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'Reasonable Efforts': A Call to Clarify Child Protection Law

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"Reasonable efforts" has been the guiding standard of child protection law for longer than any of the children currently involved under the law has been alive. But do the adults concerned really know the meaning of the term "reasonable efforts"?

Section I of this article summarizes the background of the reasonable efforts requirement found in the Adoption and Safe Families Act (ASFA). Section II examines the judicial interpretations of the reasonable efforts mandate and discusses trends in services offered to children and parents in need. Section III outlines the responsibilities of child protection attorneys to help ensure that these reasonable efforts are effective in serving the needs of abused and neglected children.

Section I: A Brief History of the 'Reasonable Efforts' Requirement

Since 1980, parents, social workers, guardians, judges, and child protection attorneys[2] have been held to a federal standard of reasonableness regarding the efforts extended to families and children in the child protection system. During this period, the efforts were intended to prevent placement and reunify families. In 1997, the Adoption and Safe Families Act[3] (ASFA) extended the mandate requiring reasonable efforts to include achieving timely permanency for children for whom reunification is not a viable alternative.[4]

Although all fifty states are guided by the same legislation, there is no clear national consensus regarding the definition of reasonable efforts in child protection cases beyond the requirement of case plans and scheduled reviews and hearings. ASFA, like the Child Welfare Act of 1980,[5] also failed to articulate a precise federal standard for the required reasonable efforts. In an attempt to remedy the confusion of prior legislation with ASFA, Congress formally added the condition that "the child's health and safety should be the paramount concern" in determining whether reasonable efforts have been made.[6] The result was a virtual cornucopia of interpretations that vary not only by state but also by case. In 1978, the Maryland Court of Appeals was not alone in lamenting that "[t]here can be very little constructive or useful precedent on the subject of custody determination, because each case must depend upon its unique fact pattern."[7] This articulation of a case-by-case approach has continued throughout the nation in post-ASFA decisions.

Courts nationwide have pointed out that reasonable efforts should be common sense; offered in relation to a court-ordered plan; peculiar to circumstances; real, genuine assistance; or sometimes a denial of services altogether. Judicially accepted reasonable efforts are not necessarily ideal, perfect, all-encompassing, or Herculean. While those are excellent characteristics to help measure the reasonableness of services/programming after they have been offered, practitioners still lack prescriptive direction as to which services should be offered under various circumstances and which services would simply be futile and fail to meet a reasonableness determination.

In light of the uncertainty of this area of law, it is important for all players to prioritize the needs of the child(ren). With that in mind, how can child protection attorneys, in their role as agency representation, best serve the needs of children when faced with cases involving not only children but also parents, family, foster parents, judges, other attorneys, agency representatives, and countless service providers?

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Section II: Court Interpretations of 'Reasonable Efforts'

On a practical level, local trends may make more of a difference in the day-to-day practice of a child protection attorney than national trends. Nevertheless, trends in other states and across the country, to the extent that they exist, can be useful to bolster arguments for change in local courts or state legislation.

By far the most prevalent national trend in any area is, in fact, an absence of trend in terms of core services viewed as necessary in every child protection situation. A growing number of state courts are affirming that each case is unique and there is no prophylactic response for each family. The Supreme Court of South Dakota has found that "[e]ach case will turn on its own peculiar facts, and compelling circumstances may require different courses of conduct"[8] and that "[w]hat is reasonable is defined by the individual circumstances of each case."[9] Many other states have also determined that a case-by-case approach is most appropriate.[10] Although court decisions are making distinct findings as to what are deemed to be reasonable efforts in each case, there are trends and notable cases in several areas that seem to affect a large number of families. The three areas common to many child protection cases are chemical dependency, domestic violence, and mental illness.

Chemical Dependency is a predominant issue in child protection cases. Nationwide, it appears that parents struggling with issues of chemical dependency are having their rights terminated after being offered and failing or refusing chemical dependency treatment programs. Courts are typically requiring at least some treatment options in order to meet the reasonable efforts standard. In *Division of Family Services v. N.X.*,[11] the Delaware Family Court held that the state did not meet its burden of demonstrating (i.e., by clear and convincing evidence) that reasonable efforts had been extended. The Court noted that DFS had provided a chemically dependent mother only with referrals for out-patient treatment programs even after

the department's drug treatment professionals had recommended in-patient programming to address the mother's addiction. Beyond chemical dependency treatment, in other cases the services provided range from a bare minimum of counseling and transportation assistance, to a comprehensive package of services, including counseling, housing assistance, parenting aides, and homemaker services.

The complex nature of addiction as a disease requiring intervention efforts over an extended period of time is often at odds with the ASFA-mandated timelines. Nevertheless, in the interest of family preservation, many courts have offered services to parents for long periods of time exceeding any recognized timeline.[12] Other courts interpret statutes uniformly and seem not to allow variances for chemical dependency. For example, Arizona and Wisconsin courts have tried to maintain a 12-month deadline for parents to achieve sobriety.[13] Avoiding any problem of interpretation, the Ohio legislature enacted a statute that permits termination without efforts to maintain or restore the family where a parent has placed the child at "substantial risk of harm two or more times due to alcohol or drug abuse" and has rejected or refused to participate in court-ordered drug treatment two or more times.[14]

In Reno, Nevada, in 1994, the first Family Dependency Treatment Court (FDTC) was opened offering a new intensive interdisciplinary case management approach to meeting the needs of the children and parents in a manner efficient enough to meet permanency timelines and still offer realistic chemical dependency treatment.[15] This approach has been adopted by a number of other jurisdictions across the nation in an effort to better serve families affected by chemical dependency.[16] The FDTC concept combines early intervention and comprehensive family assessments with frequent court visits to hold all parties accountable. The frequency of these judicial interventions is a regular way to gauge the reasonableness of efforts provided to the family. The interdisciplinary case management style means that all parties are aware of all of the efforts being extended and the compliance and outcomes on behalf of the parents involved.

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In light of the realistic possibility of relapse, and with an eye toward long-term child safety, FDTCs have incorporated a continued service provision of dependency treatment after reunification has occurred. This measure ensures that all reasonable efforts are made to reunify within the ASFA-mandated timelines, and aftercare continues as the family receives support to avoid the relapse and reentry into the child welfare system that often occur in cases where chemical dependency is a problem. While this level of aftercare may extend beyond the mere reasonable efforts, this further step assures that the central tenet of ASFA's reasonable efforts requirement, child health and safety, remains the paramount concern in the FDTC system.

Domestic Violence is a frightening reality for many children involved in child protection cases. Across the country, children living in homes in which domestic violence is a potential threat to their safety can expect to be under the jurisdiction of the court for long periods of time before their well-being in the home is assured or parental rights are terminated.[17] Unique challenges arise in cases where one parent is not a perpetrator of child abuse but either lacks the ability to safeguard the child or continues to place priority on his or her relationship with the abuser over that with the child. After offering services to an abused parent without success, several states will terminate parental rights based on a failure to protect the child from the violence of an abuser.[18] Where courts have found that reasonable efforts have been made, generally, some level of service programming directed toward the nonabusive parent has been offered.

Services offered to perpetrators of domestic violence range from nonexistent (due either to the severity of the abuse where the perpetrator is a parent, or to the fact that the abuser has no legal relationship with the child) to counseling or anger-management programs related to the abuse. In cases where the abuser has no legal relationship to the child, the jurisdiction of the court can reach only the battered parent. Ideally, the abuser would voluntarily participate in programming designed to remedy the unsafe environment, but most often the battered parents' contact with the children is restricted to times when the abuser is not present. There is a notable lack of cases where a nonabusive parent in a violent situation has successfully challenged the reasonableness of efforts.

Many courts have been struggling to determine the best approach to protecting the welfare of children without punishing the battered parent for being a victim. The Court of Appeals of New York recently ruled on a case stemming from a challenge to a New York City child welfare agency policy of removing children on the basis of neglect due to domestic violence in the home.[19] This court specifically stated the importance of balancing the potential for harm to the child in the immediate situation with the possibility that reasonable efforts can mitigate that harm and avoid removal. In looking at New York's statutory scheme for determining neglect, the court differentiated between cases where a child witnessed a single incident of spousal abuse and cases where a child witnesses repeated incidents of abuse, or has grown fearful of the perpetrator and the mother continues to allow the perpetrator into the home and lacks awareness of the impact of the violence on the children.[20] The latter scenario more clearly meets the New York statutory criteria for neglect, yet the agency policy was challenged as treating every incident of domestic violence with an extreme response, including removal of the child from the home.

The *Nicholson* opinion discusses other New York cases that demonstrate alternatives to immediate removal, such as consent removal, where the battered parent recognizes the dangers and allows the children to be taken into protective custody; orders for protection to keep the abuser away from the home, allowing the child to safely reside; or providing services to the victim. To choose among all these alterations requires a careful examination of the facts of each par-

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ticular case to determine what is best for the children involved. The safety of the child must be the paramount concern, but in determining that safety, the volatile and varied realities of domestic violence must be taken into account. As stated by the New York Court of Appeals, whether a mother has failed to exercise minimal care for her child must take into account an assessment of "the severity and frequency of the violence, and the resources and options available to her."[21] Any assessment of reasonable efforts must take into account not only the research demonstrating the harmful effects of witnessing domestic violence but also the danger inherent to the situation at hand. In all situations involving domestic violence, the players involved in the child protection case should not ignore the detrimental effects suffered by children who witness such violence.[22]

Mental Illness plagues many families and can be the circumstance that spurs the involvement of the child protection system. Where a parent suffers from a mental illness, the consequences of which adversely affect the lives of the children, most states will subject that parent to the jurisdiction of child protection courts and services to ensure the well-being of the children. Notably, in 2003, the Oklahoma Court of Appeals reversed a termination in which the condition that precipitated court involvement was mental illness and the state had moved for a termination of parental rights based upon a failure to remedy the condition that led to involvement.[23] The Court of Appeals held that substantive due process of law prevents the state from terminating parental rights for "failure to correct a mental condition when such failure is part of the mental condition itself."[24] As this case points out, it is important for both the state and the child protection attorney to pay attention to documenting the reasons for intervention and the corresponding grounds for termination in order to preserve the due process rights of both the children and the parents involved. As stated by the Missouri Court of Appeals, "the mental illness of a parent is not per se harmful to a child."[25] Thus, the decision to terminate parental rights should be based upon an inability to provide a safe and healthy environment for the child rather than the illness of the parent.

Additionally, the ABA has promulgated Standards of Practice for Lawyers Representing Child Welfare Agencies. These comprehensive standards acknowledge the different models of legal representation and also reiterate the importance of communication between the agency and the attorney in every jurisdiction, regardless of the approach taken to representation.

In most cases resulting in a termination of parental rights, reasonable efforts have been extended and the termination turns on some failure of the parent to respond to the reasonable efforts or to remedy conditions. However, Connecticut and Wisconsin have seen cases where reasonable efforts are offered but termination is held to be the appropriate remedy based upon the best interests of the child.[26] Several states have gone so far as to enact statutory provisions eliminating the requirement of reasonable efforts where a parent or guardian is the sole caregiver and mental illness renders him or her incapable of caring for the children and/or benefiting from rehabilitation or reunification services.[27]

Section III: The Role of the Child Protection Attorney in Meeting 'Reasonable Efforts'

As is true for other lawyers, the child protection attorney should be guided by national and state standards. The ABA Rules of Professional Conduct should be consulted for general guidance where specific jurisdictional rules for child protection attorneys are lacking. Additionally, the ABA has promulgated Standards of Practice for Lawyers Representing Child Welfare Agencies.[28] These comprehensive standards acknowledge the different models of legal representation and also reiterate the importance of communication between the agency and the attorney in every jurisdiction, regardless of the approach taken to representation.

As further assistance, the Children's Bureau of the Department of Health and Human Services has also published excellent guidelines for agency representation.[29] By incorporating observations from the commentary accompanying the Children's Bureau Guidelines and the ABA Standards, the following five suggestions intend to steer the practice of both novice and experienced child protection attorneys in a child-focused direction.

