing the best services possible to all APSAC members. The APSAC staff in Charleston is supported by the new Operations Manager, Daphne Wright. The new contact information for membership, chapter services, training opportunities, publication orders, and general information is as follows:

PO Box 30669, Charleston, SC 29417
Phone: 843-764-2905 or Toll Free: 877-402-7722
Fax: 803-753-9823
E-mail: apsac@comcast.net or daphnewright@comcast.net

Thanks to Tricia Gardner and John Madden in Oklahoma City, the transition to Charleston was a smooth one. The Charleston staff asks for your patience and support as they strive to provide APSAC members with exemplary services. The staff values your membership and honors the work that all members do in the field of child maltreatment.

THE APSAC WEB SITE IN TRANSITION

The web site has been a challenge for both members and staff, but major improvements are underway. The University of South Florida (USF) is designing a completely new Website. The first phase will provide members with a more user-friendly environment, enable staff to update information in a timely manner, and offer online purchases and registrations. This phase should be functional by the time you are reading this issue of the *Advisor.* The Web address is www.apsac.org.

USF is building the basic technology with the idea of adding more features in the future. The projected phase two will allow APSAC to offer online training and CEUs to its members.

WELCOME BACK TO FORMER MEMBERS

An impressive number of previous members who were not members in 2004 are renewing their memberships for 2005. This is proof, we believe, that professionals in the field of child maltreatment understand the value of belonging to APSAC. Calls regarding reenergizing existing chapters and inquiries about starting new chapters are on the rise as well.

PUBLICATION PRICE CHANGES

Due to rising costs, there has been a slight increase in prices of the APSAC sponsored publications published by Sage Publications. An order form reflecting the current prices for all APSAC publications is included in this issue of the *Advisor*. Please direct your orders to the Charleston office.

Sage Publications is working with APSAC to improve online access to *Child Maltreatment*. By now, paying members should have received a customer ID which will provide access to the journal. If you have not received an ID, please call APSAC for assistance.

BACK TO EXCITING NEW ORLEANS FOR COLLOQUIUM 2005

APSAC's 13th Annual Colloquium will be held at the Sheraton Hotel in New Orleans, Louisiana, on June 15-18, 2005. The Sheraton New Orleans was the site of the 2002 Colloquium, one of the best attended and most successful of the annual meetings. An announcement is included in this issue of the *Advisor*.

The Sheraton New Orleans

SAVE THE DATE

The next APSAC Child Forensic Interview Clinic will be held in Seattle, Washington, on April 25-29. The clinic is focused on the needs of professionals responsible for conducting investigative interviews with children in suspected abuse cases. It offers a unique opportunity to participate in an intensive forty-hour training experience and have personal interaction with leading experts in the field of child forensic interviewing.

The training includes an interview practicum component providing an opportunity to conduct interviews where constructive feedback is utilized to build and improve professional skills. This includes videotaped trainee interviews with actors utilizing real case role-plays. There is also mock court testimony regarding interviewing with attorneys who specialize in child abuse cases, as well as didactic presentations and skill-based exercises led by nationally recognized experts.

Registration is limited, so contact APSAC soon.

PLAN NOW TO ATTEND

APSAC

American Professional Society on the Abuse of Children

13th Annual Colloquium

June 15 – 18, 2005

Colleagues Connecting for Kids

- **Intensive, interdisciplinary, skills-based training seminars on all aspects of child maltreatment**
- **Field-generated skills training, research papers, poster presentations, and symposia**
- **Networking opportunities with other professionals and APSAC members in your discipline & state**
- ***A faculty of internationally recognized experts***

APSAC's Annual Colloquium is a major source of information and research necessary for interdisciplinary professionals in the field of child abuse and neglect

Learn...

In paper presentations, poster sessions, and research symposia, the most up-to-date and relevant research and practice information is discussed

Network...