1. *Know your stuff.* As an attorney your trade is law, so be sure to know and understand child protection proceedings. Keep to the federal or state-mandated timelines—avoid legal delays that are unnecessary from the child's standpoint. Appreciate not only the ASFA requirements but also the nuance of your state laws. Remember that some states do a better job of defining and guiding reasonable efforts. For example, Minnesota statutes guide court determinations of what is reasonable under the law by requiring that services provided to families be deemed "(1) relevant to the safety and protection of the child; (2) adequate to meet the needs of the child and family; (3) culturally appropriate; (4) available and accessible; (5) consistent and timely; and (6) realistic under the circumstances."[30] Furthermore, Minnesota courts are required to ensure that "case plans be narrowly tailored to solve the problems that precipitated state intervention."[31] If your state operates under ambiguous legislation, determine legislative intent by examining the history of a particular statute. Look at legislative examples of reasonable efforts law from other states to help shepherd your efforts. The National Child Protection Training Center's Web site is a good resource.[32]

2. *Be a zealous advocate for your client*. Be clear about who your client is and be sure that you are arguing the position of the client, not just what appears best to you. Child protection attorneys typically represent the state agency assigned with the care of dependent and neglected children. In that position, advocating for the child welfare agency's or department's position to terminate rights, despite a personal hesitation to terminate, is recognition of your role as an attorney as well as validation of the experience and expertise of the agency or department that made the decision to pursue termination. Being a good advocate also means that you need to be thoroughly prepared to present your case. Be well-versed not only in present-

ing expert witnesses for the department but also in combating expert witnesses and the evidence put on by other parties.[33]

3. *Speak the client's language.* Agency players possess a different background, and just as they adapt to the legal jargon of these cases, so too should the child protection attorney accommodate the client and be able to converse in the language of the case. To do this effectively, the attorney should understand the social and psychological dynamics of child protection situations. Become versed in child development. Communicate with members of the agency you represent and get to know what they do and understand the limitations of their positions. Have a working knowledge of the services provided. Try to understand not simply what each service is on paper as part of a case plan but also how each service has worked in other situations in your community, keeping in mind the case-by-case approach. By having a thorough understanding of the dynamics of child welfare cases, the players and their positions, as well as the offered and available services, the child protection attorney will be better able to illustrate to the court the reasonable efforts provided by the agency.

4. *Recognize local trends.* Take note of what services have been judicially sanctioned as reasonable in other cases in your jurisdiction. Be able to provide advice when a case situation is complicated in the eyes of the agency, for example, when multiple efforts have been extended but the assigned judge is either new or unpredictable with respect to findings of reasonableness. A well-prepared child protection attorney may recognize a pattern of efforts that has been consistently deemed reasonable across a spectrum of fact scenarios and thereby advise against any proposed continuance or delay. Similarly, a well-versed child protection attorney may be able to recommend continued efforts based on past decisions from similar facts. The National Child Protection Training Center has collected cases from around the nation in an effort to uncover possible reasonable efforts trends.[34]

5. *Take advantage of resources.* The ABA Standards of Practice for Lawyers Representing a Child in Abuse and Neglect Cases[35] call upon judges involved in child-related matters to play an active role in training the attorneys who work in child abuse and neglect cases.[36] Be attuned and willing to attend such local training for child protection professionals. The National Child Protection Training Center is available as a resource for any issue encountered by child protection attorneys. Its Web site contains state statutes on child protection, "reasonable efforts" state case law summaries, and information on training opportunities offered through the American Prosecutors Research Institute.

With these general guidelines in mind as well as an eye toward local custom and trends, child protection professionals can make great strides in defining this area of law and making all of our efforts more reasonable and more effective in bettering the lives of children in the community.

Conclusion

Indisputably, we live in a world where there are no guarantees that an alcoholic will never have another drink, that a victim of domestic violence will never again become trapped in an abusive relationship, or that a parent suffering from a treatable mental illness will not abandon treatment and harm her own child. Nevertheless, the children living in unsafe or unhealthy environments caused by these conditions deserve our utmost attention and, certainly, our most reasonable efforts. And though the meaning of reasonable efforts may not be crystalline, the need to strengthen our child protection system has never been more clear. In the words of the late U.S. Senator Paul Wellstone, "[w]hen historians write about American politics over the past several decades, the ultimate indictment will be of the ways in which we have abandoned children and devalued the work of adults who take care of children."[37] ASFA reminds us of the need to competently and comprehensively address child welfare. By instituting a requirement of reasonable efforts, ASFA ensures that the needs of abused and neglected children are not abandoned. It is now time for child protection attorneys to place value on our work as well as the work of allied professionals by pushing for clarification of child protection law through court decisions and legislation. Let it be that the history written by the children we serve today reflects a nation where each state places the needs of children above politics and truly values our reasonable efforts.

ASFA reminds us of the need to competently and comprehensively address child welfare. By instituting a requirement of reasonable efforts, ASFA ensures that the needs of abused and neglected children are not abandoned.

About the Author

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Notes

[1]The author thanks Andrea Domeyer, Tiffany Evansen, Lyndsay Haller, and Emily Stenhoff for their invaluable research assistance and dedication to children.

[2]For the purposes of this article, the term "child protection attorney" is used to indicate the attorney representing the child welfare agency or department.

[3]Pub. L. No. 105-89, 111 Stat. 2115 (1997).

[4]*See* Adoption and Safe Families Act of 1997 302, Pub. L. No. 105-89.

[5]Pub. L. No. 96-272, 94 Stat. 500 (1980) (codified as amended in scattered sections of 42 U.S.C.).

[6]42 U.S.C. §671(a)(15)(A)(1997).

[7]*Montgomery County Dept. of Soc. Serv. v. Sanders*, 381 A.2d 1154, 1163 (Md. 1978).

[8]*In the Interest of T.H. and J.H.*, 396 N.W.2d 145, 151 (S.D. 1986).

[9]*In re W.G.*, 597 N.W.2d 430, 433 (S.D. 1999).

[10]*See e.g. In the Interest of C.B. and G.L.*, 611 N.W.2d 489 (Iowa 2000); *Montgomery County Dept. of Social Services v. Sanders*, 381 A.2d 1154 (Md. 1978); *Adoption of Lenore*, 770 N.E.2d 498 (Mass. App. Ct. 2002); *In re Welfare of H.M.P.W., R.F.W., and K.W.*, 281 N.W.2d 188 (Minn. 1979); *New Jersey Div. of Youth and Family Services v. A.G.*, 782 A.2d 458 (N.J. Super. Ct. App. 2001); *In the Matter of Sara R.*, 945 P.2d 76 (N.M. 1997); *Matter of Charlene TT.*, 634 N.Y.S.2d 807 (N.Y. 1995); *In re Ryan S.*, 728 A.2d 454 (R.I. 1999).

[11]802 A.2d 325 (Del. Fam. Ct. 2002).

[12]*See e.g. Williams v. Dept. of Health & Rehabilitative Servs.*, 648 So.2d 841 (Fla. Ct. App. 1995) (nearly four years of services); *In the Interest of J.P.V.*, 582 S.E.2d 170 (Ga. Ct. App. 2003) (approximately three years of services); *In the Matter of Annette F. et al.*, 911 P.2d 235 (N.M. Ct. App. 1996) (over two years of services); and *In the Matter of Z.Z.*, 494 N.W.2d 608 (S.D. 1992) (three years of services in South Dakota for a total ten years of services from Minnesota, North Dakota, Colorado, and South Dakota).

[13]*See e.g. Matter of Appeal in Maricopa County Juvenile Action No. JS-501568*, 869 P.2d 1224, 1232-3 (Ariz. Ct. App.1994) (The court, relying on Arizona Revised Statutes §8-862 (A)(2), noted that "[i]ndividuals who are unwilling or unable, due to drug addiction, to accept their parental responsibilities, and who thereby lose custody of their children to the State, need to be aware that they run the risk of having their parental rights permanently terminated if they substantially neglect to remedy their addiction in the year following the removal of their children."); *In re Termination of Parental Rights of Timothy G.*, 2003 WL 22946492 (Wis. Ct. App.) (UNPUBLISHED) and *In the Interest of Joseph C.B.*, 2000 Wis. App. 214 (UNPUBLISHED) (Wisconsin Court of Appeals applies the general 12-month standard of Wisconsin Statute 48.415(2)(a)(3) to chemically dependent parents).

[14]Ohio Rev. Code Ann. §2151.419 (A)(2)(c) (2004).

[15]*See* U.S. Department of Justice, *Family Dependency Treatment Courts: Addressing Child Abuse and Neglect Cases Using the Drug Court Model* 4 (D.O.J. 2004).

[16]For a number of interesting and highly relevant articles on Substance Abuse in Dependency Cases please visit the February 2005 Newsletter of The Judges' Page of the National Court Appointed Special Advocates organization at: http://www.nationalcasa.org/JudgesPage/ (Last visited March 23, 2005).

[17]*See e.g. In the Interest of M.S.H.*, 656 P.2d 1294 (Colo. 1983) (attempts to rehabilitate over two years before termination); *In the Interest of J.P. and T.P.*, 770 N.E.2d 1160 (Ill. Ct. App. 2002) (ten years of services before termination); *In the Interest of J.D.D., K.W.J., and K.J.J.*, 908 P.2d 633 (Kan. Ct. App. 1995) (children were removed three times prior to termination as repeated attempts to remedy the abusive environment failed); *In re Angel N.*, 679 A.2d 1136 (N.H. 1996) (child was removed four times within her first three years; termination did not occur until the child was five years old).

[18]*See e.g. In the Interest of Doe*, 2004 Haw. App. LEXIS 19 (UNPUBLISHED) (mother's rights terminated for failure to provide a safe family home); *In re Doe*, 2002 Haw. App. LEXIS 151 (UNPUBLISHED) (mother's rights terminated for failure to provide a safe family home); *In the Matter of the Welfare of P.R.L.*, 622 N.W.2d 538 (Minn. 2001) (mother's continued contact with abuser led to termination); *In re Interest of Samuel W. and Sophia W.*, 1999 WL 170021 (Neb. Ct. App.) (UNPUBLISHED) (mother's potential rights terminated for substantial and continuous neglect and refusal of parental care and protection); *In the Interest of J.F., W.F., and M.P.S.*, 2002 WL 507174 (Utah Ct. App.) (UNPUBLISHED) (mother's potential rights terminated for failure to protect children from abusive step-father).

[19]*Nicholson v. Scoppetta*, 820 N.E. 2d 840 (N.Y. 2004).

[20]*Id.* at 847.

[21]*Id.* at 846.

[22]For a discussion of the effects of domestic violence on children and the need for collaboration among child protection professionals see UPDATE, Volume 16, Nos. 1-2 (2003), *Domestic Violence Basics for Child Abuse Professionals* and *Strategies for Handling Cases Where Children Witness Domestic Violence*, by Allison Turkel and Christina Shaw. These UPDATE articles are available online at www.ndaa-apri.org.

[23]*In the Matter of C.R.T.*, 66 P.3d 1004 (Okla. Ct. App. 2003).

[24]*Id.* at 1010.

[25]*In the Interest of N.B.*, 64 S.W.3d 907, 915 (Mo. App. 2002).

[26]*See e.g. In re the Termination of Parental Rights to Shannon G.*, 644 N.W.2d 295 (Wis. Ct. App. 2002); *In the Interest of Rayshawn P.*, 2000 Conn. Super. LEXIS 3346 (UNPUBLISHED).

[27]*See e.g.* Alaska Stat. §47.10.086(c)(5)(2002); Ariz. Stat. Ann. §8-846(1)(b); Ky. Rev. Stat. §610.127(6); N.H. Rev. Stat. Ann. §170-C:5(IV); Utah Code Ann. §78-3a-311(b)(ii)(2003).

[28]ABA Center on Children and the Law's National Child Welfare Resource Center on Legal and Judicial Issues, *Standards of Practice for Lawyers Representing Child Welfare Agencies*, http://www.abanet.org/child/rclji/online.html (Last visited March 21, 2005).

[29]U.S. Department of Health and Human Services, Administration for Children and Families: Children's Bureau, *Factsheets/Publications: Guidelines for Agency Representation*, http://www.acf.dhhs.gov/programs/cb/publications/adopt02/02adpt7.htm#guidar (Last visited March 21, 2005).

[30]M.S.A. §260.012 (c)(1)-(6).

[31]Will L. Crossley, *Defining Reasonable Efforts: Demystifying the State's Burden Under Federal Child Protection Legislation*, 12 B.U. Pub. Int. L.J. 259, 298 (2003).

[32]http://www.ndaa-apri.org/apri/programs/ncptc/ncptc_home.html.

[33]NCPTC maintains files on prosecution as well as defense experts. For information or assistance contact NCPTC at 507-457-2890 or ncptc@ndaa-apri.org.

[34]To view cases from your state, please visit the Reasonable Efforts Case Summaries link on the NCPTC Web site.

[35]ABA Center on Children and the Law, *American Bar Association Standards of Practice for Lawyers Representing a Child in Abuse and Neglect Cases*, http://www.abanet.org/child/rep-duties.html.

[36]The goal of better trained attorneys is certainly commendable; however, such a responsibility upon child welfare judges may be ill-placed. A recent survey of 2,241 dependency court judges indicated that 49% of judges enter this area with little or no training in child abuse or neglect cases. *View From the Bench: Obstacles to Safety and Permanency for Children in Foster Care* (July 2004) This survey was conducted by the Children and Family Research Center, School of Social Work, University of Illinois, Urbana-Champaign, and is available on line at www.fosteringresults.org.

[37]Paul Wellstone, *The Conscience of a Liberal*, 73, Univ. of Minn. Press, 2001.

Quick but Not Dirty: Rapid Evidence Assessments as a Decision Support Tool in Social Policy

Gavin Butler, MBA, Stuart Deaton, MA, James Hodgkinson, PhD Elizabeth Holmes, MPhil, and Sally Marshall, MA

Introduction

The demand for "evidence" to inform social policy decisions is now widespread. Its prominence within the United Kingdom emerged in 1997 with the election of the Labour government, and the government's use of principles derived from "new public management," with its emphasis on monitoring and control (Walker, 2000).

In 1999, the U.K. government called for "better use of evidence and research in policy making" (Cabinet Office, 1999, p. 16). It also set out the sources of evidence that policy makers should use, including expert knowledge, existing domestic and international research, existing statistics, and stakeholder consultation (Cabinet Office, 1999). Additionally, as Solesbury (2001) pointed out, "Most research effort is expended on new primary research and yet, on virtually any topic you can name, there is a vast body of past research that may have some continuing value" (p. 5).

This article describes a new approach to harnessing robust research evidence for policy makers in a more focussed and timely way than many other secondary research methods, namely the Rapid Evidence Assessment (REA). REA orders and filters research evidence in a similar way to a systematic review. However, systematic reviews require considerable effort and time. REAs are more likely to meet the time constraints of decision makers at national or local levels.

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This article describes the background to the first two REAs conducted and introduces the methodology. It then considers the case study examples in detail. The first is focused on the development of the methodology, and the second considers research utility and how REAs can be used with a policy and practitioner audience. The article concludes by discussing challenges and future implications for the REA approach.

Background to REAs

Good practice in conducting research requires one to first determine the extent of existing evidence relevant to the research question. Traditionally, the researcher conducts a narrative or literature review to search the evidence. In a literature review, reviewers typically seek to collate relevant studies and draw conclusions from them (Macdonald, 2003). However, there are limitations to this approach. Principally, literature reviews are susceptible to selection or publication biases, or both. Furthermore, they are often opportunistic in that they review only literature and evidence that is readily available to the researcher. Finally, limiting searches to the English language and relying on a single method for searching can also bias the results (Macdonald, 2003).

Given the limitations of literature reviews, researchers have developed new techniques in this attempt to address some of the issues. Systematic reviews of existing literature are increasingly being used as a valid and reliable means of harnessing research evidence. This type of review differs from a literature review by

- Being more systematic and rigorous in the ways in which they search and find existing evidence.
- Having explicit and transparent criteria for appraising the quality of existing research evidence, especially identifying and controlling for different types of bias in existing studies.
- Having explicit ways of establishing the comparability (or incomparability) of different studies and, thereby, of combining and establishing a cumulative effect of what the existing evidence is telling us (Davies, 2003, p. 4).

Systematic reviews involve a methodical, rigorous, and exhaustive search of all the relevant literature. Searches are conducted of both electronic and print sources. Relevant "grey literature" (i.e., unpublished studies or works in progress) is identified and hand searches are conducted when necessary. This approach helps to remove the problems of bias associated with traditional literature reviews. The search criteria used in undertaking a systematic review, and the criteria by which the literature is appraised and interpreted, are clearly defined and recorded. This leads to greater transparency and allows future studies to be added to the review, enabling an interactive and cumulative body of sound evidence to be developed on a subject area.

But undertaking a systematic review takes time, typically at least 6 to 12 months. Users of research and evaluation evidence often need quicker access to what the existing evidence can tell them. Consequently, Rapid Evidence Assessments (REAs) have been developed for use in public policy research and evaluation. REAs are based on the principles of a systematic review. The functions of an REA are to

- Search the electronic and print literature as comprehensively as possible within the constraints of a policy or practice timetable.
- Collate descriptive outlines of the available evidence on a topic.
- Critically appraise the evidence (including an economic appraisal).

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- Sift out studies of poor quality.

- Provide an overview of what the evidence is saying (Davies, 2003, pp.18-19).

Like systematic reviews, REAs are based on comprehensive electronic searches of appropriate databases and some searching of print materials, but to complete an REA in a shorter time frame, researchers make some concessions. As a result, exhaustive database searching, hand searching of journals and textbooks, and searching of "grey" literature are not immediately undertaken. This shortened time frame is essential for policy makers to meet deadlines but does introduce some publication bias. However, searching may be continued beyond the time available for an REA until a comprehensive search of the available research literature has been completed and a full-blown systematic review is achieved.

All REAs carry the caveat that their conclusions may be subject to revision when more systematic and comprehensive reviews of the evidence base have been completed. This is consistent with the important principle that systematic reviews are only as good as their most recent updating and revision (Davies, 2003).

Introduction to the Methodology

The exact approach undertaken in an REA will depend on the research question, but certain key steps need to be followed whatever the subject. Important steps include

- Formulating the policy issue into a clear research question.

- Developing a search strategy and establishing inclusion criteria for identifying relevant articles.

- Assessing the methodological quality and relevance of the identified articles. Articles are sifted using specified selection criteria. The two case studies described in this article both employed a scoring system, based on the Maryland Scale (Sherman et al., 1997), and a quality assessment tool, developed by the authors of the first REA (Deaton et al., 2004).

- Synthesizing the evidence across the different studies. Evidence may be synthesized in a number of ways, and it is necessary to adopt an approach most suitable for a particular review. One approach, for example, may be to undertake a meta-analysis,[1] in which evidence from the studies is combined and summarized statistically. However, this will be more problematic where outcome measures in studies are very different, or where the interventions covered by the studies are very different.

- Disseminating the messages. As REAs are aimed at practitioner and policy-maker audiences, it is important to consider what messages to disseminate to them and how to do this.

Using this approach ensures that the process is transparent with clearly defined appraisal criteria, thus differentiating the REA process from a traditional literature review.

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Case Studies

Although the following case studies illustrate very different aspects of the REA process, the methodology used within both studies was almost identical. Case study one describes the first REA undertaken and focuses on the development and implementation of the methodology. Case study two focuses on research utility and shows how the REA methodology has been used to produce research that is relevant and timely to policy makers and practitioners.

Case Study One – Effectiveness of Drug Treatment Within a Criminal Justice System, Deaton et al. (2004)

The roll-out of the Drug Interventions Programme in England and Wales in 2003/4 highlighted the need for further evidence on the efficacy of drug treatment for offenders within criminal justice settings. In an attempt to address this evidence gap, the Drugs and Alcohol Research program within the U.K. Home Office conducted an assessment of existing studies in this field at the end of 2003. The primary purpose was to provide policy customers with an evidence base to inform the further development of policies aimed at drug-using offenders. The aim was to complete the review in 12 weeks.

The research question posed was How effective is drug treatment for individuals in the criminal justice system in terms of reducing their drug misuse and reducing their drug-related offending?

As the primary aim of the assessment was to determine the effectiveness of drug treatment, researchers agreed that the assessment should consider evidence only from studies conducted using robust quasi-experimental designs. Time and resource constraints meant that a full systematic review could not be conducted. In consultation with Cabinet Office colleagues, their search team derived a plan to conduct an REA. As far as we were aware, this was the first time such an exercise had been attempted, so the searching, sifting, and reviewing of protocols were developed by the research team.

Search terms were devised, refined, and tested by the primary research team in cooperation with Home Office library staff, and relevant databases were subsequently searched. To cut down on the time and resources required for the abstract sift and for the assessment itself, researchers restricted analysis to post-1980 studies from all databases. In total, almost 3,000 abstracts were elicited.

The abstracts were initially sifted on the basis of (a) relevance to the research question and (b) whether the paper presented a primary study examining the effectiveness of an intervention. Researchers identified a total of 238 papers during the abstract sift stage and received 198 papers in the time available (due to time constraints, an arbitrary cut-off point was set). Of the 198 papers received, only 120 were reports of primary studies. Literature reviews were also acquired to provide further background information for the assessment and to gauge whether the studies we had found were broadly representative of the literature in this field.

The 120 primary studies were then reviewed to determine whether they were (a) relevant to the research question and (b) methodologically sound. Once a study had been acknowledged as relevant, an initial assessment of the methodology was carried out based on the "Maryland Scale," devised by Sherman et al. (1998). Only those studies with a robust comparison group design were considered for inclusion in the assessment. Sherman and colleagues argued that only these studies can provide strong evidence of causality, and hence effectiveness. The group identified for further assessment a total of 64 relevant studies based upon the Maryland Scale assessment criteria.

Further assessment was carried out using an ad hoc quality assessment tool (QAT), devised specifically for this project. The QAT was based on a combination of more detailed coding protocol prepared by Sherman et al. plus criteria established by Home Office research colleagues for a previously conducted systematic review. Each study was marked according to its methodology in four key areas: sampling, bias, data collection, and data analysis. Each element was rated as one of the following: 1 (good), 2 (average), 3 (weak) or 5 (unable to determine from the paper). The scores for each component were then added together to provide an overall rating for the study. Those studies with the lowest scores were considered the most methodologically robust.

To develop and refine the QAT, the six members of the review team each reviewed the same three studies. They then compared individual assessments and reached a consensus on any discrepancies in scores. This process had the dual effect of refining the QAT guidance and ensuring a greater degree of consistency among reviewers of the papers. In total, the reviewers chose 50 studies as methodologically sound enough for consideration in the review. Most studies included in the review focussed on evaluations of the effectiveness of drug courts, therapeutic communities, or aftercare provision. The available evidence on therapeutic communities and aftercare suggested they have a positive impact on reducing drug use and offending. However, results were more equivocal regarding the effectiveness of drug courts.

The team then prepared a narrative review of those fifty studies. To make the report more useful to policy makers, they next drew out and presented in summary form the seven key themes running through the narrative review. This is a slightly different approach to most systematic reviews, which focus primarily on whether interventions do or do not work but fail to address the question of why or why not. The report also set out appropriate caveats concerning the fact that this was not a full-blown systematic review. Therefore, policy makers could make an informed decision based on the relative strength of the available evidence.

The REA was completed at the end of January 2004, and the findings helped to support policies within the Drug Interventions program that was presented to the U.K. Treasury as part of the 2004 Spending Review. Since the completion of the REA, the initial findings have been built upon with quarterly updates of new evidence on the effectiveness of drug treatment interventions in criminal justice settings (however, it must be noted that no systematic updating of the REA has taken place to date).

Case Study Two: Evidence-Based Approaches to Reducing Gang Violence, Butler et al. (2004)

In January 2003, two young women were killed in Birmingham, England, in shootings that formed part of an ongoing conflict between two criminal gangs in the city. As well as criminal investigations, the City Council, West Midlands Police Service, and other statutory and voluntary sector partners formed an interagency group to combine and enhance efforts to reduce gang violence in the city. This group, which came to be known as Birmingham Reducing Gang Violence (BRGV), tasked the Regional Government Office[2] with advising on research and evaluation, particularly about "what works" to steer a course through conflicting options and proposals.

Although the researchers obtained a range of literature reviews and other papers on gang violence, these sources were dominated by sociological explanations of cause and risk factors, or unsystematic accounts of program evaluations without an explicit methodology. There was no readily available resource on effective approaches to reduction or prevention.