The Colloquium is where interdisciplinary members and other leaders in the field of child maltreatment join forces to advance best practice

APSAC: HELP CONTINUE THE MISSION

Almost two decades ago, a number of colleagues—social workers, psychologists, attorneys, physicians, nurses, researchers, law enforcement officers, and protective services administrators—started talking when they met at conferences of their desire for a professional society designed to meet their needs as professionals in the field of child maltreatment. This new society would give professionals from all of the different disciplines who respond to child maltreatment a common forum for addressing the difficult problems they face in their work. It would encourage research in this young field to build a knowledge base on which professionals can confidently practice, and would disseminate that research in a usable form to all professionals working in the field. This association would serve as a vehicle for approaching difficult policy and practice questions that require an interdisciplinary response, and as a "home base" for all professionals whose main concern was how best to help those affected by child maltreatment.

In 1987, these leaders founded the American Professional Society on the Abuse of Children (APSAC). In the intervening years, thousands of professionals from all 50 states and around the world have joined, and APSAC has made steady progress towards realizing its founders' goal.

It has created the *APSAC Advisor*, a highly-regarded quarterly news journal that delivers current information from leading experts in immediately useful form. It has established *Child Maltreatment*, a quarterly, peer-reviewed, interdisciplinary, policy- and practice-oriented journal that addresses all aspects of child maltreatment.

And APSAC has . . .

- submitted *amicus* briefs to the U.S. Supreme Court in cases with important implications for child abuse practice;
- published guidelines for practice on critically important aspects of practice;
- provided outstanding professional education in institutes, colloquiums, and intensive clinics;
- published books and monographs
- fostered the development of a nationwide network of chapters through which interdisciplinary professionals address issues with local import;
- issued fact sheets and letters to editors to promote accurate public awareness of the complexities of child maltreatment.

APSAC addresses all facets of the professional response to child maltreatment: prevention, assessment, intervention, and treatment. Its members and Board of Directors represent all of the major disciplines responding to child abuse and neglect, including mental health, law, medicine, child protective services, and law enforcement. Its publications and training cover all aspects of child maltreatment, including emotional neglect and other forms of neglect, psychological maltreatment, and physical and sexual abuse. Most important, all of APSAC's products are solidly based on the latest empirical research. They are designed to promote the best possible professional practice by making the latest knowledge widely available and comprehensible in a practical context.

Finally, all of APSAC's products reflect the central wealth of APSAC, which is the unstinting labor of volunteers. The authors, editors, researchers, and teachers whose names are on APSAC's publications and programs have donated their work. All proceeds from these products directly benefit APSAC. These and hundreds of other busy professionals — Board members, Advisory Board members, state chapter leaders, and others — who have given so freely of their scarce and valuable time have made APSAC a living, breathing force for all professionals in the field of child maltreatment.

Much more remains to be done. To achieve APSAC's mission, there can be no bystanders: Your active participation is required. Please join the interdisciplinary professional organization that focuses all of its energy on improving America's response to child maltreatment.

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Journal Highlights

Ernestine C. Briggs, PhD
Tracee Washington, PhD

The purpose of Journal Highlights is to inform readers of current research on various aspects of child maltreatment. *APSAC* members are invited to contribute by sending a copy of current articles (preferably published within the past 6 months) along with a two-or three- sentence review to Ernestine C. Briggs, PhD, Duke University Medical Center, Trauma Evaluation, Research and Treatment Program, Center for Child and Family Health–North Carolina, 3518 Westgate Drive, Suite 100, Durham, NC 27707 (Fax: 919-419-9353).

SEXUAL ABUSE

Deficits in Verbal Declarative Memory and Sexual Abuse-Related PTSD

Previous studies have found deficits in verbal declarative memory functioning in people with posttraumatic stress disorder (PTSD), but most of these studies included only male combat veterans as participants. The current study included women with and without sexual abuse histories and PTSD diagnoses (N=43). All participants underwent neuropsychological testing with subtests of the Wechsler Memory Scale-Revised to assess verbal and visual memory and subtests of the Wechsler Adult Intelligence Scale to assess IQ. Other measures were also included to assess PTSD and other psychiatric symptoms. Results indicated that abused women with PTSD had deficits in verbal declarative memory compared with abused women without PTSD and nonabused women without PTSD. There were no significant differences in IQ. These results suggest that early abuse with PTSD is associated with deficits in verbal declarative memory, and that these effects are not related to the nonspecific effects of childhood abuse.