At times, research can seem remote from frontline practice and policy decision making. The timeliness and rapid approach of REAs combined with practitioner involvement clearly provide a mechanism through which robust evidence can be presented and disseminated in a way that is policy-friendly.

BRGV is a multiagency, multidisciplinary group made up of operational and strategic police officers; local authority regeneration and delivery managers; the head of the city's youth service; representatives from education, training, and employment agencies; schools; and youth offending services. BRGV also represents a number of different professions, and the individuals and agencies have a range of experiences and expectations in relation to research.

The Regional Government Office proposed the REA methodology to BRGV. The virtues of an REA were that it had a transparent methodology and could provide a means to focus on evidence of effectiveness, while taking significantly less time to complete than a full systematic review. Partner agencies in Birmingham also responded positively to the term "rapid."

This REA was undertaken by a team of four staff, all based in the Regional Government Office. Three of the members were professional researchers with the Home Office's Regional Research Team, and the fourth managed youth and street crime policy and programs. The team held a range of skills and experiences, including research methodology, project management, and policy development.

The research question What is effective in preventing or reducing young people's involvement in gang and gun related activity, as victims or offenders? was framed in consultation with BRGV, who helped prepare a list of relevant terms to inform the search strategy.

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The task of searching a consensus list of social science databases was given to an information management specialist at the Centre for Evidence-Based Policy and Practice at Queen Mary University, London. This resulted in the identification of 311 abstracts. The literature was reviewed by pairs of research team members, a filter was applied, and 93 papers were ordered via the Home Office library, with 69 being received in time to be considered for the review.[3] Those papers were reviewed using the QAT (Deaton et al., 2004)), leaving six papers for inclusion in the REA. Researchers then analyzed these papers for theories of change (what was the underlying hypothesis?) and critical mechanisms (what were the most important elements of the programs and policies?). Emergent themes were discussed and analyzed.

The key findings identified the following approaches as effective in reducing gang violence:

- The coordination of gang reduction activity, using a multiagency, multimodal strategy specific to one city or locality.

- Civil injunctions, which are civil actions that prohibit named individuals from engaging in specific problematic activities within a clearly defined area.

- Peer mentoring, which involved young people ages 14 to 21 who would mentor children aged 7 to 13 through a program of 12 violence prevention lessons over an 18-month period.

- School-based learning, which involved uniformed police officers teaching students a 9-week gang prevention curriculum.

The findings were presented to BRGV as a comprehensive document that included a detailed account of the methodology. Along with the report, the team made available a one-page summary and presented the findings at local and national events.

The REA has influenced some policy decisions, but it is difficult to determine the relative influence the REA has had on subsequent events. It is clear that certain funding decisions have been made considering the REA report. The REA has also been used to validate the local use of new interventions, such as the use of civil injunctions to disrupt gang activity in the city.

In order to continue to promote evidence-based approaches to address gang violence, and the link between research and practice, the project team took the following steps:

- Forming a research subgroup with academic and practitioner input

- Ensuring that one member of the REA team attends every BRGV meeting

- Producing research updates for BRGV on relevant topics, such as definitions of gangs and summaries of recent primary research

- Advising the police and community groups on evaluation frameworks to generate U.K. evidence of effectiveness

User feedback has been generally positive. A survey by the REA team indicated that the message about targeting problematic behavior rather than gang affiliation was useful for the Prison Service, Learning and Skills Council, and especially, the police. Other agencies focussed on the REA's ability to help them make defensible decisions on prioritising resources. At least one respondent criticised the methodology, reflecting the "paradigm war," described by Tim Hope in McLaren (2002), between experimental criminologists and the "realistic evaluation" school. There have been comments about the fact that all the papers analyzed in the REA are primary studies from the United States, with attendant and understandable reservations about transferability. One outcome is that the REA has facilitated a range of debates about improving the evaluation of local programs to develop U.K. research evidence in reducing gang violence.

Given the known limitations of REAs, it is important that researchers are completely transparent about the process adopted and that stakeholders are made aware of the caveats. Systematic reviews are an established method for harnessing existing research evidence.

Practical Considerations

Managers and practitioners needing high-grade research evidence to inform a policy decision should consider whether an REA can address their needs. Practical elements to consider when commissioning such work would include

- Resources. An REA should take 6 to 12 weeks; therefore, it is important to be realistic about time commitments. Access to library resources and reference management systems to undertake the research also need consideration.

- Skills and knowledge. Those commissioned need to be familiar with research methodology and able to implement it. It is important that those reviewing papers for an evidence assessment have sufficient knowledge and experience in research methods to carry out the assessment.

- User involvement. The second case study in this article also shows that involving practitioners and policy makers in Rapid Evidence Assessment can be beneficial for all parties and increase ownership of the research findings.

Future Implications

These case studies demonstrate that REAs are an evolving approach with clear advantages for use within a policy and practice arena. The two REAs that have been completed to date have answered questions based on "effectiveness"; however, it is important to recognize that the methodology is not restricted to this type of question. Leading organizations specializing in systematic review work, such as the Evidence for Policy and Practice Information and Coordinating (EPPI) Centre, U.K., consider it perfectly possible to integrate a meta-analysis of data from controlled trials with a synthesis of findings from qualitative studies (Gough & Elbourne, 2002), and some systematic reviews have indeed managed this successfully (e.g., Thomas et al., 2004). We should track the develop-

ment of this methodology as it is applied to other questions. Precisely because the approach is developing, no standard methodology for REAs has yet been published. As the use of REAs increases, it will be important to have a standard REA methodology clearly set out so that the dilution of its focus and purpose can be avoided.

At times, research can seem remote from frontline practice and policy decision making. The timeliness and rapid approach of REAs combined with practitioner involvement clearly provide a mechanism through which robust evidence can be presented and disseminated in a way that is policy-friendly. Research utility is an area that generally warrants further investigation, and as a result, it is vital that the impact of this type of research on policy and practice is monitored.

Given the known limitations of REAs, it is important that researchers are completely transparent about the process adopted and that stakeholders are made aware of the caveats. Systematic reviews are an established method for harnessing existing research evidence. REAs can be regarded as "interim" systematic reviews and have the potential to become a new method for applying research evidence to policy decisions, in an appropriate and rapid way that also effectively scopes the ground for a full systematic review.

Notes

[1]Meta-analysis is a statistical method of combining and summarizing the results of studies that meet a minimum quality criteria.

[2]Regional Government Offices represent the central government departments within nine administrative districts or regions of England. They cover populations of about four to five million.

[3]A subsequent review of the papers omitted by the use of a fixed cut-off date revealed that only one of them would have been considered for the REA. However, this "project management bias," like any other form of bias in research, is a challenge to the validity of the findings.

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Stress, Trauma, and Support in Child Welfare Practice

Cheryl Regehr, PhD, Bruce Leslie, MSW
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Introduction

A growing body of literature spanning three decades identifies the emotional impact of providing social work services. This process, defined as burnout, is viewed to encompass a variety of symptoms, including emotional exhaustion, loss of a sense of personal and professional accomplishment, diminished capacity to meet the needs of clients, and ultimately, job departure (Brunet, 1998; Cherniss, 1980; Maslach, 1982; Um & Harrison, 1998). Child welfare practice has frequently been identified as a particularly stressful field of practice with high risk of burnout (Anderson, 2000; Jayaratne, Chess, & Kunkel, 1986). Stressful aspects of the job include excessive work demands caused by unwieldy caseloads, court appearances, and overwhelming paperwork; poor working conditions; negative public perceptions; and low salary (Bradley & Sutherland, 1990; Collings & Murray, 1996; Gutterman & Jayaratne, 1994; Vinokur-Kaplan, 1991). Added to these administrative challenges are the difficulties associated with productively engaging involuntary clients and the awesome responsibility of protecting society's most vulnerable citizens (Munro, 1996; Lindsey & Regehr, 1993). Finally, child welfare practice is fraught with social and political pressures, including conflicting pressures of the best interest of the child, concerns for the parents, and shifting public policies (Guterman & Jayaratne, 1994). Child welfare workers are charged with balancing society's wish to protect children from abuse while maintaining the family as the bastion of liberty (Munro, 1996).

In addition to ongoing workload demands and sociopolitical pressures, child welfare workers are often confronted by traumatic events as a result of working in high-risk situations. These traumatic events can include threats or injury toward themselves and the injury or death of a child for whom the worker has responsibility. In recent years, there has been a growing recognition that exposure to tragic events results in traumatic responses in emergency service workers responding to the event (McFarlane, 1988; Solomon & Horn, 1986; Regehr, Hill, & Glancy, 2000). Symptoms described include recurrent dreams; feelings of detachment, guilt, anger, and irritability; depression; memory or concentration impairment; somatic disturbances; alcohol and substance use; and reexperiencing of symptoms when exposed to trauma stimuli (Gersons, 1989; Gibbs, Drummond, & Lachenmeyer, 1993; Solomon & Horn, 1986). Several of these authors have concluded that severe emotional reactions are normal responses to exposure to traumatic events in the line of duty.

Despite the attention to individual responses to traumatic events in emergency organizations (e.g., policing, fire, and ambulance), relatively little research has focused on trauma responses in child welfare workers. Interestingly, child welfare documentation, such as case records and abuse evidence photographs, have been considered so disturbing that one study discussed the traumatic responses encountered by researchers surveying charts of child maltreatment cases (Kinard, 1996). As a result, steps were taken to protect researchers from exposure to traumatic stimuli by limiting the amount of time spent reading the material. Further, when conducting follow-up interviews with some of the families, one of the researchers was threatened because the family member assumed that she was a child welfare worker. Clearly, the exposure for children's aid workers to both disturbing material and threats of violence is likely to be substantially higher.

A recent study investigating traumatic exposure in child welfare workers determined that vicarious events (i.e., stemming from proximity to clients' lives) were more highly associated with traumatic effects than were those stemming from verbal abuse and threats directed toward the worker (Horwitz, 1999). Several factors place child welfare workers at high risk of secondary or vicarious trauma. For example, the prolonged relationship that child welfare workers often have with the victims and perpetrators. A traumatic event, in the form of violence against a child, spouse, or the workers themselves, can thus be experienced as both a betrayal and a failure. In addition, child welfare workers are particularly vulnerable due to their capacity for empathic engagement. While empathy is a major resource in assessing and intervening with clients, research suggests that it also increases the risk of experiencing symptoms that parallel those of the victim (Figley, 1995; Kilpatrick, 1998). Further, police, fire, and other emergency workers report that they are most vulnerable to traumatic impact when the incident involves children (Beaton & Murphy, 1995; Regehr, Hill, & Glancy, 2000). Finally, child welfare staff members are at greater risk than other mental health and social work practitioners because they work primarily in people's homes, exposing them directly to violence and traumatic material without the physical and psychological safety of the office environment.

Several studies have pointed to the importance of social support as a mediator of workplace stress and burnout. In general, high levels of perceived social support have been found to be associated with lower levels of stress as well as higher levels of perceived personal accomplishment and self-esteem (Davis-Sacks, Jayaratne, & Chess, 1985; Um & Harrison, 1998). However, it appears that job support may not moderate the relationship between critical incidents encountered in the workplace events and the experience of trauma (Horwitz, 1999).

The present study explores stress and traumatic events in a child welfare setting. The purpose of the research is to develop a better understanding of the ongoing stressors, critical incident stressors, and traumatic events encountered by child welfare workers; to examine the consequences on individual workers of exposure to stress and trauma; and to discuss the impact of social supports on the experience of trauma.

Methodology

This research was conducted at the Children's Aid Society of Toronto, one of the largest board-operated child welfare organizations in North America. Data collection involved both qualitative and quantitative methods. The quantitative survey was distributed to all staff following meetings describing the nature of the study. Front line, clerical, and management staff returned a total of 175 questionnaires (described in this article). This represents approximately a

30% response rate from the entire agency. However, a higher response rate came for some areas. For instance, the response rate of intake social workers was closer to 50%. This is particularly high considering that a number of workers in this area had only recently been hired and did not complete questionnaires. Lower response rates were obtained for support staff members who provided fewer services directly to clients. Actual response rates are difficult to determine as data collection occurred over a 4-month period, during which there were varying numbers of vacancies and newly hired individuals.

Thirty-eight of the respondents were men and 135 were women (for 2 questionnaires, gender data were missing). Twenty-nine percent of the respondents were single, 58.6% were married or living common-law, and 12.4% were separated, divorced, or widowed. With regard to education, 26.5% had BSWs, 32.9% had MSWs, 12.4% had other university degrees, and 20.6% had college diplomas. The mean age of respondents was 40.8 years (SD 10.3) with an age range of 23 to 63. The mean number of years in child welfare was 12.7 (SD 9.3); however, there was tremendous variation in the number of years worked in child welfare by position. As indicated in Table 1, the median number of years worked in child welfare in intake positions was 1 while the median number of years worked in other social work positions was 12, and in management the median was 19.

Table 1: Years in Child Welfare

Position	Mean Number Years	Median Number Years
Intake social worker	2.3	1
Family service social worker	6.8	3
Other social worker	14.9	12
Child and youth worker	13	13
Clerical	13	15
Management	19.3	19
Other	13.7	13

Workers who participated in the quantitative portion of the study were asked if they would be willing to participate in a one-hour interview to further discuss their experiences. A subsample of 20 workers was selected for personal interviews. These interviews explored dimensions of ongoing stressors, traumatic stressors, and support systems. At the completion of the study, group meetings were held with members of three constituencies—management, volunteer front-line workers, and union executives—at which time the initial data were presented and reactions were obtained.

Quantitative Measures

Demographic data. Demographic data were collected using a questionnaire that covered items including age, sex, marital status, education, ongoing stressors, and exposure to traumatic incidents.

Posttraumatic reactions. This variable was measured by three scales: the Beck Depression Inventory, the Impact of Events Scale, and the Stress-Related Growth Scale. The Beck Depression Inventory is a self-report scale that assesses the presence and severity of affective, cognitive, motivational, vegetative, and psychomotor components of depression (Beck & Beamesderfer, 1974). Initially standardized on 606 psychiatric inpatients and outpatients, the reported reliability coefficient was .86. Test-retest reliabilities were .48 for psychiatric patients after 3 weeks and .74 for undergraduate students after 3 months. The BDI is now one of the most widely used measures of depression in both clinical practice and with nonclinical research populations.

The Impact of Events Scale (Zilberg, Weiss, & Horowitz, 1982) assesses the experience of posttraumatic stress for any specific life event. It taps dimensions that parallel the defining characteristics of Posttraumatic Stress Disorder (PTSD) in DSM-IV, that is, signs and symptoms of intrusive cognitions and affect, concurrently or oscillating with periods of avoidance and denial or blocking of thoughts and images. Cluster analysis has shown the two subscales to have high internal consistency with Cronbach's alphas of .78 and .82. Test-retest reliability is set at .87. A score of 26 or more is considered consistent with a diagnosis of PTSD (McFarlane, 1988; Lavie et al., 1998).

The Stress-Related Growth Scale measures positive outcomes of stressful events (Park, Cohen, & Murch, 1996; Cohen, Hettler, & Pane, 1998). The SRGS was tested on 922 students in the United States and a sample of adult church members. Reported alphas were .94 and .96, respectively. Test-retest reliability after 2 weeks was .81.

Social support. A situation-specific support measure was designed by the researchers. This addressed perceived support of family, friends, coworkers, supervisors, and managers. Participants were asked to rate the level of support they received from people in their personal lives and from colleagues in their organizations on a scale of 0-5, with zero representing no support and 5 being very supportive.

The Social Provisions Scale (SPS) is a brief (24 item) multidimensional self-report instrument that offers the possibility of discriminating among six distinct types of social support, and which also assesses global support (Cutrona & Russell, 1987). The measure was tested on a total of 1792 respondents, including psychology students, nurses, and teachers. The reported alpha level for the total scale was .91. Extensive validity testing was reported by the developers (Cutrona & Russell, 1987).

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Results

Ongoing Stressors

Participants were provided with a list of potential ongoing stressors in their jobs and were asked to indicate whether or not each of the items represented a stressor for them. The highest-ranked ongoing stressor was the quantity of work, which was rated as a stressor by 75% of respondents. Other highly endorsed items were documentation requirements (59.9%), dealing with difficult or disruptive clients (55.2%), and organizational change (50.6%). In addition, approximately one third of participants indicated that job stressors included conflicts with staff, supervisors, or managers; changing policies and standards; risk of civil or legal liability; court-related activities; public or media scrutiny; and/or lack of community resources. These are reported in Table 2.

Table 2: Ongoing Stressors

Type of Stressor	% Reporting
Amount of work	75.0%
Documentation	59.9
Difficult or disruptive clients	55.2
Organizational change	50.6
Conflicts with staff, supervisors, managers	39.5
Changing policies / standards	36.6
Risk of civil or legal liability	33.7
Court-related activities	33.1
Public or media scrutiny	32.2
Lack of community resources	31.6
Mandatory training	26.9
Travel	18.0
Conflict with community individuals	14.6

Qualitative information collected during interviews and consultation group meetings reinforced this data. It was noted that in response to recent increases in workload and accountability requirements, workers were expected to simultaneously and immediately attend to a large number of competing demands. As a result, respondents reported second guessing their decisions, exhibited concerns that clients' needs had not been met, and felt no sense of accomplishment in their work. In addition, some workers reported feeling disempowered by the requirements of the system and the pressures under which they worked. Respondents reported frequently working overtime to meet the excessive demands. This had negative implications for their personal health and for their family life. Many reported concern about not adequately meeting their responsibilities to their own children.

Other ongoing stressors reported by workers included negative and scathing publicity by the media about the agency, or about particular workers, or both. Workers also expressed frustration about the lack of time available to work directly with families, and expressed concern that their work was focused more on meeting the needs and requirements of legislation rather than providing service to clients. Further, concerns were expressed about the high turnover, the addition of many new workers, and the agency's inability to properly train personnel. Supervisors experienced the increased responsibility of reviewing each step of every case for new workers. New workers expressed concerns that they did not possess the knowledge to manage all situations.

Critical Incident Stressors

Table 3 presents a list of events that respondents may have encountered during their work in child welfare. Respondents were asked to indicate whether they had encountered any of the listed events and whether they experienced emotional distress as a result of exposure to these event(s). A total of 145 or 82.7% of respondents indicated that they had been exposed to at least one critical incident at work, including the death of a child, the death of an adult client, and/or assaults and threats against themselves. Of the 145 CAS staff who reported exposure to these events, 101 or 70% indicated that they had experienced distress as a result of their exposure. This represents 58% of the total sample of 175.

Table 3: Traumatic Incident Stressors

Type of Incident	% Who Report Experiencing Item	% Who Report Distress
Death of a child in service due to accident	31.2%	21.5%
Death of a child in service due to abuse	*	77.8
Death of a child for whom you had service responsibility	24.9	62.8
Death of an adult client	20.8	50.0
Assault against self	23.7	26.8
Threats of violence against self	52.6	63.7
Threats or injury to other staff	46.8	50.6
Other serious event	22.5	78.2
Any traumatic event	82.7	70.0

***Researchers assumed that all employees had experienced a death of a child within the agency.**

The types of traumatic events encountered by respondents did not vary greatly by position. Approximately 20% of staff in all job categories had been victims of assault on the job at one time during their career. The exception was child and youth workers, of whom 70% reported having been assaulted on the job. In addition, almost 50% of staff throughout the agency (and 60% of child and youth workers) had experienced verbal threats against themselves at some time in their career. The mean number of months since the most recent traumatic event was 8.5 for intake workers, 7.75 for clerical staff, 18.6 for family service social workers, 16.7 for management staff, 24.0 for child and youth workers, and 27.6 for other social workers. This is summarized in Table 4.

Table 4: Frequency of Critical Events

Job Category	Most Recent Event (Mean Number of Months)	Mean Number of Incidents in Past Year
Intake	8.59	1.19
Family service social worker	18.61	1.20
Other social worker	27.63	1.25
Child and youth	24.00	1.00
Clerical	7.75	2.00
Management / supervisor	16.68	1.55
Other	33.94	1.56

During the feedback sessions with the consultation groups, workers were not surprised by the rates of assault and joked that if you hadn't been hit, you hadn't been at the agency long enough. They identified risks that resulted from working alone in dangerous neighborhoods. Several noted that police had said they would never go to those neighborhoods alone. Further, workers identified that the threats of violence had a powerful effect because these raised safety fears for both workers and their families. Finally, workers noted that removal of children from their family had not been included in the study as a specific critical event, even though this was a highly stressful traumatic event. In most cases, removing children from their families is very traumatic for the family, often precipitating threats and violence.

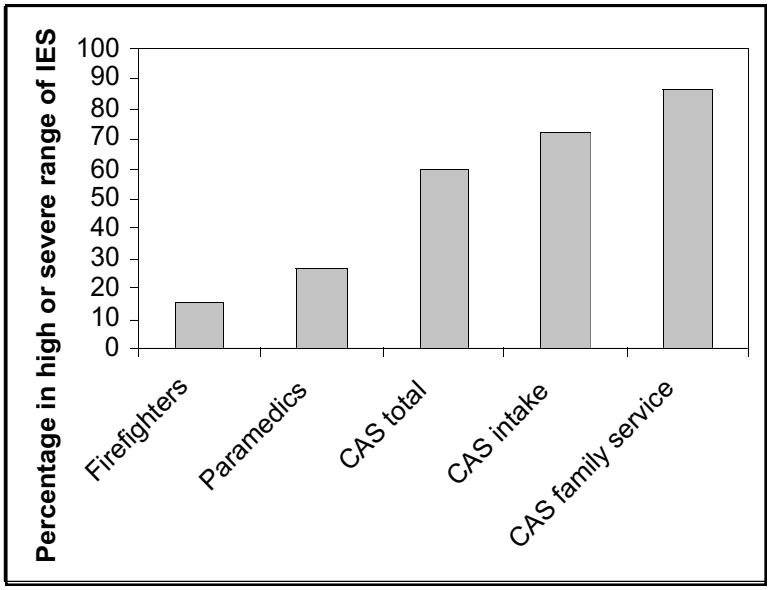
Relative Ranking of Stressors

Participants were asked to rank four categories of stressors: workload, traumatic events, working environment, and reviews/accountability. Using this system, 68% of workers rated workload as the most stressful part of their job, 14% rated traumatic events, 11.5% rated the working environment, and 11.5% rated reviews and accountability. Thus, while workers do experience high rates of posttraumatic distress, it is important to recognize that stress is experienced most often as a result of high workloads and multiple, often competing, demands.

Signs and Symptoms of Traumatic Stress

Scores on the Impact of Event Scale indicated that staff members experience high degrees of traumatic stress reactions. The IES is divided into categories indicating low, moderate, high, or severe levels of distress. The severe distress category relates to a symptom score that is associated with a diagnosis of Posttraumatic Stress Disorder (PTSD) according to other researchers (McFarlane, 1988; Lavie, et al., 1998). In this sample, 46.4% of respondents reported symptoms scoring in the severe category. These high levels of posttraumatic stress symptoms are particularly striking when the respondents were sorted by job categories. Among intake social workers, 52.0% scored in the severe range, and an additional 20% scored in the high range; 64% of family service social workers were in the severe range, and an additional 12% were in the high range; and 75% of children's services social workers were in the severe range, with an additional 12.5% in the high range. To better identify the significance of these levels of traumatic response, the levels of distress are compared with a sample of firefighters and paramedics (Regehr, Hill, & Glancy, 2000; Regehr, Goldberg & Hughes, 2002). Figure 1 reports the number of respondents in the high or severe range of symptoms on the IES.

Figure 1: Comparing Traumatic Stress With Others



While workers identified high levels of posttraumatic stress symptoms, they did not report symptoms of depression. Ninety-four percent of respondents scored in the none to mild depression range on the Beck Depression Inventory, according to guidelines set by the developers (Beck, Steer, & Garbin, 1988). No respondents scored in the severe range.

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The Stress-Related Growth Scale does not have established means of high growth and low growth. However, there was a mildly positive correlation between reports of postraumatic growth and level of posttraumatic symptoms as measured by the IES (r=0.19, p=0.05).

To assess the association between ongoing stressors and traumatic response, a variable was created which was a sum of the number of different ongoing stressors that individuals reported. Therefore, each respondent could obtain a cumulative workload stressors score of 0 to 14. A correlational analysis then revealed a moderately strong association between the cumulative workload stressors and both the IES (r= 0.30, p=.001) and the BDI (r=0.23, p=.001).