Bremner, J. D., Vermetten, E., Afzal, N., & Vythilingam, M. (2004). Deficits in verbal declarative memory function in women with childhood sexual abuse-related posttraumatic stress disorder. *Journal of Nervous and Mental Diseases, 192*(10), 643-649.

Protecting Children From Online Sexual Predators

Although there are many beneficial aspects of the Internet, one of its more malevolent aspects is its potential use for online sexual predation. The Internet allows sexual predators access to numerous children in a fairly anonymous environment. This article reviews sexual predators' characteristics and their strategies. The authors review technological, psychoeducational, and legal considerations and present ways to protect children. The authors also describe relevant laws about online solicitation and how they relate to practicing psychologists.

Dombrowski, S. C., LeMansey, J. W., Ahia, C. E., & Dickson, S. A. (2004). Protecting children from online sexual predators: Technological, psychoeducational, and legal considerations. *Professional Psychology: Research and Practice, 35*(1), 65-73.

PHYSICAL ABUSE

Two Subgroups of Physically Abusive Parents Observed

This study included subgroups of physically abusive parents and a comparison group of nonabusive parents (N=149). Parents in the physically abusive group either had a substantiated report of physical abuse themselves (n=71) or a partner with a substantiated report of physical abuse (n=12). Cluster analysis of observed parenting and self-reported discipline was used to categorize the abusive parents into subgroups. Parents in the first cluster were warm, positive, sensitive, and appeared engaged with their children during parent-child interactions, while parents in the second cluster were relatively negative, disengaged, intrusive, and insensitive. The two clusters also differed in terms of emotional health, parenting stress, perceptions of their children, and problem-solving abilities. Parents in the first cluster were similar to nonabusive parents on parenting and related constructs, while parents in the second cluster were significantly different from nonabusive parents on all of the clustering variables. The results highlight several differences among abusive parents in parenting practices and functioning.

Haskett, M. E., Scott, S. S., & Ward, C. S. (2004). Subgroups of physically abusive parents based on cluster analysis of parenting behavior and affect. *American Journal of Orthopsychiatry, 74*(4), 436-447.

Study Examined Responses of Physically Abusive Mothers

This study utilized a sequential analysis to examine mother-child dyads following episodes of compliance and noncompliance (N=30). Half of the sample consisted of physically abusive mothers (n=15), while the other half of the sample consisted of nonabusive, low-risk mothers (n=15). The children in the study ranged from 2 to 6 years of age. The results indicated that when children were noncompliant, physically abusive mothers were more likely to respond negatively and give another command than nonabusive mothers. When children were compliant, abusive and nonabusive mothers were equally likely to praise their children's behavior, but abusive mothers were less likely to demonstrate other forms of positive behavior, such as positive touch. The authors discuss the clinical implications of these findings in the context of working with physically abusive parents.

Borrego, J., Timmer, S. G., Urquiza, A. J., & Follette, W. C. (2004). Physically abusive mothers' responses following episodes of child noncompliance and compliance. *Journal of Consulting and Clinical Psychology, 72*(5), 897-903.

cont'd on page 20

Does PCIT Prevent Further Reports of Physical Abuse?