Support Systems

Participants were asked to rate the level of support that they received from people in their personal lives and from others in the organization on a scale of 0-5 (0 being not at all supportive, and 5 being very supportive). Approximately two thirds of those who were in a significant relationship felt that their spouses/partners were supportive at a level of 4 or 5. Sixty-five percent rated friends and over half rated family as highly supportive (4 or 5 ratings).

Respondents also reported high levels of support from colleagues (74% at level 4 or 5) and from managers (53% at the level of 4 or 5). Ratings for the Employee Assistance Programs and union were lower, in large part because respondents did not feel they were appropriate sources of support for job-related distress. The mean score on the social provision scale was 80.43 (SD 8.3). This is not significantly different from norms established for samples of university students, teachers and nurses of 82.45 (SD 9.9) (Cutrona & Russell, 1987).

Interestingly, despite high reported levels of support, none of the measures of social support was significantly associated with scores on the Impact of Event Scale. That is, while support may be important in many ways, it does not appear to reduce symptoms of traumatic distress. Levels of social support from family (r= -.232, p=.01) and colleagues (r= -.294, p=.01) were, however, moderately related to depression scores. Similarly, scores on the Social Provision Scale were not significantly associated with IES scores, but were associated with scores on the Beck Depression Inventory (r= -.254, P=.01). That is, people with higher levels of perceived support reported lower levels of depression symptoms.

In the qualitative component of the study, several individuals commented on the fact that they loved their jobs and felt committed to the agency. Workers commented on supervisors who nurtured staff, encouraged staff to take breaks, and took an interest in the lives of their staff outside of work. Many workers stated that they had learned to set clear boundaries in their lives so that the work-related stress did not interfere in their personal lives. This included developing leisure time activities and not discussing work issues at home. Nevertheless, most respondents had experienced or continue to experience stress in their personal lives because of their preoccupation with the demands and stressors from work.

Discussion

Consistent with earlier literature on stress and burnout in social workers in general (Bradley & Sutherland, 1995; Collings & Russell, 1996) and child welfare workers in particular (Jayaratne, Chess, & Kunkel, 1986; Kilpatrick, 1998), 68% of respondents in this study identified workload as the primary stressor in their jobs. This included documentation requirements and multiple demands for service resulting from recent legislative changes. Further, new legislative requirements had resulted in organizational changes and concerns regarding liability, which were augmented by scathing media attention. All of these increased the pressures experienced by staff and also increased their vulnerability to posttraumatic stress symptoms. The qualitative component of the study underscored how these ongoing stressors depleted the resources of staff and increased vulnerability in dealing with crisis situations.

Study findings further demonstrate that child welfare staff members are exposed to a significant number of traumatic stimuli. Approximately 20% of staff in all job categories and 60% of child and youth workers had been victims of assault on the job; 50% of all staff and 70% of child and youth workers had been verbally threatened. This is consistent with the findings in another study that suggested 11% of rural child protection workers had been assaulted in the previous year, and 33% had been verbally threatened (Horejsi, Garthwait, & Rolando, 1994). In the present study, one fourth of respondents indicated a child for whom they had service responsibility had died, and one fifth of respondents had experienced the death of an adult client. Other traumatic events reported included riots, and attending coroners' inquests. In addition, several staff members indicated that apprehensions of children were particularly traumatic due to the highly emotional reactions of family members, which often led to verbal or physical assault. These events occurred more recently for intake workers and clerical workers than for other staff members. In total, 82.7% of respondents reported encountering a traumatic event on the job, and 70% of these workers reported significant emotional distress as a result.

The subjective ratings of emotional distress were corroborated by scores on the Impact of Event Scale. Previous researchers have concluded that scores falling in the severe range of the IES are consistent with a diagnosis of posttraumatic stress (McFarlane, 1988; Lavie, et al., 1998). In this study, 46.4% of all individuals in the study, 52% of intake workers, 64% of family service social workers, and 75% of children's services social workers had scores consistent with a diagnosis of PTSD. Clearly, staff members within this large urban child welfare organization in general and social workers in particular are experiencing high levels of posttraumatic distress.

Symptoms associated with posttraumatic stress disorder measured by the IES fall into two categories: 1) avoidance symptoms, which include feelings of detachment, efforts to avoid thoughts or feelings associated with the trauma, and efforts to avoid activities or places that are reminiscent of the trauma; 2) intrusion symptoms, which include intrusive thoughts or memories of the event, distressing dreams, and physiological symptoms. However, while workers identified high levels of posttraumatic stress symptoms, they did not report symptoms of depression. This suggests that the symptoms are event-specific and do not translate into generalized depression.

Workers also reported strong levels of distress, even though workers also report strong support systems within both their personal lives and within the organization. This was consistent in both the quantitative and qualitative components of the study. Therefore, contrary to the general research on stress and burnout (Um & Harrison, 1999; Davis-Sacks, Jayaratne, & Chess, 1985), social support did not appear to mediate posttraumatic stress symptoms in this sample. There was no significant association between scores on the IES and any measure of social support.

Finally, while workers did report traumatic distress, they also reported experiencing rewards and satisfaction with their work. In the qualitative interviews, workers reported feelings of commitment and enjoyment. Other authors have similarly indicated that social workers reported that their jobs were satisfying and meaningful despite high levels of stress (Watson, 1979; Reagh, 1994). In addition, the association between the IES and the SRGS, found in this study, suggests that increased levels of distress are associated with higher reports of personal growth or positive outcome. This conclusion is consistent with other reports that suggest that stress and trauma can be energizing for workers (Jones, 1993).

This study raises some important questions for further research. One is the impact of staff's posttraumatic distress on worker-client interactions and case decision making. For instance, heightened anxiety and hypervigilance may influence decisions regarding case openings, apprehensions, court recommendations and risk ratings. This could potentially increase both workload and hostile reactions of clients, thus perpetuating two of the stressors ranked highly in this study. A second issue relates to the scores on the Impact of Event Scale by management. While lower than those of front-line social workers, they also fell above the range associated with PTSD. The manifestations of these symptom levels on supervision and policy development are as yet undetermined.

Implications for Practice

In summary, workers from a large urban child welfare agency who participated in this study identified that ongoing workload pressures were the most stressful part of their job. Suggestions provided by workers for assisting with these pressures included increased support staff, reduced caseloads, and streamlining of recording procedures. In addition, staff scored the importance of encouraging workers to take lunch breaks and not work excessive amounts of unpaid or unclaimed overtime.

The finding that traumatic stress symptoms are not ameliorated by support is somewhat troubling for administrators of child welfare organizations. While support is clearly important for workers, it does not eliminate or even significantly reduce the symptoms of traumatic stress. As a result, the most effective solution would appear to be reducing workers' exposure to traumatic experiences. In part, this could be accomplished by reduced workloads and improved safety measures to reduce staff's exposure to threats and violence. In addition, child welfare organizations can promote resilience in staff through self-esteem building strategies, such as creating the conditions to allow for task accomplishment, validation, and professional growth (Horwitz, 1998).

Finally, it is important to celebrate the dedication and strengths of workers who continue to work in this difficult area of practice. Their power to reframe traumatic events as learning experiences and to overcome their fears are truly remarkable skills. We must ensure that the efforts of these child welfare are acknowledged. Their accomplishments need to be presented to both legislators and the public to increase the awareness of child welfare workers as valuable resources that we must support and protect.

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A Message from the President

Anthony P. Mannarino, PhD

I feel extremely privileged to be able to provide our membership with a message regarding the "state of APSAC." And I am quite pleased to inform you that APSAC is doing very well. I have been a member of APSAC since its inception, and as with any organization, there have been ups and downs. Fortunately, APSAC has weathered a number of storms and has even picked up some strength along the way. APSAC's survival as a vibrant organization is important to all of us because it remains the most well-recognized, interdisciplinary, national group that addresses the needs of professionals who work in the child maltreatment arena.

There are a number of updates that I would like to provide. First, APSAC moved its administrative office in late 2004 from Oklahoma City to Charleston, South Carolina. We owe much thanks to Trish Gardner and John Madden for the wonderful job they did managing the office in Oklahoma City. Our new operations manager in Charleston is Daphne Wright. Daphne has taken charge of the administrative office with great energy and enthusiasm and brings to APSAC a history of providing leadership to nonprofit organizations. There is no small detail that gets past Daphne's scrutiny, and we look forward to having her and her consulting group manage the central office for many years to come. By the way, one of the things that Daphne has been working on is to update and modernize APSAC's Web site (www.apsac.org). It is almost completed and we all should be able to access it this spring.

Despite this change in location of the APSAC office, our membership base remains very solid. We continue to have over 2,000 members and our renewals this winter have been quite high. In this regard, APSAC owes a great deal of appreciation to Cindy Swenson, our vice president, who has headed the Membership Committee for several years and who has provided tremendous leadership for our organization. Developing a membership list, tracking renewals, recruiting new members, and so forth can be daunting tasks for an organization, and Cindy has truly excelled in helping APSAC to move forward in these areas.

As I write this message to our membership, I am gratified to report that APSAC remains financially sound. Our Board has been prudent in its decision making related to financial concerns. Although we always strive to move the organization forward to fulfill its mission, we have tried very hard to keep our finances in order. Sometimes this has meant discontinuing specific educational activities that have been losing money. In this regard, Pam Gosda, APSAC's treasurer, has done an outstanding job in reminding the Board that there can be no mission or even an organization if there is no money.

In May 2004, APSAC's Board of Directors conducted a two-day strategic planning meeting in Chicago. This meeting was led by Bill Treasurer, an organizational consultant, who helped us to clarify our mission and develop some targeted organizational objectives for the next several years. A new mission statement came out of this meeting: "APSAC's mission is to enhance the ability of professionals to respond to children and their families affected by abuse and violence." There were also four priority areas identified by the Board: Operational Excellence, Education and Training, Professional Awareness, and Diversity. Since the meeting, workgroups have been meeting via conference calls to address each of these areas and to promote the objectives identified by the strategic planning process. I believe that our Board found this meeting to be very productive, and I believe it renewed our dedication to APSAC and its mission.

The Annual Colloquium continues to be APSAC's showcase educational meeting. The Colloquium was held in Hollywood, California, last August and was attended by over 500 people. Most people expressed that the educational offerings were excellent and that the hotel venue turned out to be terrific. It was kind of fun walking around Hollywood among "the stars." As always, the Cultural Institute was a highlight of the Colloquium. It provided professionals with the unique opportunity to acquire the skills necessary to work with diverse populations and to understand the impact of culture on child maltreatment. Additionally, we were pleased to establish our initial collaboration with the National Child Traumatic Stress Network (NCTSN). The NCTSN is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) to increase the quality of and access to services for traumatized children and their families across the country. The APSAC-NCTSN collaboration included several pre-Colloquium Institutes as well as an NCTSN track during the Colloquium. This collaboration was a great success and will continue at the 2005 Colloquium. It is noteworthy that the 2004 Outstanding Professional Award was given jointly to Dr. Robert Pynoos and Dr. John Fairbank, Co-Directors of the National Center for Child Traumatic Stress, for their marvelous leadership of the NCTSN.

The 2005 APSAC Colloquium will be held in New Orleans June 15-18. Hopefully, all of you have received the program brochure via e-mail or by regular mail. Highlights of the 2005 Colloquium include the always well-received and respected Cultural Institute, a NCTSN sponsored pre-Colloquium Institute addressing childhood trauma in rural areas, a NCTSN track throughout the Colloquium, the membership luncheon and awards ceremony, and the Plenary Session featuring Dr. Sharon Cooper. So, make your hotel reservations early and join us for what should be a wonderful educational experience, plus the great food, music, and excitement of the incomparable New Orleans.

APSAC continues to sponsor other educational activities, including training institutes at the San Diego Conference (every January) on Responding to Child and Family Maltreatment and forensic interviewing clinics. This fall there will be two forensic clinics, one in Virginia and the other in Seattle. Recently, Jon Conte became the Chair of APSAC's Education and Training Committee and, under his leadership, APSAC will begin to explore other possible training and educational endeavors.