This study was a randomized trial designed to test the efficacy and sufficiency of parent-child interaction therapy (PCIT) with physically abusive parents to determine if it can prevent further reports of physical abuse. The sample consisted of physically abusive parents (N=110) who were randomly assigned to one of three intervention conditions: (1)PCIT, (2)PCIT plus individualized enhanced services, or (3)a standard parenting group in the community. All of the parents had multiple child welfare reports, severe parent-to-child violence, low household income, and significant levels of depression, substance abuse, and antisocial behavior. A median follow-up conducted 850 days after treatment found that 19% of parents assigned to PCIT had another report of physical abuse compared with 49% of parents assigned to the parenting group. Additional services did not enhance the efficacy of PCIT. The relative superiority of PCIT was mediated by a greater reduction in negative parent-child interactions, which is consistent with the PCIT change model.

Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., Jackson, S., Lensgraf, J., & Bonner, B. L. (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology, 72*(3), 500-510.

Can Preventing Maltreatment Prevent Antisocial Behavior?

The authors posited two hypotheses to explain the finding that child physical maltreatment predicts later antisocial behavior. One hypothesis is that physical maltreatment causes antisocial behavior, and the second hypothesis is that genetic factors transmitted from parents to children influence the chances that parents will be physically abusive and that children will then engage in antisocial behavior. The sample consisted of twins and their parents (N=1,116) from the Environment-Risk cohort. The twins were 5 and 7 years of age at the time of the assessments. Mothers provided reports about child physical abuse, and both mothers and teachers provided reports about the children's antisocial behavior. The results indicated that child physical abuse plays a causal role in the development of antisocial behaviors and that the prevention of child maltreatment can prevent antisocial behaviors.

Jaffee, S. R., Caspi, A., Moffitt, T. E., & Taylor, A. (2004). Physical maltreatment victim to antisocial child: Evidence of an environmentally mediated process. *Journal of Abnormal Psychology, 113*(1), 44-55.

OTHER ISSUES IN CHILD MALTREATMENT

Social Work Misconduct May Lead to Liability

The authors analyze a recent court ruling in the U.S. Court of Appeals case, *Currier v. Doran* (2001). The court ruled that state-employed social workers can be held liable for harmful acts of others when those social workers "created the danger" that allowed the harm. In this case, a child was removed from his mother's custody by the state and placed and maintained with his father, in spite of significant risk in his father's care, both at the time of placement and ongoing. The father subsequently abused the child. The social worker's assertions of qualified immunity were not upheld. In their discussion of the implications of the case, the authors explain that (1) although the concept of qualified immunity remains intact, "social workers who blatantly fail to heed warning signs of abuse or potential abuse will not be protected from liability" (p. 611), (2) being underfunded or overworked will not shield social workers from charges of professional malpractice, and (3) civil and criminal lawsuits may succeed when a child suffers maltreatment *after* the agency worker knew or should have known that the child was improperly placed in a dangerous situation. The case also had implications for child welfare supervisors. The social worker's supervisor was held liable for "deliberate indifference" to the plaintiff's constitutional rights by failing to assure that her subordinates were properly trained.

Pollack, D., & Marsh, J. (2004, October). Social work misconduct may lead to liability. *Social Work, 49*(4), 610-612.

Psychological Effects of Domestic Violence on Children and Their Mothers

The goal of this study was to examine the effects of domestic violence, child abuse, and related areas of functioning on mothers who are the victims of domestic violence and their children. The sample consisted of mothers and children who were referred for independent structured interviews and psychological assessment by social service agencies (N=50). The assessments evaluated posttraumatic symptoms, including posttraumatic re-experiencing, avoidance, physiological arousal, associated symptoms, and parenting skills. The results found a complex pattern of high levels of abuse and associated trauma disorders in both children and their mothers. However, the presence of disorders was not correlated between children and their mothers. Mothers experiencing symptoms were less likely to seek treatment for their children.

Chemtob, C. M., & Carlson, J. G. (2004). Psychological effects of domestic violence on children and their mothers. *International Journal of Stress Management, 11*(3), 209-226.

Study Examined Methodological Issues Associated With Measuring Maltreatment

This study compared prospective parent self-reports with retrospective adolescent reports of early childhood physical abuse. The authors explored the correspondence, predictive equivalence, and outcomes associated with conflicting reports of abuse. Correspondence between the parents' and adolescents' reports was moderate. Both parent and adolescent reports were significant predictors of key adolescent outcomes. These results indicate that both parents' self-reports and adolescents' recall of abuse are valid measures of child maltreatment. This study underscores the methodological challenges of measuring child maltreatment.

Tajima, E. A., Herrenkohl, T. I., Huang, B., & Whitney, S. D. (2004). Measuring child maltreatment: A comparison of prospective parent reports and retrospective adolescent reports. *American Journal of Orthopsychiatry, 74*(4), 424-435.

Infant Mental Health and Juvenile Court: Impetus for Practice and Policy Change

The authors contend that the passage of the Adoption and Safe Families Act (ASFA) in 1997 required the courts to make the safety and well-being of the child their primary concern, rather than focusing on the parents. Since infants are now the largest group of children in the child welfare system, an emphasis on their needs could prevent intergenerational transmission of child maltreatment. The authors present a case example and review some programs currently in place in the Miami-Dade Juvenile court to highlight ways that courts can partner with various agencies to provide treatment.

Lederman, C. S., & Osofsky, J. D. (2004). Infant mental health interventions in juvenile court: Ameliorating the effects of maltreatment and deprivation. *Psychology, Public Policy, and Law, 10*(1), 162-177.

Potential Mediators Between Child Maltreatment and Dating Violence

This study examined the relationship between childhood maltreatment, dating violence, and potential mediators (i.e., trauma-related symptoms, attitudes justifying dating violence, and empathy and self-efficacy in relationships) between maltreatment and dating violence in midadolescence. The sample consisted of high school students from 10 local schools (N=1,317), and the study occurred over a one-year period. Results suggest that child maltreatment is a distal risk factor for adolescent dating violence. Trauma-related symptoms had a significant cross-time effect on predicting dating violence for both girls and boys, making them a significant mediator between child maltreatment and dating violence. Attitudes justifying dating violence, as well as empathy and self-efficacy, were correlated with dating violence but did not predict it. The authors discuss the importance of longitudinal methodology that separates correlates from predictors.

Wolfe, D. A., Wekerle, C., Scott, K., Straatman, A-L., & Grasley, C. (2004). Predicting abuse in adolescent dating relationships over 1 year: The role of child maltreatment and trauma. *Journal of Abnormal Psychology, 113*(3), 406-415.

Emotion Regulation, Therapeutic Alliance, and Successful Outcomes

This study examined the effects of the therapeutic alliance and negative mood regulation on treatment outcome for childhood abuse-related posttraumatic stress disorder (PTSD). The treatment consisted of two phases: Phase one focused on stabilization and preparatory skills building, and phase two focused on imaginal exposure to traumatic memories. The findings suggested that the therapeutic alliance had a significant impact on treatment outcome, and that the relationship between the therapeutic alliance and treatment outcome was mediated by the patient's mood regulation during the second phase of treatment. The authors conclude that the therapeutic alliance and the mediating influence of mood regulation significantly influence the treatment outcome for childhood abuse-related PTSD.

Cloitre, M., Stovall-McClough, K. C., Miranda, R., & Chemtob, C. M. (2004). Therapeutic alliance, negative mood regulation, and treatment outcome in child abuse-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 72*(3), 411-416.

The Gap Between Need for Services and Access to Services

The goal of this study was to examine the relationship between the need for mental health services and the use of those services for maltreated children who were involved in child welfare investigations. The children in the sample were drawn from the National Survey of Child and Adolescent Well-Being and ranged in age from 2 to 14 years (N=3,803). Approximately half of the children in the sample had clinically significant emotional or behavioral problems. Children who exhibited clinically significant symptoms were more likely to receive services than children who did not exhibit clinically significant symptoms, but only approximately 25% of the children with significant symptoms received specialized mental health treatment services. Young children (ages 2 to 5 years) were more likely to receive services if they were sexually abused than if they experienced neglect. Having a mentally-ill parent increased the likelihood that a child would receive mental health services. Adolescents who remained in the home were less likely to receive treatment. In light of these findings, the authors suggest that children need to be routinely screened and provided access to mental health services early in their contact with the child welfare system.