I would like to conclude my message by saying that it is an honor and privilege to be the President of APSAC. I am always amazed by the compassion of our membership and its dedication to improving the lives of children and families affected by child maltreatment, violence, and other childhood trauma. I would like to express my appreciation to APSAC's Board of Directors for all of its hard work and commitment in advancing our mission. I would like to express my sincere thanks to all of you for giving me the opportunity to lead an organization that I care so much about.

APSAC WEB SITE

APSAC has completed the first phase of the new Web site design with the University of South Florida (USF). Although this has been a challenge for members and staff, the initial outcome is a positive one. Daphne Wright,Operations Manager of APSAC, stated, "One primary goal of this office is to provide members and Web site visitors with the most up-to-date information on resources and upcoming training worldwide." Daphne also expects that the Web site will be an essential tool in building APSAC's relationship with established state chapters and in assisting to build others. Visit our new Web site at www.apsac.org.

STATE CHAPTER REPORTS

Just a reminder to state chapter leaders that the 2004 Chapter Annual Reports are due NOW. If you have not completed this report and need assistance, contact the APSAC home office at 843-764-2905 or 877-40A-PSAC. Take advantage of the Chapter Rebate and submit your complete Annual Report Today! Watch for the Chapter Annual Report form on our new Web site at www.apsac.org.

Take advantage of Chapter Rebates; encourage state chapter members to join the National APSAC organization. Help us to enhance the ability of professionals to respond to children and their families affected by abuse and violence.

A SPECIAL THANKS TO STATE CHAPTERS

APSAC would like to thank the state chapter leaders who participated in the APSAC survey and conference call in April. The input provided was valuable, and it will help APSAC move forward and strengthen its relationship with each state chapter in the future.

If chapter leaders are not aware of this survey or conference call, please contact the APSAC home office at 843-764-2905 or e-mail apsac@comcast.net. It was not our intent to leave you out of this process; attempts were made to reach you with the information available. Please accept APSAC's deepest apologies for our lack of updated contact information. If you contact the home office, our information will be updated immediately. Please assist this effort to strengthen our relationship with each state chapter. The APSAC home office looks forward to hearing from you.

ARE YOU INTERESTED IN RECEIVING THE *APSAC ADVISOR* ELECTRONICALLY?

The APSAC home office is polling members as to their level of interest in receiving the *APSAC Advisor* electronically, or print only, or both electronically and as a printed publication. Give us your input at apsac@comcast.net or call 843-764-2905.

REGISTRATION FORMS ONLINE

With the first phase of the Web site now completed, we are pleased to offer up-to-date information on clinics and colloquiums, registration forms, and contact information at www.apsac.org.

WELCOME ANDREA WRIGHT

Please welcome Andrea Wright to the operations management team of APSAC. Andrea has a master's degree in nonprofit management. Her areas of expertise include organizational development, marketing, grant writing, and fundraising. Andrea comes from organizations such as the American Red Cross, Girl Scouts of America, YMCA, the Group Home, and Good Will Hinckley Home for Boys and Girls. Please join us in welcoming her to the team.

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.

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CALL FOR PAPERS for the *APSAC ADVISOR*

Purpose: The *APSAC Advisor*, a quarterly publication of the American Professional Society on the Abuse of Children, serves as a forum for succinct, practice-oriented articles and features that keep multidisciplinary professionals informed of current developments in the field of child maltreatment. *Advisor* readers are the more than 2,500 social workers, physicians, attorneys, psychologists, law enforcement officers, researchers, judges, educators, administrators, psychiatrists, nurses, counselors, and other professionals who are members and supporters of APSAC.

Appropriate material: *Advisor* editors are seeking practical, easily accessed articles on a broad range of topics that focus on particular aspects of practice, detail a common problem or current issue faced by practitioners, or review available research from a practice perspective.

Inappropriate material: Articles should be well documented and of interest to a national multidisciplinary audience. The *Advisor* is not an appropriate outlet for poetry or fiction, anecdotal material, or original research-based articles heavy on statistics but lacking clear application to practice.

Length: *Advisor* articles range from 4 to 12 double-spaced manuscript pages set in a 12-point typeface.

Previous publication: The *Advisor* prefers original material but does publish excerpts from previously published articles on topics of unusual or critical interest.

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Submission: All articles should be typed and double-spaced in 12-point type on 8.5 x 11 inch white paper, and submitted with an accompanying disk in Microsoft Word and a brief cover letter indicating that the article is offered for publication in the *APSAC Advisor*. The *Advisor* uses the manuscript format set forth in the latest edition of the style manual of the American Psychological Association.

Please send unsolicited manuscripts to:
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NOTE: An abbreviated style sheet prepared by APSAC to assist *Advisor* authors in manuscript preparation is available from the editor in chief on request.

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Washington Update

Thomas L. Birch, JD
National Child Abuse Coalition

Budget Politics Threaten Child Welfare Funding

Congress returned from spring recess the first week of April to get back to work on reconciling the House and Senate budget resolutions that guide spending decisions for the 2006 fiscal year. In March, both houses of Congress passed by close votes—51 to 49 in the Senate and 218 to 214 in the House—their versions of the federal budget resolution for FY06. The budget bills pose serious consequences for services to children and families. More children who are abused or neglected will go unnoticed, and fewer of them will get the protection they need; less money for childcare means more children will be left alone or left in unsafe care while their parents work.

Both budget bills contain over $200 billion in cuts to domestic discretionary programs outside of defense and homeland security spending. Both budgets impose a 3-year cap on discretionary spending, locking in the proposed cuts in domestic programs. In addition, deep cuts are proposed in entitlement spending, significantly in Medicaid, and cuts are threatened in other programs serving low-income families, including the Earned Income Tax Credit, Temporary Assistance to Needy Families (TANF), food stamps, and child care.

Only the Senate measure withholds the Medicaid cuts. By a 52 to 48 vote, the Senate approved an amendment proposed by Sens. Gordon Smith (R-OR) and Jeff Bingaman (D-NM) to strike the Medicaid cuts from the Senate budget resolution. Unfortunately, Smith has offered that he will not insist on his amendment if it becomes a contentious issue when House and Senate meet in conference committee to develop a unified budget plan.

Although spending cuts are made in the name of deficit reduction, both budget resolutions would increase rather than decrease the deficit in the coming years. Provisions for further tax cuts are included in the budget bills, benefiting the wealthiest Americans, such as an extension on dividend income and capital gains tax cuts due to expire in 2008. The Urban Institute-Brookings Institution Tax Policy Center estimates that nearly three quarters of the benefits from these tax cuts will go to just 3.1% of American households.

During debate on the Senate budget resolution in March, Sen. Russell Feingold (D-WI) offered an amendment on the Senate floor to apply "pay-as-you-go" rules to tax cuts. The rule—which applies to spending increases, requiring a spending increase to be offset by a spending cut elsewhere in the federal budget—does not apply to proposed tax cuts. The Feingold amendment lost on a tie vote, 50 to 50. According to the Center on Budget and Policy Priorities, low revenues are the main reason for the rise in the deficit. As a share of the economy, revenues are lower than in any year in the past four decades, the Center says.

Despite the talk in Washington about the importance of reducing the size of the federal budget deficit—the President has promised to cut the deficit in half in 5 years—an analysis of the President's FY06 budget, prepared by the nonpartisan Congressional Budget Office, asserts that the President's budget not only fails at deficit reduction but would in fact increase the deficit by $104 billion over the next 5 years (2006 through 2010) and $1.6 trillion over the next 10 years (through 2015), compared with the deficits that would occur if no changes were made in current policies.

In fact, the tight budget President Bush sent to Congress in February set the tone for the direction taken by the congressional budget resolutions. In contrast to the election year budget the President proposed last year—to double funding for the Child Abuse Prevention and Treatment Act (CAPTA) basic state grants and community-based prevention grants, and to increase prevention and family support funds in the Safe and Stable Families Program—the budget proposal for 2006 would freeze most child welfare funding.

The Bush administration's $2.57 trillion budget request freezes most domestic spending and proposes eliminating or slashing funds for more than 150 federal programs, while providing significant increases in spending for defense and homeland security—and that does not include future expenses in 2006 for war operations in Afghanistan and Iraq.

The Administration's budget proposal explains that overall growth in discretionary spending is being held below the projected rate of inflation to 2.1%, meaning a reduction in real terms for total discretionary spending in the budget proposal. In fact, the President has proposed to cut spending by 1% in nonsecurity discretionary accounts, in effect to finance an increased national deficit program and to begin attempts to reduce the projected $427 billion federal budget deficit.

Several of the Bush administration's special initiatives receive priority attention in the 2006 budget. The administration proposes new spending at $10 million on maternity group homes, an initiative Congress has refused to fund in the past absent specific statutory authority. A major funding increase has been proposed as well for abstinence education. In 2005, $25 million in mandatory spending is allocated to the program, along with $99 million in discretionary spending. For 2006, the administration's budget eliminates the mandatory funding and requests a total of $138 million in discretionary appropriations to support abstinence education—an 11% increase overall. The Compassion Capital Fund, initiated by President Bush to support social services grants to faith-based organizations and other charitable groups, would almost double in the proposed budget.

Although the budget resolution's spending blueprint is still being developed, the appropriations process is already beginning in the background to consider funding priorities for the next fiscal year. While no date has been set for the House or Senate Appropriations Committee's consideration of the appropriations bills, congressional appropriators will start drafting their funding measures with the final spending levels for next year. Advocates are hoping the appropriators will be more generous than the budgeters have indicated.

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TANF Renewal Back on Congressional Agenda; Senate Panel Approves Service Provisions

Having failed last year to reauthorize the Temporary Assistance to Needy Families (TANF) program, Congress is making another go at it this year. Child protection and family support advocates scored a win in March with the Senate Finance Committee's agreement to include in its version of the TANF reauthorizing legislation provisions that would allow states to count rehabilitative activities toward work requirements to provide needed services to individuals with disabilities, mental impairments, and substance abuse problems.

The amendment to address the issue of individuals facing such barriers to employment derives from legislation introduced in February by Sens. Gordon Smith (R-OR) and James Jeffords (I-VT). Their bill, the Pathways to Independence Act of 2005, S.456, incorporated into the TANF measure, would permit a state to receive credit toward the work requirements under the TANF program for these individuals for more than 6 months.

Historically, the majority of children entering foster care come from families receiving cash assistance. Because the challenges that interfere with employment—such as disabilities, mental health problems, and substance abuse—can also interfere with adequate parenting, families facing these barriers to employment are at risk of coming to the attention of the child welfare system if their needs are not addressed in the public assistance program.

The Personal Responsibility and Individual Development for Everyone (PRIDE) Act, S.667, which reauthorizes TANF for 5 more years, passed the Finance Committee by voice vote on March 9. While giving states more flexibility in meeting the TANF work requirements by counting additional activities that help parents overcome barriers to employment, the bill would raise the number of work hours from 30 to 34. The bill increases by $6 billion funding for child care and adds $1 billion for the Title XX Social Services Block Grant. According to the Center for Law and Social Policy, the $6 billion in new child care funds would keep pace with inflation over the next 5 years and would meet the cost of a limited increase in TANF work participation requirements, but it would not expand access or increase quality of federal child care assistance.

In addition, the Senate measure designates dollars for programs to promote responsible fatherhood and encourage two-parent families and healthy marriages. It would also extend the annual appropriation for abstinence education programs for 5 years.

In the House, the Ways and Means Subcommittee on Human Resources, by a 7 to 4 vote on March 15, passed H.R. 240, the Personal Responsibility, Work, and Family Promotion Act of 2005, also reauthorizing TANF for 5 years. In addressing flexibility to count substance abuse treatment and mental health counseling toward the work requirement, the House bill would allow these rehabilitative activities to count only for the first 3 months of an individual's time on welfare, but not for the longer duration offered in the Senate bill.

The House bill adds only $1 billion in new money for child care, compared with $6 billion in the Senate's bill, and increases the required work hours to 40 instead of 34 as stated in the Senate measure. H.R. 240 also contains provisions regarding the promotion of healthy marriages, responsible fatherhood, and abstinence education.

In the last Congress, the House passed its TANF reauthorization bill in 2003. A companion bill stalled in the Senate in 2004 over procedural issues and partisan differences. The measure ground to a halt on the Senate floor after a bipartisan amendment passed adding $6 billion more in child care funding. Key issues in the TANF reauthorization again remain around child care funding, work requirements, and marriage promotion.