Burns, B. J., Phiillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(8), 960.

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_____Psychosocial Evaluation of Suspected Sexual Abuse in Children, 2nd Edition (1997)
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_____Hardcover (582pp., 8.5"x11") Members **$104.00** Nonmembers **$117.00**
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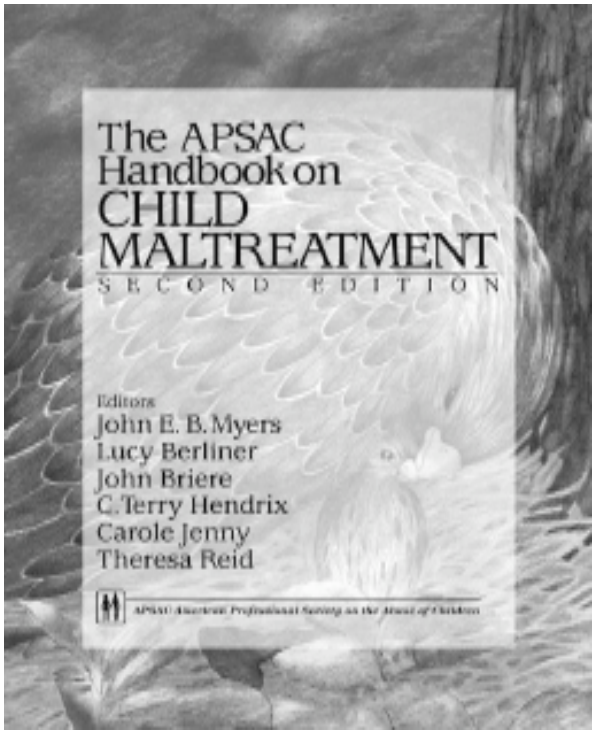
The APSAC Handbook on Child Maltreatment Second Edition

Sage Publications in cooperation with the American Professional Society on the Abuse of Children

Edited by
John E. B. Myers, JD; Lucy Berliner, MSW; John Briere, PhD; C. Terry Hendrix, MA; Carole Jenny, MD, MBA; and Theresa A. Reid, PhD



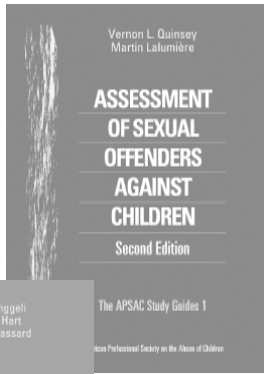
The Second Edition of *APSAC Handbook* was published in January 2002. An up-to-date, 582-page resource of unparalleled thoroughness, it provides comprehensive, interdisciplinary coverage of the causes, consequences, treatment, and prevention of child abuse and neglect. Engaging and straightforward chapters offer research-based applications for practice, including medical, psychological, and legal points of view about physical and sexual abuse, neglect, and psychological maltreatment. Leading authorities in a variety of specialized areas have designed each chapter to inform advanced students and practitioners in social work, mental health, law, medicine, nursing, law enforcement, child protective services, and education of the most current research literature available as well as strategies for intervention and prevention.