Court Finds Right to Counsel for Abused Children

Abused and neglected children "have both a statutory and a constitutional right to counsel," according to a February 7, 2005, ruling by a judge in the U.S. District Court for the Northern District of Georgia. In the case of *Kenny A. v. Perdue*,[1] a class action brought against Georgia's child welfare agency by Children's Rights, a national advocacy organization, charging the state with failure to provide adequate legal counsel to children while in the state's custody, Judge Marvin H. Shoob ruled that abused and neglected children in the Atlanta metropolitan area of Fulton and DeKalb Counties were denied effective legal representation.

Evidence presented to the court showed that counsel appointed to represent abused and neglected children in Fulton County had an average caseload of 439 children, and in DeKalb County an average of over 182 children, while the national standard for such caseloads is no more than 100 cases per attorney. In a survey conducted in 2003-4 by First Star, a Washington, D.C.-based advocacy organization, only about half the states require courts to appoint lawyers for abused children. The Child Abuse Prevention and Treatment Act requires of all states "that in every case involving an abused or neglected child which results in a judicial proceeding, a guardian ad litem…who may be an attorney or a court appointed special advocate…shall be appointed to represent the child in such proceedings."[2]

The Children's Rights organization is reported to say that no previous federal ruling has guaranteed the right to counsel for children in child welfare cases.

Notes:

[1]*Kenny A. v. Perdue*, 218 F.R.D. 277, 290-293 (N.D.Ga. 2003) at http://www.firststar.org/documents/KennyAOrder20050207.pdf.

[2]Child Abuse Prevention and Treatment Act [42 U.S.C. 5106a], Sec 106(b)(2)(A)(xiii), as reauthorized and amended by the Keeping Children and Families Safe Act of 2003.

About the Author

Since 1981, Thomas Birch, JD, has served as legislative counsel in Washington, D.C., to a variety of nonprofit organizations, including the National Child Abuse Coalition, designing advocacy programs, directing advocacy efforts to influence congressional action, and advising state and local groups in advocacy and lobbying strategies. Birch has authored numerous articles on legislative advocacy and topics of public policy, particularly in his areas of specialization in child welfare, human services, and cultural affairs.

Journal Highlights
Ernestine C. Briggs, 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

Can We Improve Decision Making in Forensic Child Sexual Abuse Evaluations?

Mental health professionals are often asked to provide data to assist legal decision makers in responding to allegations of child sexual abuse. Mental health professionals collect and compile data through the use of forensic interviews, psychological testing, and case record reviews, as well as by summarizing relevant findings from social science research. However, there is significant controversy related to the use of mental health professionals to help make decisions whether or not to substantiate unconfirmed allegations of sexual abuse. The available evidence indicates that, on the whole, these substantiation decisions currently lack adequate psychometric reliability and validity. An analysis of the empirical research indicates that at least 24% of these decisions reflect either false positives or false negatives. A more hopeful finding, however, is that reanalysis of existing research indicates that it may be possible to develop reliable, objective procedures to improve the consistency and quality of decision making in this domain. The authors propose a preliminary, empirically-grounded procedure for making substantiation decisions.

Herman, S. (2005). Improving decision making in forensic child sexual abuse evaluations. *Law & Human Behavior, 29*(1), 87-120.

PHYSICAL ABUSE

Identifying Factors and Responding to Families With Maltreated Infants

This study used a multistate data set of child protective services reports to examine factors seen in investigations of first incidents of infant maltreatment, and to determine which of these factors might predict future physical abuse. The Detailed Case Data Component of the National Child Abuse and Neglect Data System (NCANDS-DCDC) was reviewed to assess repeat reports of maltreatment on a cohort of children under the age of 3, who had first been maltreated during infancy. In NCANDS-DCDC data covering 1995-1999, there were 24,900 confirmed first-time reports of physical abuse among infants in eight states, an incidence rate of 2.4 confirmed reports per 1,000 infants. A second confirmed report of maltreatment occurred for 21.1% of these physically abused infants, but most repeat episodes of malreatment were designated as neglect. Emotional disturbance of caretakers, violence between caretakers, and prior physical abuse were all associated with increased risk of later physical abuse. The authors suggest that prevention strategies should address emotional disturbance of caretakers and violence within families of maltreated infants.

Palusci, V. J., Smith, E. G., & Paneth, N. (2005). Predicting and responding to physical abuse in young children using NCANDS. *Children & Youth Services Review, 27(*6), 667-682.

Cumulative Risks and Child Behavior Outcomes

Cumulative risk research has established the deleterious effects of co-occurring risk factors on child behavior outcomes. However, questions remain whether a threshold model or a linear risk model better describes the impact of cumulative risk on behavior outcomes. The current study examined the impact of cumulative risk factors (i.e., child maltreatment, interparental violence, family disruption, low socioeconomic status, and high parental stress) in early and middle childhood on child behavior outcomes in adolescence (N=171). The findings support the cumulative risk hypothesis that the number of risks in early childhood predicts behavior problems in adolescence. Evidence was found for a linear, but not a threshold, model of cumulative risk: the more risks present, the worse the child outcome. The authors conclude that there is a need for comprehensive prevention and early intervention efforts with high-risk children and that every risk factor we can reduce matters.

Appleyard, K., Egeland, B., van Dulmen, M., & Sroufe, L. A. (2005). When more is not better: The role of cumulative risk in child behavior outcomes. *Journal of Child Psychology & Psychiatry, 46*(3) 235-245.

Impact of Exposure to Marital Violence

The goal of this study was to examine the psychological and physiological functioning of children who had been exposed to marital violence. The researchers compared a group of children who had been exposed to marital violence with a clinical comparison group of children who had not been exposed to marital violence. The researchers found higher levels of symptoms of trauma among children who had been exposed to marital violence. They also found differences between the two groups of children regarding sympathetic nervous system functioning and hypothalamic-pituitary-adrenal (HPA) axis functioning. Children who had been exposed to marital violence had increased heart rates and higher levels of salivary cortisol. These findings suggest that children who have been exposed to marital violence experience physiological reactions to trauma in addition to psychological trauma symptoms.

Saltzman, K. M., Holden, G. W., & Holahan, C. J. (2005). The psychobiology of children exposed to marital violence. *Journal of Clinical Child and Adolescent Psychology, 34*(1), 129-139.

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Child Abuse and the Clinical Course of Bipolar Disorder

The investigators examined the relationship between childhood abuse and traumatic events in childhood, and bipolar disorder in adulthood. This relationship was examined by evaluating the prevalence of childhood abuse among a sample of in-patients (N=100) who had been admitted to a specialty center for bipolar disorder. The investigators found that severe emotional abuse was significantly related to lifetime substance use, as well as to rapid mood cycling within the previous year. Logistic regression analysis found that the lifetime number of suicide attempts was significantly related to severe childhood sexual abuse. Approximately half of the study participants reportedly had experienced severe abuse in childhood. Multiple forms of abuse were related to both a graded increase in risk of suicide attempts and rapid mood cycling. The authors concluded that severe childhood trauma could lead to further psychopathology in adulthood.

Garno, J. L., Goldberg, J. R., Ramirez, P. M., & Ritzler, B. A. (2005). Impact of childhood abuse on the clinical course of bipolar disorder. *British Journal of Psychiatry, 186*(2), 121-125.

Effects of Trauma Across the Lifespan

The investigators explored the relationships among exposure to childhood abuse and other traumatic events, adolescent conduct problems and substance abuse, and adult psychological distress and criminal behaviors in a sample of substance-abusing women offenders (N=440). The results indicated direct relationships between childhood traumatic events and both greater adolescent conduct problems and substance abuse. Conduct problems predicted adult criminal behaviors; substance abuse in adolescence predicted higher levels of adult psychological distress. The investigators found direct relationships between different types of traumatic events and current psychological distress, as well as direct relationships between traumatic events and specific criminal behaviors. Ethnic differences were found within the sample, suggesting potentially different pathways to criminal behavior. The investigators concluded that their findings provided support for the need to provide trauma-related services to substance-abusing women offenders.

Grella, C. E., Stein, J. A., & Greenwell, L. (2005). Associations among childhood trauma, adolescent problem behaviors, and adverse adult outcomes in substance-abusing women offenders. *Psychology of Addictive Behaviors, 19*(1), 43-53.

OTHER ISSUES IN CHILD MALTREATMENT

Is PTSD a Culture-Bound Phenomenon?

The researchers compared adolescents (N=2,157) from the United States (n=1,212) and Russia (n=945). Data were collected using surveys administered to randomly-selected adolescents living in urban areas. The research compared adolescents from the two countries who reported posttraumatic symptoms. In both groups, posttraumatic symptoms, such as reexperiencing an event, avoidance, and arousal, and internalizing psychopathology increased as the levels of posttraumatic stress increased. As posttraumatic stress increased, expectations about the future also tended to decrease for both groups of adolescents. The two groups were not significantly different, nor were there differences in significant interaction effects for symptom levels. The authors concluded that posttraumatic symptoms, the relationship between posttraumatic symptoms and other mental health problems, and the psychological consequences of trauma are not culture-bound but, instead, are similar cross-culturally.

Ruchkin, V., Schwab-Stone, M., Jones, S., Cicchetti, D. V., Koposov, R., & Vermeiren, R. (2005). Is posttraumatic stress in youth a culture-bound phenomenon? A comparison of symptom trends in selected U.S. and Russian communities. *American Journal of Psychiatry, 162*, 538-544.

Biological Aspects of PTSD in Children

The investigators expanded on previous research findings that children with chronic posttraumatic stress disorder (PTSD) had altered levels of catecholamines and cortisol compared with traumatized children who did not meet the diagnostic criteria for PTSD. These findings were expanded by examining urinary hormone levels in children immediately upon admission to a Level I trauma center, before acute PTSD symptoms were recorded. The goal was to study the relationship between catecholamines and cortisol levels and the development of PTSD symptoms. PTSD symptoms were assessed 6 weeks later. The investigators found that initial urinary cortisol levels were significantly correlated with subsequent PTSD symptoms. After removing the variance associated with demographic variables and depressive symptoms, urinary cortisol and epinephrine levels continued to predict a significant percentage of the variance in 6-week PTSD symptoms. Individual examination of boys and girls suggested that significance was primarily driven by the strength of the relationships between hormone levels and acute PTSD symptoms in boys.

Delahanty, D. L., Nugent, N. R., Christopher, N. C., Walsh, M. (2005). Initial urinary epinephrine and cortisol levels predict acute PTSD symptoms in child trauma victims. *Psychoneuroendocrinology, 30*(2), 121-128.

CONFERENCE CALENDAR

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: 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

July 18-20, 2005
National Institute of Justice's 12th Annual Conference
Washington, DC
call 703-864-5300
or visit: www.nijpcs.org/RE

August 25-28, 2005
NACC 28th National Children's Law Conference
Los Angeles, CA
call 303-864-5322 or fax: 303-864-5351
or visit: www.naccchildlaw.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

September 19-23, 2005
APSAC's Forensic Interviewer Clinic
Portsmouth, VA
call Patti Toth 206-835-7293
or 877-40APSAC
or e-mail: ptoth@cjtc.state.wa.us
or visit: www.apsac.org

October 10-14, 2005
APSAC's Forensic Interviewer Clinic
Seattle, WA
call Patti Toth 206-835-7293
or 877-40APSAC
or e-mail: ptoth@cjtc.state.wa.us
or visit: www.apsac.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: www.nbcdi.org/ac/cfp/05/

October 24-28, 2005
Our Kids Training in the Evaluation and Management of Child Sexual Abuse
Nasheville, TN
call 615-341-4920
or e-mail: Suzanne.v.petrey@vanderbilt.edu

October 26-28, 2005
7th Annual Conference on the Power of Mission Centered Grantsmanship, Scottsdale, AZ
call 913-980-5310
or visit: www.grantprofessionals.org

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
ATSA's 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

April 24-28, 2006
APSAC's Forensic Interviewer Clinic
Seattle, WA
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APSAC's 13th Annual Colloquium
June 15-18, 2005
Sheraton Hotel, New Orleans

APSAC Child Forensic Interview Clinics
September 26-30, 2005
Portsmouth, VA
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October 10-14, 2005
Seattle, WA
&
April 24-28, 2006
Seattle, WA

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