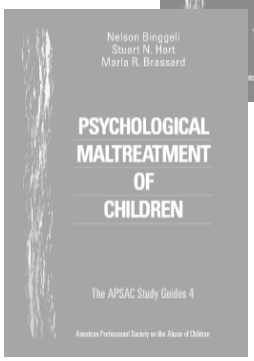
The Second Edition includes a thorough update of retained chapters as well as over 630 new references that did not exist when the previous edition was published in 1996. It also includes new chapters focusing on

- Munchausen by proxy syndrome
- Child abuse in the context of substance abuse
- Child abuse in the context of domestic violence
- Child fatalities
- Risk management for professionals working with maltreated children and adult survivors
- Mental health services for children reported to child protective services

Assessment of Sexual Offenders Against Children Second Edition
Vernon L. Quinsey, PhD; and Martin Lalumiere, PhD

This indispensable guide reviews the range of relevant literature covering issues in assessing child molesters. Fully updated with literature published through the end of 1999, the Second Edition steers professionals to the most current knowledge available on the subject in a compact, accessible form. Learn from this resource what characteristics do and do not distinguish child molesters, what situational factors are related to molestation, what instruments are used in the assessment of child molesters, how assessment information is used to appraise risk and guide treatment, and the elements of a useful assessment report.





Psychological Maltreatment of Children
Nelson Binggeli, PhD; Stuart N. Hart, PhD; and Marla R. Brassard, PhD

Psychological maltreatment is probably the most common form of child abuse. Not only is it a type of maltreatment existing in its own right, but it also is imbedded in and interacts with all other forms of child abuse and neglect. This book is a brief introduction to the psychological maltreatment of children and youth for mental health professionals, child welfare workers, and other professionals involved with research, education, practice, and policy development in child maltreatment. The book's objectives are to define, outline theories, and describe the effects of psychological maltreatment, as well as to examine this form of abuse as a social problem. It also covers assessment, prevention, and treatment strategies and shows how to analyze a case of child psychological maltreatment. Both practicing professionals and advanced students will find this concise work to be an excellent introduction to this highly pervasive yet often-ignored form of child abuse.

CONFERENCE CALENDAR

January 24-28, 2005
19th Annual San Diego Conference on Child and Family Maltreatment, San Diego, CA
call Linda Wilson 858-576-1700 - 4972
or e-mail: sdconferences@chsd.org
or visit: www.chadwickcenter.org

January 24-28, 2005
Indian Child Welfare Training Institute, Nashville, TN
call Shannon Romero 503-222-4044
or e-mail: shannon@nicwa.org
or visit http://www.nicwa.org

Jan 31- Feb 2, 2005
National Headstart Latino Institute, Albuquerque, NM
write to: Administration for Children and Families, Head Start Bureau, 330 C Street, SW, Washington DC, 20447

February 6-9, 2005
Symposium 2005: Connect, Support, Empower 30 Years of Reflections and Revelations in Youth Services, Washington, DC
call Joe E. Johnson 202-783-7949
or e-mail: jejohnson@ou.edu
or visit: http://www.nrcys.ou.edu/symposium05sym05home.htm

February 21-23, 2005
2nd International Conference on Post-Adoption Services, Dublin Ireland
call 617-547-0909 or fax 617-497-5955
or visit: http://www.kinnect.org/ACTION/

March 6-9, 2005
18th Annual Research Conference: A System of Care for Children's Mental Health: Expanding the Research Base, Tampa, FL
call Catherine Newman 813-974-8429
or e-mail: cnewman@fmhi.usf.edu
or visit: http://rtckids.fmhi.usf.edu/rtcconference

March 8-11, 2005
21st National Symposium on Child Abuse, Huntsville, AL
call 256-533-0531 or fax 256-534-6883
or visit: http://www.nationalcac.org

March 9-11, 2005
Children 2005: Crossing the Cultural Divide, Washington, DC
call Child Welfare League of America
202-638-2952 or fax 202-638-4004
or visit: http://www.cwla.org

March 21-22, 2005
13th Annual Children's Justice Conference, Seattle, WA
call Thomasenia James 360-902-7966
or fax 360-902-7903
or e-mail: jamt300@dshs.wa.gov

March 20-23, 2005
32nd National Conference on Juvenile Justice "Shine Your Light", Orlando, FL
call 775-784-6012
or e-mail: admin@ncjfcj.org
or visit: http://www.ncjfcj.org

April 6-9, 2005
6th National Conference on Family and Community Violence Prevention Navigating Pathways to Violence Prevention: Exploring & Strengthening Links Between Families & Communities, Honolulu, HI
call Community Violence Program 888-496-2667
or fax 937-376-6180
or visit: http://www.fcvp.org

April 16-19, 2005
The 24th Annual National CASA Conference "Growing a Better Tomorrow....for Every Child,"Atlanta, GA
call Tracy Flynn 800-628-3233

CONFERENCE CALENDAR

April 18-23, 2005
15th National Conference on Child Abuse and Neglect "Supporting Promising Practices and Positive Outcomes: A Shared Responsibility," Boston, MA
call Nhu-My Nguyen 703-528-0435
or visit: http://nccanch.acf.hhs.gov/profess/conferences/cbconference/index.cfm

April 24-27, 2005
23nd Annual "Protecting Our Children" Conference National American Indian Conference on Child Abuse and Neglect, Albuquerque, NM
call Kim Just 503-222-4044
or e-mail: justkim@nicwa.org
or visit: http://www.nicwa.org

April 28-29, 2005
Child Protection: Our Responsibility, Cedar Rapids, IA
call 319-369-8136 or fax 319-369-8726
or e-mail: matuszrm@crstlukes.com

May 2-4, 2005
Finding Better Ways: Addressing the Mental Health Needs of Children, Youth and Families, New Orleans, LA
call the Child Welfare League of America
202-638-2952 or fax 202-638-4004
or visit: http://www.cwla.org/conferences/2005fbwrfp.htm

May 5-7, 2005
3rd Annual Violence in the World of Our Youth Conference: Partners in Prevention, San Diego, CA
call the Family Violence & Sexual Assault Institute 858-623-2777 or e-mail: fvtrain@alliant.edu
or visit: http://www.fvsai.org/Training/Workshops/YV%202005/2005YouthViolenceCall.doc

May 23-25, 2005
Comprehensive Forensic Interviewer Training, Cedar Rapids, IA
call Julie Kelly 319-369-8702 or fax 319-369-8726
or e-mail: kellyja@crstlukes.com

June 1-3, 2005
2005 Juvenile Justice National Symposium: Joining Forces for Better Outcomes, Miami, FL
call Dodd White 202-639-4959
or e-mail: dwhite@cwla.org
or visit: http://www.cwla.org

June 15-18, 2005
APSAC 13th Annual Colloquium, New Orleans, LA
call Jim Campbell 608-772-0872
or e-mail: apsaccolloquium2005@charter.net
or visit: www.apsac.org

August 29-31, 2005
Comprehensive Forensic Interviewer Training, Cedar Rapids, IA
call Julie Kelly 319-369-8702
or fax 319-369-8726
or e-mail: kellyja@crstlukes.com

September 18-21, 2005
10th International Conference on Family Violence, San Diego, CA
call 858-623-2777 ext. 427 or fax 858-646-0761
or e-mail: fvconf@alliant.edu or visit: www.fvsai.org

October 16-18, 2005
Bridging Culture in a Changing World, Orlando, FL
call the National Black Child Development Institute (NBCDI)
202-833-2220
or visit: http://www.nbcdi.org/ac/cfp/05/

October 31-Nov 1, 2005
Comprehensive Forensic Interviewer Training, Cedar Rapids, IA
call Julie Kelly 319-369-8702
or fax 319-369-8726
or e-mail: kellyja@crstlukes.com

November 2 -5, 2005
24th Annual Research and Treatment Conference, New Orleans,, LA
write to: 4900 SW Griffith Drive, Suite 274, Beaverton, OR 97005
or visit: www.atsa.com

APSAC ADVISOR

ISSN 1088-3819

Save these dates!!!!!

APSAC's 13th Annual Colloquium
June 15-18, 2005
Sheraton Hotel, New Orleans

APSAC Child Forensic Interview Clinics
April 25-29, 2005
Seattle, WA
&
September 26-30, 2005
Portsmouth, VA

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